AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 27TH SEPTEMBER 2016 VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting of the Board of Directors held on **21st July 2016**.		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 8	To consider the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**
Item 9	To receive and note a progress report on actions to address waiting times in Children and Young People's Services.	**BK**	**Attached**

Strategic Items (10.20 am)

Item 10	To approve the Trust's submission to NHS England with regard to compliance with the Core Standards for Emergency Preparedness, Resilience and Response. (Note: The recommendation of the Audit Committee on the above matter will be reported verbally to the meeting).	**BK**	**Attached**

Performance (10.25 am)

Item 11	To consider the Finance Report as at 31st August 2016.	**DK**	**Attached**
Item 12	To consider the Trust Performance Dashboard as at 31st August 2016.	**SP**	**Attached**
Item 13	To consider the Strategic Direction Performance Report for Quarter 1, 2016/17.	**SP**	**Attached**

Governance (10.45 am)

Item 14	To review the terms of reference of the Board's Committees.	**PB**	**Attached**
Item 15	To appoint Non-Executive Directors to seats on the Board's Committees.	**Chairman**	**Attached**
Item 16	To approve the indicative Board Business Cycle for October 2016 to December 2017.	**PB**	**Attached**
Item 17	To receive and note the Register of Interests of the Board of Directors.	**PB**	**Attached**

Items for Information (11.00 am)

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

Item 20 To note that the next meeting of the Board of Directors will be held in public on Tuesday **25th October 2016** in The Hilton York, 1 Tower Street, York, YO1 9WD at 9.30 am.

Confidential Motion (11.05 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 any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

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

Any 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.

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
21st September 2016

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 21ST JULY 2016 IN ROOM J007/8 CLEVELAND WAY, ROSEBERRY PARK, MIDDLESBROUGH 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
Mr. D. Jennings, Non-Executive Director
Mrs. B. Matthews, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. D. Kendall, Interim Director of Finance and Information
Mr. B. Kilmurray, Chief Operating Officer and Deputy Chief Executive
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:
Dr. L. N. S. Murthy and Mr. P. Burgess, Public Governors for Durham
Mr. N. Ayre
Mr. D. Brown, Director of Operations for Teesside (minute 16/180)
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications

Ms. A. Gilmore, Ms. P. Godfrey, Ms. S. Golden, Mr. S. Gradon and Ms. Y. Halpin, student nurses

16/174 APOLOGIES

Apologies for absence were received from Dr. H. Griffiths, Non-Executive Director.

16/175 MINUTES

Agreed *– that the public minutes of the meeting held on 21st June 2016 be approved as a correct record and signed by the Chairman.*

16/176 PUBLIC BOARD ACTION LOG

It was noted that there were no outstanding matters included in the Public Board Action Log.

Further to minute 16/135 (24/5/16), and in response to interest being expressed by the Non-Executive Directors, the Chairman considered that it would be beneficial to provide a briefing on pathways to a future Board Seminar.

Action: Mr. Bellas

16/177 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/178 CHAIRMAN'S REPORT

The Chairman reported that:

(1) Her activities since the last meeting had been curtailed due to leave.

(2) Her engagements over the next few weeks included meetings with the Experts by Experience in York and of the NHS Providers Chairs and Chief Executives Network.

(3) It was also hoped that a meeting of the Chairmen of local provider Trusts would be held in the near future.

(4) At its meeting held on 12th July 2016 the Council of Governors had appointed two new Non-Executive Directors (Mrs. Shirley Richardson and Mr. Paul Murphy) whose terms of office would commence on 1st September 2016.

16/179 GOVERNOR ISSUES

No issues were raised.

16/180 LOCALITY BRIEFING – TEESSIDE

Mr. Brown (Director of Operations) gave a presentation on the key issues facing the Teesside Locality.

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

Arising from the presentation Board Members raised the following issues:

(1) The resilience of staff on wards.

The Chairman highlighted the excellent work being undertaken by staff but raised concerns about their resilience in the face of constant pressure.

(2) The review of the 12 hour shift system.

The Chairman welcomed the review of the 12 hour shift system including whether greater flexibility could be provided for staff.

On this matter Board Members noted that staff had differing views on the benefits of 12 hour shifts; the evidence base to support the review was limited; and any changes to the shift system were likely to have financial implications.

(3) Bed occupancy in learning disability inpatient services.

It was noted that Commissioners had raised the issue of high bed occupancy in learning disability services in the Locality; however, Mr. Brown reported that the number of admissions to assessment and treatment beds had reduced significantly since the introduction of the extended learning disability community

teams and work was being undertaken, through supporting care providers in difficulty, to seek to ensure suitable and sustainable placements could be arranged for service users.

(4) The response to the Trust's decision to withdraw from providing IAPT services in the Locality.

Mr. Brown reported that:

(a) As a result of staff flexibility and excellent redeployment processes, only two, of the 40 staff previously employed by the IAPT service in Teesside, would not be placed in other services by the end of September 2016.

He also advised that staff formerly employed in the IAPT service had made a significant contribution to other services in the Locality e.g. through supporting the reduction in waiting times for children and young people's services (C&YPS) in Stockton.

(b) The withdrawal from the contract had resulted in an increase in referrals to the Trust's affective disorder teams particularly in Redcar and South Tees but this had now levelled out. This increase in referrals had been expected and the contingency arrangements put in place had been effective.

(c) The positions of other providers of IAPT services since the Trust's withdrawal from the contract were unknown; however, it appeared that the Commissioners had spent more on the services than planned.

(5) Whether any action could be taken to address the difficulties being experienced in the nursing home sector.

Mr. Brown advised that there was little prospect of any changes which would improve nursing home provision.

It was noted that the key issues being experienced in the nursing home sector were as follows:

(a) The lack of placements and high costs for patients with challenging behaviour.
(b) Difficulties in recruiting staff.
(c) The lack of support for registered nurses working in the homes.
(d) The regulatory requirements placed on nursing homes.

(6) The foresight of Commissioners in the Locality.

Mr. Brown acknowledged that the Commissioners in the Locality had acted positively in supporting the Trust's response to the Five Year Forward View and national investment in C&YPS and liaison services.

It was also noted that the Commissioners had been the first to agree to ring fence the budget for mental health services and had, thereby, provided headroom for the Trust to make investments.

At the conclusion of the discussions the Chairman asked Mr. Brown to pass on the Board's thanks to staff in his Locality for their hard work and to inform them that the

difficulties they faced and the fantastic achievements they had made were recognised and appreciated.

16/181 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 2th June 2016 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 7th July 2016.

Mrs. Moody reported that, at the latter meeting, the Committee had:

(1) Received the Safeguarding and Patient Safety Annual Reports.

(2) Reviewed its results, and feedback received, under the Board Performance Evaluation Scheme.

Mrs. Moody outlined the areas with the lowest scores and the actions taken to address them as follows:

(a) Clarity of responsibilities with reference made to the need for greater consistency of LMGB/QuAG reporting into QuAC; issues around a lack of understanding of assurance in reports; and some reports being too descriptive.

It was noted that:

- Members of the Committee believed this area had improved considerably since the evaluation.
- The feedback had highlighted a lack of shared understanding of assurance and the Committee had recommended that this topic should be explored further at a Board Seminar.

(b) Compliance with the terms of reference with uncertainty around any review of Sub-Groups reporting into QuAC.

It had been noted that the terms of reference of the sub-groups had been reviewed since the evaluation.

(c) The adequacy of the induction programme.

It had been noted that a revised induction programme would be in place for newly appointed Members of the Committee from the autumn.

(d) The length and format of information provided to the Committee.

On this matter it was noted that the Committee considered that further improvements could be made to the analysis and presentation of information included in reports.

With regard to the above recommendation, the Chairman:

(1) Agreed that a Board seminar on assurance should be arranged but the discussions should be seen in the broader context of Board effectiveness and the relevance of the topic to all the Board's Committees.

Action: Mr. Martin

(2) Agreed to consider a suggestion that the Internal Auditors should be asked to support the discussions at the seminar.

(3) Highlighted that staff preparing reports for and attending committee meetings needed to be supported in understanding the role and requirements of the Non-Executive Directors.

16/182 NURSE STAFFING REPORT

The Board received and noted the report on nurse staffing for May and June 2016 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").

Mrs. Moody highlighted the following matters included in the report:

(1) The number of rosters had remained static within the reporting period at 67.

(2) The month on month trend showed a deterioration in June, when compared to May, but the position remained within the Trust's tolerance levels.

(3) The number of wards with "red" rated fill rates had increased to 51 in June, from 32 in May, with the majority falling into the Registered Nurse on Day shifts category; however, the position for the former month was not unusual when compared to other months.

Mrs. Moody considered that the position in June could be attributed to the amount of leave being taken at that time of year and the level loading of holidays across the year might need to be reviewed.

(4) Forensic services continued to have the highest number of wards rated as "red" across all metrics at 26. This represented a significant increase on May (14) but, once again, the position was not unusual compared to other months.

(5) Five wards had bank usage in excess of 50% in May and June 2016.

It was noted that the accuracy of the data for the ward with the highest bank usage at 75%, Westerdale South, was being checked.

(6) Agency usage remained low equating to 0.5% of the total hours worked in May and 0.73% of the total hours worked in June.

(7) The triangulation of staffing and quality data had not identified any direct risks or implications to patient safety or experience within the reporting period.

(8) Further to minute 16/159 (21/6/16) serious incidents and complaints where staffing levels were cited as a contributory factor would be explored in the next monthly safe staffing report.

(9) The findings of the pilot of the escalation protocol in the Tees Locality were due to be reported to the Operational Management Team in August 2016 prior to being rolled out.

(10) Revised guidance ("Safe, Sustainable and Productive Staffing") had been published by the National Quality Board (NQB) in July 2016.

It was noted that:

(a) Overall the content built on previous guidance and was largely as expected.

(b) The guidance remained focused on acute services. This included the implementation of the Carter metric based on care hours per patient day which did not measure direct patient care hours.

(c) In terms of Board reporting the guidance proposed:

- An annual strategic staffing review.
- Comprehensive six monthly staffing reports to assess the strategic staffing review and to monitor its implications.
- A broader multi-disciplinary approach to the consideration of safe staffing including recruitment, retention and staff skills.

Mrs. Moody undertook to provide further information on the NQB guidance in the next monthly safe staffing report.

Action: Mrs. Moody

(11) The resources being developed by NHS Improvement for specific care settings, including mental health and learning disability services, were not yet available and were now expected to be published in 2017.

Board Members raised the following matters:

(1) The ease by which amendments could be made to the rostering system to take into account service changes.

Mrs. Moody advised that the process of making changes to the roster was not straightforward and work was ongoing through the safe staffing sub-group, with support from the Finance Directorate, to address issues; however, this would need to be reviewed in line with the outputs from the strategic staffing review when completed.

(2) The lack of explanations received from services in relation to high/low fill rates.

Mrs. Moody explained that:

(a) Under usual circumstances, data was extracted from the healthroster on a particular date, validated with services and then considered by the Operational Management Team so that explanations could be provided for any anomalies.

(b) It had not been practicable to follow the process this month due to the early Board meeting and, therefore, the information contained the report had not been validated by services.

The Board noted that the Chairman and Mrs. Moody had discussed future reporting arrangements to the Board based on brief monthly exception reports with more comprehensive six monthly reports (with greater analysis of the data, consideration of issues and identification of actions) to enable in-depth discussions at meetings.

However, Mrs. Moody highlighted that, under minute 16/159, the Board had recognised that the present approach to the triangulation of data provided some assurance that the Trust had sought to identify clusters of complaints, etc. and

there would be a gap if this information was not reported elsewhere e.g. to the LMGBs.

It was noted that this issue was being considered by the Director of Quality Governance.

(3) The apparent inconsistency between the information on bank and agency usage/costs in the safe staffing report and the finance report.

In response it was noted that:

(a) Agency expenditure in the finance report included medical staffing whilst the safe staffing report focussed solely on nursing staff.

(b) Bank usage in the safe staffing report was based on the percentage of total hours worked and the costs of this might, therefore, be offset by vacancies, etc.

16/183 ANNUAL REPORT ON PROGRESS ON ACTIONS FROM DIRECTORS' VISITS

The Board received and noted the annual report on progress on actions arising from Directors' visits.

Mr. Kilmurray reported that:

(1) This was the first annual report on Directors' visits since it had been agreed to increase their frequency from bi-monthly to monthly in response to learning from the approach adopted by East London NHS Foundation Trust (minute 15/C/259 - 18/8/15 refers).

(2) The Executive Management Team had discussed future reporting arrangements in response to the changes and the increase in the number of actions arising from the visits.

The Board discussed whether there were sufficient opportunities to meet with staff during the visits.

The Chairman advised that feedback had been received from staff that they had difficulty meeting with Directors during visits. The reasons given for this included that they were unaware that the visits were being held and that they were hesitant in raising issues with Directors due to senior staff from the Locality being present. She considered that the opportunities to meet with groups of staff during Structured Board visits (as previously held), which had been beneficial to both Directors and staff, had been lost under the revised arrangements.

Board Members recognised the importance of meeting with staff during their visits in view of the assurances this provided.

The following points were raised during the discussions:

(1) It was, generally, considered easier to meet staff in ward based or corporate services as staff in community services tended to be working away from their bases; however, the Chairman reported that difficulties in meeting with Directors had also been fed back by ward based staff.

(2) Services had been required to prepare for Structured Board Visits, including arranging meetings with groups of staff, but this was not now required as the visits were informal.

Board Members recognised the importance of the visits remaining informal but considered that further guidance on the expectations of Directors, including opportunities to meet with groups of staff, should be issued to services prior to visits.

(3) It would be beneficial to restrict the number of visits undertaken on each occasion as, at present, time pressures arising from visiting up to three wards on the same afternoon made engagement with staff difficult.

Arising from the discussions it was:

Agreed -

(1) that the guidance provided to services be amended to emphasise that opportunities should be provided for Directors to meet with groups of staff during their visits;

Action: Mr. Kilmurray

(2) that limits be placed on the number of teams/wards to be visited on each occasion when the visiting schedule is refreshed; and

Action: Mr. Martin

(3) that the approach taken to Director visits by East London NHS Foundation Trust be revisited to seek further learning.

Action: Mr. Martin

16/184 LOCAL FREEDOM TO SPEAK UP GUARDIAN

Further to minute 16/128 (24/5/16), consideration was given to the report on proposals for the establishment of the Trust Freedom to Speak Up Guardian.

Mr. Levy reported that:

(1) In view of the limited number of responses, it had not been possible to draw any firm conclusions about the Trust's approach to the appointment and role of the Freedom to Speak Up Guardian from the consultation exercise undertaken during June and July 2016.

(2) The views of other Trusts, who had already appointed their Freedom to Speak Up Guardians, had also been sought.

(3) The Board was recommended to take a wide ranging approach to the appointment of the local Freedom to Speak Up Guardian through seeking applications from both within and outside the Trust.

(4) It was suggested that the Freedom to Speak Up Guardian should be engaged for one day per week.

The focus of the discussions was on the role description for the Freedom to Speak Up Guardian (Appendix 1 to the above report) in view of concerns that:

(1) The duties were unrealistic in both number and scope e.g. the ability to "Be a highly visible individual, who spends the majority of their time with 'front line' staff" within the proposed working hours.

(2) The framing of certain duties lacked specificity e.g. in relation to the range and nature of complaints to be reviewed.

Mr. Levy responded that:

(1) It was not expected that the Freedom to Speak Up Guardian would work in isolation but that a network would be developed to support them undertake their role.

(2) It was recognised that the Trust would need to go through a process to distinguish the role of the Freedom to Speak Up Guardian from other approaches.

However, he undertook to review the role description, drawing on national guidance, in response to the concerns raised.

Action: Mr. Levy

In addition, in response to questions, Mr. Levy advised that:

(1) At present it was expected that the Freedom to Speak Up Guardian would be treated as an employee rather than an office-holder, in common with the approach taken by other Trusts, but this could be reviewed in the light of the applications received.

(2) It was recognised that work was required to raise awareness of the role within the Trust (e.g. through the development of a communications plan and reference in training on the whistleblowing procedure) but, in doing so, care was needed to ensure the post-holder did not become overwhelmed with enquiries.

Agreed –

(1) that the proposed Freedom to Speak Up Guardian role description (attached as Appendix 1 to the above report) be reviewed with a view to moderating expectations and to provide greater clarity on the duties to be undertaken by the post-holder; and

(2) that following the review and approval of the role description:

(a) applications for appointment as the Local Freedom to Speak Up Guardian be invited from candidates both inside and outside the Trust; and

(b) that the Chief Executive and Lead Executive and Non-Executive Director, together with a nominated service user and a nominated staff representative participate in the recruitment process for the Trust Freedom to Speak Up Guardian.

Action: Mr. Levy

16/185 SUMMARY FINANCE REPORT AS AT 30TH JUNE 2016

Consideration was given to the summary Finance Report as at 30th June 2016 including the declarations in relation to finance for Quarter 1, 2016/17, as required under NHS Improvement's Risk Assessment Framework.

Mr. Kendall reported that:

(1) The comprehensive income outturn for the period was a surplus of £3.9m and ahead of Plan.

(2) Identified CRES savings as at 30th June 2016 were in line with Plan.

(3) The Trust had maintained a Financial Sustainability Risk Rating of 4 for Quarter 1, 2016/17.

Agreed –

(1) that the report be received and noted; and

(2) that the following declarations for Quarter 1, 2016/17, be signed off and submitted to NHS Improvement:

(a) "The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months."

(b) "The Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return."

Action: Mr. Kendall

16/186 PERFORMANCE DASHBOARD AS AT 30TH JUNE 2016

The Board received and noted the Performance Dashboard Report as at 30th June 2016.

With regard to "out of locality admissions" (KPI 9) Mrs. Pickering advised that:

(1) The bed reductions at Cross Lane Hospital, referenced in the report, had not yet been made but were planned.

(2) The key issues impacting on performance against the indicator in the North Yorkshire Locality were the level of admissions and the difficulties being experienced in placing people into care packages.

Board Members considered that:

(1) The Trust's overall performance was positive in the context of known pressures (e.g. the increases in referrals, etc.) and the key risks identified in the report reflected feedback received from services.

(2) The position on "out of locality admissions" should improve from September 2016 with the opening of Peppermill Court in York.

However, Mrs. Pickering advised that there were risks that the impact of the opening of the new development might not be as great as hoped.

In response to a question, Mr. Kilmurray confirmed that it was extremely rare for the Trust to admit a patient out of the Trust's area with only one instance of this in recent years.

16/187 QUARTERLY WORKFORCE REPORT

The Board received and noted the Workforce Report for the period April to June 2016 including:

(1) Performance information about the whole Trust workforce (Appendix 1 to the report).

(2) Information about medical staffing issues and performance (Appendix 2 to the report).

(3) The results of the Trust's Staff Friends and Family Test (FFT) for Quarter 1, 2016/17 (Appendix 3 to the report).

(4) Information on the Trust's culture metrics (Appendix 4 to the report).

Mr. Levy advised that:

(1) He was part way through revising the workforce report and it was planned that the final version would be available for the Board meeting to be held on 25th October 2016.
(2) The changes made to date included greater focus on recruitment; the health and wellbeing of staff; and the reasons for staff leaving the Trust.
(3) It was hoped that data provided in the revised reports would be more useful to the Board and the Localities.

In response to a question, it was noted that the data included in the report, that 17 staff from the York and Selby Locality had left the Trust in the last six months, was incorrect.

The Board's discussions focussed on the following matters:

(1) The number of consultants leaving the Trust.

Dr. Land drew attention to tables 8 and 9 included in the Medical Staffing Report which showed that over the last two years:

(a) Ten consultants had retired; however, five had returned to work under flexible retirement arrangements.
(b) Eight consultants had moved abroad; approximately half to take advantage of interesting opportunities and the remainder not wishing to continue working in the NHS.
(c) Eight had left to join other Trusts.
(d) Five had left to undertake alternative work e.g. in the private sector.

In addition, it was noted that, in the last three months, seven consultants had left the Trust and only two new ones had been recruited.

Dr. Land assured the Board that every effort was made to persuade consultants to remain with the Trust and, to support this, he intended to present a range of further proposals to support recruitment and retention to the Executive Management Team.

The Chairman, noting the difficulties in attracting applicants for consultant posts, highlighted the general inexperience of appointees and sought clarity on whether this was a national trend.

Dr. Land responded that:

(a) The Trust had a very good record of recruiting consultants from its higher trainees; however, it was recognised that they required support and mentoring following their appointment.
(b) A significant risk to the Trust's approach was that difficulties had been experienced in filling core trainee schemes but the position was improving.
(c) Consultants also tended to have less experience than previously due to the reduction in the length of the training period.

In response to a question, the Board noted that there was some optimism that the expansion into York and Selby, with the development of strong academic

liaison between the Trust and the University of York, would support the future recruitment of consultants.

(2) The guidance sought from the Board on the future approach to the culture metrics.

In the report the Board was recommended to decide whether to retain the current culture metrics, to enhance the current culture metrics or to cease reporting on them.

The Chairman considered that:

(a) Some of the information provided by the culture metrics contradicted other data e.g. on reasons for leaving the Trust.
(b) The CQC had found that the Trust's values and behaviours were well embedded.
(c) The Trust's values were appropriate but further thought needed to be given to the linkages between values, behaviours and culture.

It was noted that the "embedding the values" course was focused on helping staff, through reflection on practical examples, to achieve a full understanding of the Trust's values.

At the conclusion of the discussions Mr. Levy undertook to bring forward proposals on refreshing the Trust's approach to embedding the values including working with the Director of Nursing and Governance to ensure it was more aligned to feedback provided by patients and carers.

Action: Mr. Levy

(3) The percentage of staff leaving the Trust to seek promotion (the reason given by approximately 35% of leavers).

On this matter:

(a) Mr. Levy advised that professional staff appeared to be less willing to wait before seeking promotion than previously.
(b) Dr. Land reported that there were very limited opportunities within the Trust for psychologists employed at band 8a to progress to bands 8b or 8c and they were, therefore, attracted to take positions on those grades at other Trusts which were more prevalent due to their staffing structures.

In response to questions it was noted that:

- Changes to the staffing structure to create more 8b posts would be costly and there were no difficulties, at present, in recruiting psychologists.
- There could be opportunities for promotion through making appropriate changes to the skill mix e.g. the successful appointment of a consultant clinical psychologist to fill a consultant position at Roseberry Park.

(c) It was also noted that staff could give more than one reason for leaving the Trust.

At the request of Board Members, Mr. Levy undertook to include a breakdown of leavers by professional group in future reports.

Action: Mr. Levy

16/188 RISK ASSESSMENT FRAMEWORK REPORT

Further to minutes 16/185 and 16/186 above, consideration was given to the Risk Assessment Framework Report for Quarter 1, 2016/17.

Agreed –

(1) that the Quarter 1, 2016/17 Risk Assessment Framework submission be approved including:

(a) confirmation of the following governance statements:

- *"The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards."*
- *"The Board confirms that there are no matters arising in the quarter requiring an exception report to NHS Improvement (per Risk Assessment Framework page 21 Diagram 6) which have not already been reported."*

(b) the declaration that no subsidiaries were consolidated in the financial information provided;

(c) the information required on Executive Team turnover, as included in the above report;

(d) the Election Report, as included in the above report;

(e) the exception report set out in Annex 2 to the above report including information on the progress of capital works in the York and Selby Locality as requested by NHS Improvement in its "feedback" letter dated 30th June 2016; and

(2) that the Quarter 1, 2016/17 Risk Assessment Framework return be submitted to NHS Improvement by 29th July 2016.

Action: Mr. Kendall and Mr. Bellas

16/189 USE OF THE TRUST SEAL

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

16/190 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.

16/191 DATE AND TIME OF NEXT MEETING

The Board discussed whether the special Board meeting and seminar, scheduled for 16th August 2016, should be held in view of a lack of pressing business.

It was noted that:

(1) In accordance with usual practice, finance, performance dashboard and nurse staffing reports would be circulated to Board Members under separate cover.

(2) One issue likely to arise during the month was the pre-publication of a report on an independent inquiry by NHS England.

Board Members, taking into account Mrs. Moody's advice that the report was unlikely to contain material recommendations for the Trust, considered that this matter could be dealt with under the Emergency Powers included in Standing Orders.

In the circumstances, it was:

Agreed -

(1) that the Board meeting and seminar, scheduled to be held on 16th August 2016, be cancelled; and

(2) that any matters requiring a Board decision prior to the next meeting, due to be held on 27th September 2016, be either dealt with under emergency powers or, if inappropriate, a special meeting be arranged.

16/192 CONFIDENTIAL MOTION

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

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

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

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

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

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

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

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

16/193 MRS. BARBARA MATTHEWS

The Chairman reported that, as a result of the decision under minute 16/191 above, this would be Mrs. Matthews's last Board meeting prior to her retirement as a Non-Executive Director at the end of August 2016.

On behalf of colleagues, the Chairman thanked Mrs. Matthews for her excellent work and support for the Trust over the last six years and wished her well for the future.

Following the transaction of the confidential business the meeting concluded at 1.05 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees Locality Board Presentation 23rd July 2015

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

- Last time
  - Patient experience, SWEMWEBs, HoNOS
  - CQC Feedback
  - Crisis Assessment Centre, CYP Crisis Team, 0-4 services including perinatal care,
- Now
  - Rehabilitation community service,
  - Extended ALD teams,
  - Roseberry Park bed use
  - CYP waiting times and external feedback

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work.

- Last time
  - QIS
  - Productivity
- Now
  - QIS
  - PPCS
  - PIPA reboot

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Last time
  - A lot of internal circulation to staff new developments
  - Talent management
  - Locality Head of Nursing post appointed full time
- Now
  - Better arrangements to recruit registered nurses
  - Ability to recruit medical and nursing staff still a concern

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
  - Children's Hubs
  - Better Care Fund extension too ICLS
- National
  - No formal links nationally
- International
  - Asklepios – use of beds, FACT, Refugees.

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**
  - Then, medical locums– no change, enhanced observations – still a pressure
  - Now, also respite services in LD, delayed CRES and nursing home closures impacting on discharges
  - But - investment in new services and money for pressures has still come through
- **LMGB**
  - QAGs managing broad range of issues
  - Looking to review LMGB arrangements after several years!

making a difference together

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th September 2016**
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
24/11/2015	15/321	In future assurance on the self-assessment ratings of the Core Standards for Emergency Preparedness, Resilience and Response to be provided to the Board by the Audit Committee	BK	Sep-16	See Agenda Item 10
26/01/2016	16/12	The Equality Data Document to be used in the 2016/17 Annual Planning Cycle	SP	Oct-16	
22/03/2016	16/65	The action plans and governance arrangements to take forward the Trust's equality objectives for 2016/2020 to be more explicit on the carrying forward and embedding of work to support the 2012 objectives	DL	Sep-16	
26/04/2016	16/94	Report to be provided to the Board on the impact and lessons learnt from the Safe Staffing Project	EM	Nov-16	
24/05/2016	16/121	Dr. Alison Brabban to be invited to provide a briefing on the Recovery Programme when the business case for its next phase of development is due to be considered by the Board	BK/PB	Dec-16	See Agenda Item 16
24/05/2016	16/121	The Experts by Experience to be invited to attend Board Seminars to provide their stories	BK/PB	Dec-16	See Agenda Item 16
24/05/2016	16/123	A briefing on human rights to be provided to a future Board Seminar	DL/PB	-	See Agenda Item 16
24/05/2016	16/126	A progress report on the work being undertaken to address waiting times in CAMHS, including an update on the York and Selby position, to be provided to the Board	BK	Sept-16	See Agenda Item 9
24/05/2016	16/127	A progress report on the Composite Action Plan to be presented to the Board	DL	Nov-16	

Date	Minute No.	Action	Owner(s)	Timescale	Status
21/06/2016	16/160	A further report on nurse recruitment, development and retention. Including forecast data, to be presented to the Board	DL	Nov-16	
21/07/2016	16/176	A briefing on pathways to be provided to a Board Seminar	BK/PB	Apr-17	See Agenda Item 16
21/07/2016	16/181	A Board Seminar to be held on the topic of assurance	CM/PB	Nov-16	See Agenda Item 16
21/07/2016	16/182	Further information on the revised NQB guidance to be included in the nurse staffing report	EM	Sept-16	See Agenda Item 7
21/07/2016	16/183	The guidance to services to be amended to emphasise that opportunities should be provided for Directors to meet with staff during their visits	BK	Oct-16	
21/07/2016	16/183	Limits to be placed on the number of wards/teams to be visited on each occasion when the visiting schedule is refreshed	CM	Jan-17	
21/07/2016	16/183	The approach taken by East London NHS Foundation Trust to be revisited to seek further learning	CM	Dec-16	
21/07/2016	16/184	The role description for the Freedom to Speak Up Guardian to be reviewed, drawing on national guidance, with a view to moderating expectations and to provide clarity on the duties to be undertaken by the postholder	DL	-	Completed
21/07/2016	16/184	Approval of the arrangements for the recruitment and appointment of the Freedom to Speak Up Guardian	DL	-	Approved
21/07/2016	16/185 & 16/188	The Quarter 1, 2016/17 Risk Assessment Framework return, as approved, to be submitted to NHS Improvement	DK/PB	Jul-16	Completed
21/07/2016	16/187	Proposals to be brought forward on refreshing the approach to embedding the Trust's values including working with the DoN&G to ensure it is more aligned to feedback provided by patients and carers	DL	Nov-16	
21/07/2016	16/187	Data on leavers in future workforce reports to be broken down by professional group	DL	Oct-16	

ITEM NO 6

FOR GENERAL RELEASE

Board of Directors

DATE:	**Tuesday, 27 September 2016**
TITLE:	**To receive the 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 1 September 2016:

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 Forensics and North Yorkshire where ongoing concerns were around pressure on IP beds, demand on the crisis service, nurse staffing shortfalls and the ongoing uncertainty around the Transforming Care agenda.
- Updates from the Patient Safety Group with reference to the thematic review of patient leave planned in September 2016 and the issue of compliance around Trust policies.
- An update on the Clinical Risk and Harm Minimisation project. 3 part time experts by experience trainers had been appointed and work was underway to develop an E learning package.
- The monthly update around CQC compliance was received as well as updates on Safeguarding and Public Protection and the Infection, Prevention & Control report.
- Governance matters were considered and noted through assurance and work streams of the Drug & Therapeutics Committee and the Force Reduction Project update.
- The Terms of Reference for the Quality Assurance Committee were reviewed and would be approved by the Board of Directors at its meeting on 27 September 2016.

Recommendations:

That the Board of Directors receive and note the report of the Quality Assurance Committee from its meeting held on 1 September 2016.

MEETING OF:	**Board of Directors**
DATE:	**27 September 2016**
TITLE:	**To receive the 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 1 September 2016.

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 of the Quality Account. Monthly compliance with the Care Quality Commission regulatory standards, with copies of assurance reports to support the regulatory standards are also considered.

3. KEY ISSUES

The Committee received the updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from the Forensic Services and North Yorkshire. The Locality reports for Durham & Darlington, Teesside and York & Selby had been circulated for information.

3.1 Forensics LMGB – where key issues raised were:

1. With regard to shortage of registered nurse staffing, it was noted there were a significant number of preceptees ready to commence in September/October 2016 and interim work was ongoing with wards to address pressures and ensure safe staffing on wards.
2. Uncertainty around the Transforming Care work stream and lack of clear agreement with Commissioners, (CCGs and NHS England) regarding service models and investment into community services. This was impacting on the ability for service planning and staff recruitment and retention and had subsequently been identified as a risk through the Cumbria and Northeast TC Board.
3. A serious security issue with windows had been identified with the secure estate on 22 August 2016. NHS Commissioners and the CQC had been advised and mitigating plans were in place.
4. Despite activity pressures the level of sickness had been below the Trust target for June, reflecting the significant, sustained commitment by managers, in conjunction with HR to support staff appropriately on an individual level.
5. Under-reporting of incidents on Datix due to staff pressures had been identified as an issue and would be discussed at QuAG.

3.2 North Yorkshire LMGB - where key issues raised were:

1. Pressure on MHSOP beds across the North Yorkshire area, with some solutions being sought for delayed discharges.
2. An overall increase in requests for assessments through the crisis service, which could be seen in peaks and troughs and some data analysis was underway to understand this fluctuation. In addition, there was twice daily management of bed status in place. There had been a significant amount of patients from out of area, as well as the impact from patients in the York area.
3. A deep dive was underway in MHSOP to understand a recent sharp rise in admissions. MHSOP and AMH were currently piloting a letter for patients and carers to set out expectations of length of stay, with the aim to provide care as close to home for patients as possible.
4. Due to nurse vacancies business continuity plans had been instigated from August 2016 on Rowan Lea and Springwood and a number of patients were on enhanced observations. Some new recruits due to take up post in September 2016 had withdrawn and a resignation had also taken place on Springwood.
5. There continued to be a lack of clarity around Transforming Care, community pathways and commissioning.
6. Following the recent serious incidents at Aykbourne unit, the incidents have been reviewed and learning points are being addressed for which there is a good level of assurance. Supervision was now in place.

5 QUALITY ASSURANCE - EXCEPTIONS/ASSURANCE REPORTS FROM SUB-GROUPS OF THE COMMITTEE

The Committee received key assurance and exception reports from standing Sub-Groups of the Committee, highlighting any risks and concerns. Key issues raised were:

5.1 Patient Safety Group Report – The Committee was assured on the monitoring of quality and performance indicator data, planned work streams and system implementation relating to patient safety.

1. There had been a sustained performance (100% for the last 3 months) for 2 key performance indicators for serious incidents reported to STEIS within 2 working days and initial reports received within 3 working days to be reported onto STEIS.
2. An event had been held on 8 July 2016, following the Southern Health report recommendations aiming to achieve collective agreement from 9 provider Trusts on how deaths should be reported internally and externally and would be part of the mortality review process.
3. An additional category of Datix had been added to allow recording deaths, which were as a result of physical health or natural causes.
   All unexpected deaths would be reported as normal under STEIS.
4. In relation to patient harm on leave, discussion took place regarding the issue of non-compliance with Trust leave policy was a matter that needed further analysis and understanding, as well as to look at peer organisations to share information. It was highlighted that as well as cultural issues the Trust should also consider the amount of standard processes that staff were faced with and the need for training and policy to contain clear, consistent messages.

5.3 Safeguarding & Public Protection (S&PP) & Annual Report – The Committee were updated with regard to serious case reviews

1. The Serious Case Review (SVR) in Durham, which related to a MAPPA review in Durham had been published on 10 August 2016. The findings for the Trust had

focussed on disseminating learning from the SCR and challenging and supporting agencies through MAPPA processes.

2. A MAPPA Serious Case Review had commenced in Teesside, initiated due to further offences by a person already subject to a MAPPA. This person had been assessed by TEWV several times and had been known to both community and IP services. Completion of the review was expected to be December 2016.
3. A Serious Case Review had commenced in Durham and the young person had been under the care of CAMHS for a period of 6 months in 2015.
4. A disciplinary investigation was underway following safeguarding concerns captured on CCTV footage at Westerdale South.
5. A young person discharged from Tier 4 CAMH's had been placing themselves in risky situations. A multi-agency plan was in place, however this young lady was being taken care by the Local Authority, which did not fully meet her complex medical needs.

5.4 Clinical Risk & Harm Minimisation Project

1. The Harm Minimisation Policy and Supportive Engagement and Observation Procedure had been ratified at EMT on 22 June 2016.
2. 3 part time experts by experience trainers commenced employment on 1 July 2016 to co-produce and co-deliver training.
3. The next piece of work would be with the support of IT trainers from NHS North of England Commissioning Support Unit to develop an e-learning package to be interactive and to include service users and carers perspectives.
4. The next stage would be how this work fits into stage 2 of the Recovery Project and an evaluation of projects would be completed at the end of December 2016.

6. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

Compliance with CQC Registration Requirements.

1. Registration details for the ECT suite at Bootham Park had been confirmed by the CQC. This would mean that Bootham Park would no longer appear on TEWVs certificate of registration once the S136 suite moves to Peppermill Court.
2. A Regulation 28 letter had been received in connection with a patient death, following ingestion of foreign objects and the Trust would provide all information and evidence to assist with this case.
   On this matter it was noted that an SBARD had been issued and the observation policy had been amended to consider higher levels of observation following suspected ingestion.
3. There had been 4 MHA inspections and associated monitoring reports received in the last quarter and further reports still to be received.
4. Audit One would carry out an audit to evaluate the design and test the effectiveness of controls to ensure Trust compliance with CQC Fundamental Standards.
5. There had been a discussion at EMT following feedback from a number of CQC/MHA inspection reports stating that staff had reported not been trained in the Mental Health Act Code of Practice. Consideration would be given to making this training mandatory going forward.

7. GOVERNANCE

7.1 Quality Account Quarter 1 2016/17, Performance Report

1. The Trust was on track (ie Green) for 100% of the quality priorities.

2. There were 3 quality metrics in each RAG category reporting red and 1 reporting grey at Quarter 1.
   Patient falls per 1000 admissions had been 52.40, which is 23.61 above target and a slight deterioration on Quarter 4 performance.
3. The grey metric related to where there were no NICE audits scheduled to be completed during Quarter 1.
4. Length of stay for Adult Mental Health had remained steady and better than target in Q1, MHSOP had worsened, reporting the highest average length of stay since monitoring began in 2013/14.
5. The percentage of complaints satisfactorily resolved at Quarter 1 was 76%, which was 14% below target. This accounted for 12 complaints, 4 in Durham and Darlington, 4 in Tees, 3 in North Yorkshire and 1 in York & Selby.
6. Within MHSOP a sleep share and spread event had taken place. The aim of the event was to provide staff with knowledge and skills to support patients sleep patterns using therapies as opposed to prescribed medication. The speciality had been unable to secure funding for an expert facilitator and therefore an in-house version of the event had been planned and held.

7.2 Quality Account Stakeholder Event Outcomes and possible priorities for 2016/17 Quality Account

1. There had been 5 areas identified at the Quality Account Stakeholder Workshop which were recommended to the September 2016 Board of Directors:
   i) Reduce preventable deaths.
   ii) Reduce serious harm resulting from patient falls.
   iii) Implement the principles of the National Quality Board's Safe and sustainable staffing report.
   iv) Improve clinical effectiveness and patient experience at times of transition.
   v) Implement the second phase of the TEWV Recovery Strategy.

7.3 Infection, Prevention and Control Quarterly Report

The Committee received a report from the Infection, Prevention and Control Group for Quarter 1, April – June 2016 and the Infection Prevention Control Report.

1. There were no concerns from Quarter 1 and significant assurance had been provided following a review by Audit North of the IPC service.
2. The IPC team and Matrons for MHSOP would continue to monitor the action plans for Westerdale South during Quarter 4 for 2015/16.
   Improvements had been made after concerns around returned audits and clinical leadership would be a key factor to making continued progress.
3. It was noted that there had been a significant improvement regarding the Essential Steps monitoring data following the introduction of the escalation process.

7.4 Drugs & Therapeutics Committee – assurance was given around the following matters.

1. The Safe Transfer of Prescribing Guidance had now been supported in County Durham & Darlington, Tees and parts of North Yorkshire. The harmonisation in York & Selby was ongoing through the York & Scarborough Medicines Commissioning Committee, with an anticipated resolution due in September 2016.
2. The key guidelines: Controlled Drug Standard Operating Procedures had been revised to take into account recent NICE guidance and legislative changes with the SOP to be implemented from September 2016.

3. There had been discussion at the Drug & Therapeutics Committee to look at the range and costs of tests used by the Trust to identify psychoactive substances that patients may have taken when admitted.

7.2 Force Reduction Project Quarterly Update

1. The project remained on track to fully implement the core interventions set out within the Trust Wide Restraint Reduction Plan.
2. There had been significant reduction in the use of severe types of restrictive interventions; however data had shown that ongoing support and monitoring would be required to continue to maintain these levels.
3. The Force Reduction team had worked in conjunction with Workforce development to revise the Management of Violence & Aggression Training (MoVA) and this would go to EMT in October 2016 for formal ratification.
4. The overall incidents reported had increased during the quarter however there had been no increase demonstrated in the more severe types of restraint used.
5. There were 2 patients that accounted for 17% of all incidents of restrictive interventions and 5 patients within CAMHS services that had been involved in 24% of total incidents. These areas would continue to be supported more intensively.

8. IMPLICATIONS

8.1 Quality

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

8.2 Financial/value for money

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

8.3 Legal and Constitutional (including the NHS Constitution)

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

8.4 Equality and Diversity

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

9. 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.

10. RECOMMENDATIONS

That the Board of Directors note the issues raised at the QuAC meeting on 1 September 2016 and to note the confirmed minutes of the meeting held on 7 July 2016 (appendix 1).

Mrs Elizabeth Moody
Director of Nursing & Governance

Sept 2016

APPENDIX 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 7 JULY 2016, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Jennifer Illingworth, Director of Quality Governance
Mr David Jennings, Non-Executive Director
Mr Brent Kilmurray, Chief Operating Officer
Dr Nick Land, Medical Director
Mr Colin Martin, Chief Executive
Mrs Barbara Matthews, Non-Executive Director
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr David Jennings, Non-Executive Director
Mr Jim Tucker, Non-Executive Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing & Governance (for minute 16/98)
Mr Phil Bellas, Company Secretary
Mr Levi Buckley, Director of Operations, Forensic Services (for minute 16/94)
Mrs Adele Coulthard, Director of Operations, North Yorkshire (for minute 16/95)
Mr Craig Hill, Head of Nursing, North Yorkshire
Dr Ahmad Khouja, Clinical Director, Forensic Disability Services
Mr Neil Mayfield, Deputy Medical Director
Mr Chris Williams, Chief Pharmacist (for minute 16/102)
Mrs Donna Oliver, Deputy Trust Secretary

16/91 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Lesley Bessant, Chairman of the Trust

16/92 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 2 June 2016 be signed by the Chairman of the Committee.

16/93 ACTION LOG

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

The following updates were noted:

15/45	"Review of table on Page 8 of the Patient Safety Report". This would be reviewed in the Patient Safety Report presented at the September QuAC meeting.
16/48	"Analysis of dashboard indicators, to discuss at OMT". Due to staff sickness, this matter had been delayed reaching OMT, however it was anticipated that it would be within the next month.
16/69	"Report on developments around escalating and monitoring seclusion".

Mrs Moody outlined proposals for amendments to the policy and processes around escalating and monitoring seclusion.
These included steps to be taken for patients exceeding 12 hours and 21 hours in seclusion, with daily emails to the Head of Service. The revised policy would go to the Mental Health Legislation Committee and then to the Board of Directors for formal ratification.
Following discussion it was noted that on a weekend the second on call Director would be informed.

16/81a) "Clarification around the patient without capacity on Springwood treated without the authority of a T3 and detained for more than 3 months".
This action would come back to the September QuAC meeting.

16/81b) "Resolve the hazard of a pudding sink on Ward 15 at NH AMH".
This issue would be picked up with Estates to ensure there was no ongoing safety hazard and brought back to the September QuAC meeting.

16/94 FORENSIC LMGB REPORT

The Committee received and noted the Forensic LMGB report.

Mr Buckley highlighted the top concerns at present, which were:

1. Nurse staffing continued to be problematic with a lack of band 5 nurses for inpatient areas. FLD vacancies were currently at 22.5% and FMH was in a similar position. Although there are some newly qualified nurses starting in September 2016 these would be at preceptor level and would not immediately alleviate the problem. Various mitigating factors were in place to support the position' such as the use of agency staff, redeployment of registered nurses and increased hours offered to part time staff.
2. Problems with new ways of working on Paris around future leave, CPA and harm minimisation and force reduction work. Issues had been found around Paris training, felt to be inadequate and not responsive enough to the needs of clinical staff.

   On this matter it was noted that SDG had developed a Paris Forensic Training Manual, which would be disseminated to all ward areas and the general feedback around Paris had been positive, which would improve further once confidence was gained in using the system.

3. Ongoing issues with the build quality of Roseberry Park with a recent concern regarding fire safety, which had been resolved.

   On this matter it was noted that:

   i) A big piece of work around quantifying and surveying the site from a fire safety perspective would be undertaken with Lang O Rourke and this was on the Trust risk register.
   ii) The remedial support of HCAs acting as escorts would continue to be invoiced; however was not a sustainable position.

Following discussion it was noted that:

a) Since there had not been an LMGB meeting in June the risk register would be updated for the September QuAC meeting.

b) The issue of security of PATTI computers was being addressed to ensure that computers did not go into default mode before 25 hours.
On this matter it was noted that checks would be made to ensure that there were no other PATTI computers doing the same.

ACTION: Mr L Buckley

c) The lack of support from Patient Safety for death in custody reviews had been around the inability to attend meetings at short notice, particularly when meeting with external partners, leaving the team feeling unsupported and vulnerable. Future meeting dates would be sent to Mrs J Illingworth.
d) Two FMH social workers had been appointed recently with further plans to recruit TEWV social workers. This would reduce the costs of paying LA Social Workers.
e) There were ongoing problems at HMP Durham, due to the ramifications of illegal highs, with complete lock down and prisoners not able to get to clinics.
On this matter it was noted that the Drug & Therapeutics Committee would be looking at the Standard Operating Procedures on handling the substances involved.

16/95 NORTH YORKSHIRE LMGB REPORT

The Committee received and noted the North Yorkshire LMGB report.

Mrs Coulthard highlighted the top concerns at present, which were:

1. Significant pressures on the use of adult acute inpatient beds across the North Yorkshire area.

   On this matter it was noted that:

   i) There had been some delays in securing long term solutions for some patients, with little flexibility around beds.
   ii) There had been an overall increase in requests for assessments through the crisis services.
   iii) A detailed data analysis was underway with twice daily management of the bed status since this

2. There had been a number of incidents across adult acute inpatient services in Scarborough. Stop the line process had been undertaken and remedial actions were being implemented.
   On this matter it was noted that SI investigations were still underway and would be completed by the end of August 2016.
3. MHSOP – there were continued issues with delayed discharges.
4. CCG funding constraints would reduce the investment into Children's transformation plan. Discussions with NHS England continued around funding allocations.
5. Sickness levels were reducing in CAMHS with all long term sickness back to usual duties.
6. Staffing in Scarborough remained a problem with 4.1 WTE vacancies currently out of 16 staff.

16/96 i) PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee received and noted the Patient Safety Group Assurance report, following a meeting of the PSG held on 20 June 2016.

Arising from the report it was highlighted that:

1. Following the revised targets on the Quality Strategy Scorecard the first metric was now reporting as 'green', whilst the other continued to underperform.
2. NRLS reporting - A task and finish group had been established to ensure assurance could be given that our incident management system is configured correctly as the incident numbers reported nationally by NRLS did not correlate to the numbers reported internally.
3. A procedure was currently being developed around the Independent Investigation Procedure to provide clear roles and responsibilities when a homicide occurs. This would then be expanded within the revised incident reporting policy.
4. The Falls Executive Group had met on 23 May 2016, chaired by Mrs C McCann. There had been 12 recorded incidents of fractured neck of femur during 2015/16, 8 of which had been in MHSOP. Going forward QuAGs would receive this information and any concerns would be raised to SDG. (The Report following the meeting held on 23 May 2016, by the Falls Executive Group was attached as appendices to the Patient Safety Group Assurance Report).
   On this matter it was noted that there was some work required to standardise reporting and categorising fractured neck of femurs Trust wide
5. An event was planned for 8 July 2016, based around the recommendations of the Southern Health report. The outcome of this workshop would be fed back to QuAC.

19/96 ii) PATIENT SAFETY ANNUAL REPORT

The Committee considered and noted the Patient Safety Annual Report for 2015/16 and it was agreed

Arising from discussion it was noted that:

1. The report would be a good basis on which to start providing further analysis of themes and trends.
2. Some further analysis would be needed to understand the upward trend on SI's, which could be benchmarked with other Trusts. (13 SI's reported in April 2016, 9 in March 2016) It was known that other Medical Directors in the North West were also reporting significant increases around Sis and this was thought to be partly due to the way the information was being reported.
3. Assurance was given to the Committee that SI panels did look for any emerging themes and patterns to make sure any lessons could be learned from SI's.

16/97 PATIENT EXPERIENCE GROUP REPORT

The Committee considered and noted the report of the Patient Experience Group, following a PEG meeting held on 14 July 2016.

Following discussion it was noted that:

1. The matter on page 2, 3.3, related to 5 complaints raised relating to attitude would be looked into in more detail and brought back to the September QuAC meeting.
   ACTION: Dr I Whitton

2. **Agreed**: that this report would present to the Quality Assurance Committee on a bi-monthly basis, unless there were any exceptions to report. The next report would come to QuAC in September 2016.

16/98 i) SAFEGUARDING & PUBLIC PROTECTION GROUP REPORT

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

Arising from the report it was highlighted that:

1. The MAPPA serious Case Review in Durham had concluded, with publication due on 3 August 2016. Press statements would be prepared by the LSCB and the TEWV communications department would be involved.
2. A MAPPA serious case review had started in Teesside in relation to further offences from a person subject to a MAPPA, which had been reviewed by TEWV.
3. The safeguarding team continued to work with York and Selby, where there had been larger than expected numbers of safeguarding adult alerts and the CQC had been informed and would be kept up to date with progress.
4. A Serious Case Review had commenced in Hartlepool, involving 1 adult and 2 children, which due to complexity was not due to complete until early 2017.
5. There were incidents across other localities underway in Durham, Redcar and Scarborough, including serious matters involving child sexual exploitation and a domestic homicide review following the murder of 2 women.

16/99 ii) SAFEGUARDING & PUBLIC PROTECTION ANNUAL REPORT

The Committee received and noted the Safeguarding & Public Protection Annual Report for 2015/16.

It was highlighted that there had been a dramatic increase in activity for both teams over the last year and improvements would be needed around data gathering, with more analysis of the data for meaningful assurance.

16/100 CLINICAL RISK AND HARM MINIMISATION PROJECT

The Committee considered and noted the update around the Clinical Risk and Harm Minimisation Project.

Arising from the report it was highlighted that:

1. The Harm Minimisation Project had been approved at EMT on 18 August 2015 and the PM3 on 10 February 2016.
2. The Harm Minimisation Policy and Supportive Engagement and Observation Procedure had been ratified by EMT on 22 June 2016.
3. Three part time expert by experience trainers had been appointed on 1 July 2016 to co-produce and co-deliver training.
4. Face to face training would deliver recovery orientated harm minimisation training, which would support and align with implementation of the new risk documentation on Paris.
5. It was anticipated that training would be delivered to 65% of all clinical staff by the end of Q4 2016/17 and mandatory harm minimisation training would be refreshed every 2 years with a new e-learning package to be developed by the end of Q3 2016/17.

Following discussion it was noted that future induction and training for new staff, particularly nurses would need to embed the principles of harm minimisation into other elements of mandatory learning, such as Safeguarding. One clear organisational focus with high level coordination and interdependency of related projects would improve the quality of clinical risk assessment and management.

16/101 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

Arising from the report it was noted that:

1. The Trust had received a positive draft CQC report following the visit to Roseberry Park Learning Disability Forensic services on 22 February 2016.
2. A CQC Assurance Event had been held on 6 June 2016 which fed back the findings from the Trust wide Mock Inspections held in April/May 2016.
3. The Compliance Team had undertaken work at Cross Lane to support staff on the adult wards in the event of an inspection following 4 incidents.
4. The Fundamental Standards Group had met 3 times since reporting to QuAC previously. The members continued to assist the Trust with the mock inspection process.
5. The CQC had visited York's EIP services at the end of June 2016. This service is subcontracted to the Trust by Community Links.
6. Confirmation remained outstanding from CQC on whether the ECT suite could open at Bootham Park.
7. A whistleblowing concern had been raised via the CQC website from a staff member regarding accessing patient records in York and Selby.
8. There have been two MHA reports received.
   On this matter it was noted that there were 2 actions to be taken forward, however nothing of major significance.
9. CQC had published their strategy for 2016 to 2021 called "Shaping the Future".
10. CQC are reviewing how NHS acute, community healthcare and mental health trusts investigate deaths and learn from their investigations.

16/102 DRUG AND THERAPEUTICS COMMITTEE BI-MONTHLY REPORT

The Committee considered and noted the Drug and Therapeutics Committee bi-Monthly report.

Arising from the report it was noted that the following had been considered at the meeting held on 26 May 2016:

1. Various policies, procedures and guidelines had been discussed and approved.
2. Formulary issues had been considered for ADHD drugs.
3. Following an internal consultation on the "Safe Transfer of Prescribing Guidance", the revised guideline would now go out for consultation with the interface prescribing groups, following some concerns raised by primary care representatives.
   On this matter it was noted that a meeting held on 7 July 2016 the document had been accepted by GPs, which would be the guidance going forward for TEWV to apply across all CCGs and representatives. This would form the basis for pending discussions with Tees CCG.

Following discussion it was noted that:

1. The rapid tranquilisation audit had been scored "red" due to a number of reasons, including pre and post monitoring of patients and various actions had been agreed with the Heads of Nursing to improve the rag rating.
2. The rise and fall of nicotine replacement therapy across various Wards had reflected the demand for stocks, going up to £12,000 at the peak of expenditure, which had now reduced to £6,000 at May 2016.

16/103 QUAC ANNUAL PERFORMANCE ASSESSMENT

The Committee considered the Annual Performance Assessment Evaluation Scheme 2015/16 in relation to the Quality Assurance Committee.

It was highlighted from the results that the following areas had received the lowest scores:

1. Clarity of Responsibilities – reference was made to the need for more consistency of LMGB/QuAG reporting into QuAC, as well as fundamental issues around a lack of understanding of assurance in reports, with some reports too descriptive.

   On this matter it was noted that:

   i) This area had improved considerably since the Annual Assessment had been completed and that this area was very much an ongoing and evolving process.
   ii) There was a lack of a shared understanding around assurance and what assurance means.
   Agreed: that this should be escalated to the Board of Directors Seminar for further discussion and consideration to refine the understanding around "assurance" and that authors of QuAC reports should be included for an inclusive debate.

   ACTION: Mr P Bellas/Mrs L Bessant

   iii) Work being led by the data quality team would improve the reporting of data in future reports.
   iv) Further refinements to the LMGB reports would finalise standardisation of the report template from localities, tying in with this the information fed through from the QuAGs, where a statement of assurance would be provided through to the Quality Assurance Committee. Committee members did welcome the new LMGB report template, which enabled easier reading and understanding.

2. Compliance with the terms of reference – uncertainty around any review of Sub-Groups reporting into QuAC.
   The Sub-groups reporting through to QuAC had been reviewed by Mrs E Moody and Mrs J Illingworth and the Annual Schedule of reporting to QuAC had been amended accordingly.

3. Adequate induction programme – This has been revised and would be available for newly appointed Non-Executive members of the Committee from autumn 2016, following any comments/amendments from members of the QuAC.

4. Appropriate number of meetings – not focussed enough on exceptions, too formulaic, too long and a query as to whether too much information is reported through QuAC. A comment was made however that the meetings are well managed.
   On this matter it was noted that the Committee recognised that there was insufficient analysis of the exceptions reported through QuAC and this could be improved upon.
   It was also highlighted that
5. Effectiveness of decision making – There was occasionally some doubt regarding which body within the governance structure was responsible for certain decisions, however this was becoming clearer over time.
   On this matter it was noted that this issue related to a time when the Quality Assurance Committee considered and agreed to the reporting mechanisms of

policies and procedures, which when of a clinical nature would report through to EMT for formal ratification.

16/104 IMPLICATIONS OF JOHN'S CAMPAIGN FOR TEWV

The Committee considered the report on the implications of the St John's Campaign.

Arising from the report it was highlighted that:

1. The initiative, primarily aimed at Acute Trusts was to support and welcome carers to spend more time, including overnight if needed, on the ward with their relative/friend if they had dementia.
2. Introducing John's Campaign would not be a new approach for TEWV, since a lot of principles were already in place.
3. There would be some risks and costs involved around differentiating carers from visitors, environmental issues, confidentiality and impact on staff time, however the advantages and benefits to patients would outweigh these risks and would be worth exploring further.

Following discussion it was noted that:

i) There would be a trial of John's Campaign on Westerdale Ward, whilst considering the implications of introducing the Campaign in other areas.
ii) Consideration would be given to each individual patient, according to their needs and around managing carers expectations.
iii) The outcome of the trial would go to EMT for further consideration and a further report would then be presented to the QuAC.

16/105 EXCEPTION REPORTING (LMGBs, QuaC sub-groups)

The Committee noted the exception of a recent occurrence where there had not been a qualified member of staff present on a shift in a Ward at West Park Hospital, Darlington.

On this matter it was noted that:

1. Escalation processes would be reinforced and that provision would be made through the safe staffing work stream in future to overstaff in some areas, where it would be difficult to find staff at short notice.
2. This kind of incident should be prevented in future with a clear process for escalation within 24 hours of shifts not covered.

16/106 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD

The matter of assurance would be escalated to the Board of Directors.

ACTION: Mr P Bellas/Mrs L Bessant

16/107 ANY OTHER BUSINESS

There was no other business to note.

16/108 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 1 September 2016,
2.00pm – 5.00pm in the Board Room, West Park Hospital.

Email to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 4.30pm

……..

Dr Hugh Griffiths
CHAIRMAN
1 September 2016

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th September 2016**
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 July and August 2016 data.

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

- The number of rosters equates to 67 inpatient wards.
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 40 in July and 38 in August.
- The Forensic directorate have the highest level of 'red' fill rates.
- The lowest fill rate indicators in July relate to Meadowfields, Fulmar and Primrose Lodge.
- The lowest fill rate indicators in August relate to Picktree (reduction in the number of beds in preparation for closure of the unit), Meadowfields (due to a number of RN vacancies, agency staff are being utilised to cover any gaps) and Fulmar (due to maternity leave and long terms sickness).
- The Highest fill rates in July were observed by Westerdale South, Oakwood and Oak Rise.
- The highest fill rates in August were observed by Westerdale South (agreed uplift to account for continued enhanced observations), Hamsterley Ward (additional staffing from Picktree Ward following the closure of the unit) and Westwood.
- In relation to bank usage there were no wards identified that was utilising in excess of 50% bank over the period. The highest bank user was identified as Westerdale South with 43% in July and 42% in August.

- Agency usage equated to 0.77% (July) and 0.96% (August) of the total hours worked.
- In terms of triangulation with incidents and complaints:

July 2016:

- Westerdale South have been highlighted as having a high fill rate, the highest user of bank within the Trust. Incidents and concerns occurring during the period have related to skills and behaviour of staff but not directly to staffing fill rates.
- Cedar (NY) have been utilising agency staff and have been cited as having 2 level 3 incidents and 3 PALS related issues which are being reviewed.
- Northdale had 2 PALS related issues whilst utilising agency staff. In addition an incident was raised citing staffing levels.
- The Evergreen Centre raised an incident in relation to staffing levels. They were also cited as having the highest number of incidents requiring control and restraint during the period.

August 2016:

- Westerdale South have been highlighted as having a high fill rate, the highest user of bank within the Trust. Incidents and concerns occurring during the period have related to skills and behaviour of staff but not directly to staffing fill rates.
- Worsley Court had 2 PALS related issues whilst utilising agency staff. In addition an incident was raised citing staffing levels.

There were 562 shifts (305 related to days and 257 related to nights) allocated in July and 611 (443 related to days and 168 related to nights) in August where a break had not been taken.

There were 12 incidents raised in July and 25 (2 were in relation to community services) in August citing staffing levels. The triangulation of the staffing incidents has been included above.

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:	**28th September 2016**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the exceptions falling out of 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 July and August 2016 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) 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 (www.tewv.nhs.uk/nursestaffinginfo). The full monthly data set of day by day staffing for each of the 67 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

3. EXCEPTIONS JULY AND AUGUST 2016:

3.1 Safe Staffing Fill Rates

3.2 The daily nurse staffing information aggregated for the month of July and August 2016 are presented at Appendices 1 and 2 of this report.

The highest numbers of red fill rate indicators relate to Registered Nurses on Days shifts which equates to 40 wards in July and 38 in August.

The top 3 inpatient areas for each of 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
July 2016		
Meadowfields	56.3% for RN on Nights	The use of agency nurses used to meet planned staffing levels have not been included in the numbers. The fill rate is an increase when compared to June whereby the fill rate was reported at 53.5%.
Fulmar	58.7% for RN on Days	A shortage of 2 registered nurses down due to maternity and career breaks. This fill rate is a decrease when compared to June whereby the fill rate was reported at 89.6%.
Primrose Lodge	61.2% for RN on Days	No explanation has been provided for the low fill rate. This fill rate is a decrease when compared to June whereby the fill rate was reported at 68.8%.
August 2016		
Picktree	37.5% RN Nights 41.1% RN Days	The reduced fill rates are in response to a planned reduction of patients in preparation for the closure of the unit.
Meadowfields	46.6% RN Nights	There are a number of RN vacancies, agency staff have been used to cover the shortfall ensuring that all shifts were filled. As above these have not been included in fill rates.
Fulmar	55.8% RN Days	There is a shortage of RNs as a result of maternity and long term sickness.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In July there were 41 wards and 38 in August that had staffing in excess of their planned requirements to address specific nursing issues.

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
July 2016		
Westerdale South	272.7% HCA on Days 223.4% HCA on Nights	Agreed uplift on the budgeted established as a result of enhanced observations and clinical activity.
Oakwood	176.3% HCA on Days	Additional staffing has been used to fill vacant RN shifts due to vacancies and secondment.
Oak Rise	137.3% RN on Days	Additional staffing has been used to fulfil vacant HCA shifts. This is evident in the fill rates.
August 2016		
Westerdale South	257.7% HCA on Days 202.5% HCA on Nights	Agreed uplift on the budgeted established as a result of enhanced observations and clinical activity.
Hamsterley	219.1% HCA on Days	The increase is due to staff from Picktree working on Hamsterley Ward following the closure of the ward.
Westwood	208.9% HCA on Nights	Additional staffing has been used to cover RN shortages, increased clinical activity.

3.3 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 both July and August. The highest ward in both reporting periods was in relation to Westerdale South (43% in July and 42% in August).

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

3.4 Agency Usage

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

In July the agency usage equated to 0.77% and 0.96% in August 2016.

It is positive to note that agency usage is extremely 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 clinical areas.
The full ward breakdown is available within the appendices of this report.

3.5 Quality Data Triangulation

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

July:

- There were 4 Serious Incidents that occurred within the month of July 2016 from 4 different wards. Westerdale South was one of these areas and has been highlighted as having high staffing fill rates and the highest bank usage within the Trust. Further to investigation, concerns are related to staff skills, clinical leadership and behaviour not staffing levels or numbers.
- There were 9 level 3 incidents (self-harm) that occurred within the reporting period. 2 of which occurred within Cedar (NY) who have utilised agency staffing within the reporting period. Issues being addressed by the leadership team in this area are regarding clinical leadership, skill mix and staffing levels.
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was The Evergreen Centre with a total of 137 incidents. To date The Evergreen Centre has been highlighted within this report as having high fill rates, largely due to use of non-registered nursing bank usage due to high levels of clinical activity.

August:

- There were 10 level 3 incidents (self-harm) that occurred within the reporting period. 2 related to Westwood who have been highlighted as having a high fill rate indicator.
- There were 6 complaints that occurred within the reporting period of which none of the wards have been cited within this report.
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was The Evergreen Centre with a total of 50 incidents requiring control and restraint. The Evergreen Centre has been highlighted within this report as having high fill rates, largely due to use of non-registered nursing bank usage due to high levels of clinical activity.

3.6 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 562 shifts in July 2016 and 611 shifts in August 2016 where unpaid breaks had not been taken. The majority of the shifts where breaks were not taken occurred on day shifts (305 in July and 443 in August). The number of night shifts where breaks were not taken equated to 257 shifts in July and 168 shifts in August.

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

3.7 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. Within the reporting period there were 12 incidents raised citing issues with staffing in July and 25 in August (2 incidents recorded in August that related to community services).

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

July 2016:

- Westerdale South raised an incident in relation to staffing levels. This ward has been cited in this report as having a high staffing fill rate, the highest user of bank and a Serious Incident during the period.
- Northdale Centre also raised an incident in relation to staffing levels and they have been cited as utilising agency staffing.
- The Evergreen Centre raised an incident in relation to staffing levels and have been cited as the highest number of incidents requiring control and restraint and high usage of non-registered bank staff.

August 2016:

- Springwood and Worsley Court have both raised incidents in relation to staffing levels and have both utilised agency nurse staffing within the reporting period

An escalation process has been piloted in Tees locality and following further consultation this has been agreed to roll out across the Trust, in order to gain a more standard approach to escalation of incidents and clearer accounts of how shortages have been addressed.

3.8 Other

The Forensic directorate have the highest number of ‘red’ fill rates for

registered nurses on day shifts. Pressures contributing to this include the inpatient services vacancy factor at Band 5 is approximately 20%. The majority of the vacancies are recruited into with preceptees, predominantly starting in October 2016. A number of staff are on restricted duties which is currently being reviewed. Sickness has not been a contributing factor as it has decreased and is at the lower end of the spectrum. The impact of registered nurse pressures has been felt more noticeably in FLD, partly because they have less wards and have a smaller overall pool of staff to pull from. The FMH service has three wards that are established for 2 registered nurses per night shift, whereas the other FMH wards and all the FLD wards are established for 1 registered nurse per night per ward, providing little flexibility of having a 2nd nurse as a 'buffer' to move. The recent appointment of night coordinators should help to offset this going forward.

The Safer Staffing Steering Group 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 with the Operational Management Team.

In addition work is being undertaken within Durham & Darlington and will:

- Test out NHS England evidence based staffing framework and tools for MH wards in agreed in-patient areas.
- To ensure above indicators are compliant with emerging NICE guidance or other DH documentation.
- To put in place Triangulation and hot spot systems for predicting planned requirements.
- To implement regular reporting and monitoring systems within services to enable timely and informed intervention to occur.
- Test out a hospital based flexible staffing deployment pool.

The output from the project will have a bearing on the format and quality of reports ultimately received by Board on this issue.

Work has commenced to review the process of validation and context information being sought from the wards, as this is currently a manual process; any information collected is retained within the department for reference, outliers will be followed up and consideration is being given as to how best to use this information to present it in a more meaningful summary for future reports.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

No direct risks or implications to patient safety from the staffing data have been identified this month, although 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 recent inspection reports for other mental health trusts and poses a risk as to our ratings as we are due to be re-inspected.

4.2 **Financial/Value for Money:**

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. This work is being progressed and will be a feature of this financial years Safe Staffing project 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.

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:

Safe staffing and the risks regarding the Trusts ability to meet planned staffing levels on a daily basis has 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 workstreams.

The current lack of an evidence based tool for workforce planning and monitoring in mental health and learning disability nursing increases the risk that the publication of the workforce data will be compared to other Trust's data without appreciation of context.

6. CONCLUSIONS:

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.

A strategic staffing review will be undertaken during the financial year 2016/17 which will refine the usage of the data further. 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 although 'hot-spots' are beginning to emerge and work is underway to address shortfalls.

7. RECOMMENDATIONS:

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

Emma Haimes
Head of Quality Data
September 2016

JULY 2016 DATA

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN July							
				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	13	78.3%	117.7%	100.0%	98.4%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	13	64.5%	104.0%	106.2%	92.1%
Bedale Ward	Teesside	Adults	10	88.5%	138.7%	100.0%	112.2%
Bilsdale Ward	Teesside	Adults	14	95.2%	106.4%	100.0%	100.0%
Birch Ward	Durham & Darlington	Adults	15	70.0%	97.6%	90.3%	112.9%
Bransdale Ward	Teesside	Adults	14	82.2%	126.3%	97.1%	97.0%
Cedar Ward	Durham & Darlington	Adults	10	116.0%	138.6%	103.4%	134.2%
Cedar Ward (NY)	North Yorkshire	Adults	18	90.2%	100.1%	104.7%	94.4%
Elm Ward	Durham & Darlington	Adults	20	101.1%	98.4%	110.6%	103.2%
Farnham Ward	Durham & Darlington	Adults	20	132.2%	102.2%	100.0%	108.8%
Kirkdale Ward	Teesside	Adults	16	91.9%	104.7%	109.7%	123.4%
Lincoln Ward	Teesside	Adults	20	100.8%	104.0%	93.7%	120.6%
Lustrum Vale	Teesside	Adults	20	95.9%	102.1%	100.0%	100.0%
Maple Ward	Durham & Darlington	Adults	20	111.4%	85.0%	100.0%	100.0%
Overdale Ward	Teesside	Adults	18	86.2%	115.6%	109.7%	90.0%
Primrose Lodge	Durham & Darlington	Adults	15	61.2%	138.7%	100.0%	96.8%
Stockdale Ward	Teesside	Adults	18	99.9%	101.8%	100.5%	92.1%
The Orchards (NY)	North Yorkshire	Adults	10	90.4%	93.5%	87.8%	126.2%

Tunstall Ward	Durham & Darlington	Adults	20	104.4%	111.3%	109.7%	103.2%
Ward 15 Friarage	North Yorkshire	Adults	14	76.7%	134.5%	97.6%	95.6%
Willow Ward	Durham & Darlington	Adults	15	96.2%	159.0%	103.2%	100.0%
Baysdale	Teesside	CYPS	6	117.7%	112.5%	113.1%	104.8%
Holly Unit	Durham & Darlington	CYPS	4	110.9%	137.3%	106.7%	135.3%
Newberry Centre	Teesside	CYPS	14	86.8%	115.2%	107.6%	105.9%
The Evergreen Centre	Teesside	CYPS	16	95.7%	142.3%	103.6%	160.3%
Westwood Centre	Teesside	CYPS	12	88.0%	154.1%	90.9%	167.7%
Clover/Ivy	Forensics	Forensics LD	12	98.1%	108.0%	100.0%	148.1%
Eagle/Osprey	Forensics	Forensics LD	10	82.0%	95.0%	100.0%	100.0%
Harrier/Hawk	Forensics	Forensics LD	10	77.1%	111.7%	100.0%	109.9%
Kestrel/Kite.	Forensics	Forensics LD	16	74.9%	118.9%	100.0%	101.4%
Langley Ward	Forensics	Forensics LD	10	88.5%	125.9%	102.9%	200.0%
Northdale Centre	Forensics	Forensics LD	12	63.5%	100.8%	90.3%	97.6%
Oakwood	Forensics	Forensics LD	8	86.4%	176.3%	100.0%	100.0%
Robin	Forensics	Forensics LD	6	64.9%	118.9%	96.8%	98.4%
Thistle	Forensics	Forensics LD	5	87.4%	110.4%	90.3%	100.0%
Brambling Ward	Forensics	Forensics MH	13	78.1%	109.1%	93.5%	97.1%
Fulmar Ward.	Forensics	Forensics MH	12	58.7%	100.3%	100.3%	98.5%
Jay Ward	Forensics	Forensics MH	5	80.6%	109.7%	100.3%	96.9%
Lark	Forensics	Forensics MH	15	81.8%	117.5%	97.1%	100.3%
Linnet Ward	Forensics	Forensics MH	17	71.5%	104.3%	99.4%	98.7%
Mallard Ward	Forensics	Forensics MH	16	85.9%	105.9%	96.0%	123.7%
Mandarin	Forensics	Forensics MH	16	76.0%	114.5%	100.3%	98.6%
Merlin	Forensics	Forensics MH	10	86.1%	133.6%	77.6%	165.4%
Newtondale Ward	Forensics	Forensics MH	20	91.5%	100.4%	74.5%	108.8%
Nightingale Ward	Forensics	Forensics MH	16	82.9%	108.2%	120.1%	93.7%

Sandpiper Ward	Forensics	Forensics MH	8	91.0%	103.3%	73.5%	132.2%
Swift Ward	Forensics	Forensics MH	10	81.2%	160.7%	110.3%	220.2%
Aysgarth	Teesside	LD	6	114.0%	140.6%	100.0%	99.8%
Bankfields Court	Teesside	LD	19	74.4%	92.5%	96.1%	97.6%
Bankfields Court Unit 2	Teesside	LD	5	105.3%	102.7%	100.4%	109.9%
Bek-Ramsey Ward	Durham & Darlington	LD	16	100.5%	105.3%	100.0%	100.0%
Oak Rise	York and Selby	LD	8	137.3%	79.6%	100.0%	100.0%
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	81.8%	125.8%	100.0%	93.5%
Cherry Tree House	York and Selby	MHSOP	16	75.6%	103.6%	97.2%	155.1%
Hamsterley Ward	Durham & Darlington	MHSOP	10	70.8%	142.7%	100.0%	100.0%
Meadowfields	York and Selby	MHSOP	14	79.5%	107.3%	56.3%	114.5%
Oak Ward	Durham & Darlington	MHSOP	12	93.8%	100.0%	100.0%	100.0%
Picktree Ward.	Durham & Darlington	MHSOP	10	73.8%	109.8%	100.0%	98.4%
Roseberry Wards	Durham & Darlington	MHSOP	15	93.4%	89.8%	100.0%	98.4%
Rowan Lea	North Yorkshire	MHSOP	20	93.6%	100.2%	122.1%	99.4%
Rowan Ward	North Yorkshire	MHSOP	16	81.7%	114.4%	100.0%	88.8%
Springwood Community Unit	North Yorkshire	MHSOP	14	78.3%	130.2%	106.5%	133.5%
Ward 14	North Yorkshire	MHSOP	9	83.9%	98.1%	103.2%	98.4%
Westerdale North	Teesside	MHSOP	18	81.4%	125.0%	100.6%	100.4%
Westerdale South	Teesside	MHSOP	14	111.3%	272.7%	100.3%	223.4%
Wingfield Ward	Teesside	MHSOP	10	71.9%	113.8%	96.8%	100.3%
Worsley Court	York and Selby	MHSOP	14	80.5%	120.2%	97.7%	174.6%

Scored Fill Rate compared to Quality Indicators - JULY 2016				Total score	Agency Usage Hours	Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers			Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Aysgarth	Teesside	LD	6	9		2394.34	376.25	16%									
Tunstall Ward	Durham & Darlington	AMH	20	8		2916.18	144	5%					1	2		2	2
Westerdale South	Teesside	MHSOP	14	10		4842.04	2074	43%	1					7		8	8
Bankfields Court Unit 2	Teesside	LD	5	8		2307.54	372.85	16%									
Holly Unit	Durham & Darlington	CAMHS	4	10		1245.66	140.26	11%									
Lincoln Ward	Teesside	AMH	20	9		3297.82	344	10%						1		1	1
Westerdale North	Teesside	MHSOP	18	8		2632.25	27	1%	1	1				11		13	13
Westwood Centre	Teesside	CAMHS Tier 4	12	9		5335.38	1163.75	22%			1			77		126	126
Farnham Ward	Durham & Darlington	AMH	20	9		2822.47	324	11%	1					1		1	1
Hamsterley Ward	Durham & Darlington	MHSOP	10	8		2496.15	332.83	13%					1				
Mallard Ward	Forensics	FMH	16	8		3267.95	395.7	12%				1	3	4		5	5
Rowan Ward	North Yorkshire	MHSOP	16	6		2643.57	407.8	15%						1		1	1
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	8		2621.7	233	9%						1		1	1
Elm Ward	Durham & Darlington	AMH	20	8		2784.68	228	8%	1	1	1		2	5	1	7	8
Stockdale Ward	Teesside	AMH	18	8		2709.1	817.3	30%					2	7		9	9
Northdale Centre	Forensics	FMH	12	7	112.5	4301.42	315.42	7%					2				
Bedale Ward	Teesside	AMH	10	8		3283	517	16%					1	21	2	37	39
Bek-Ramsey Ward	Durham & Darlington	LD	16	8		4324.25	120	3%						12	2	15	17

Brambling Ward	Forensics	FMH	13	7		2775.6	365.5	13%									
Bransdale Ward	Teesside	AMH	14	8		2635.5	405.75	15%			3	1					
Lustrum Vale	Teesside	AMH	20	8		2773.67	107	4%									
Bilsdale Ward	Teesside	AMH	14	8		2642.34	184	7%						1		3	3
Birch Ward	Durham & Darlington	AMH	15	7		2819.35	420	15%				1		2		2	2
Cedar Ward (NY)	North Yorkshire	AMH	18	8	32.25	3236.75	172.75	5%			2		3	5		5	5
Eagle/Osprey	Forensics	FLD	10	7		3133.5	256.75	8%				1					
Maple Ward	Durham & Darlington	AMH	20	7		2746.59	475	17%						1		1	1
Picktree Ward.	Durham & Darlington	MHSOP	10	7		2479.18	764.51	31%						2		2	2
Primrose Lodge	Durham & Darlington	AMH	15	8		2676	132	5%									
Newberry Centre	Teesside	CAMHS Tier 4	14	7		3678.97	204.67	6%			1			5		8	8
The Evergreen Centre	Teesside	CAMHS Tier 4	16	10		6008.58	1132.5	19%					1	137		244	244
Ward 14	North Yorkshire	MHSOP	9	7		2421.34	0	0%									
Willow Ward	Durham & Darlington	AMH	15	9		2939	187	6%									
Baysdale	Teesside	CAMHS	6	8		2753.01	83.59	3%									
Langley Ward	Forensics	FLD	10	9		2909.82	682.25	23%				1	1	2		4	4
Merlin	Forensics	FMH	10	8		4147.48	1235.25	30%						6		9	9
Oak Ward	Durham & Darlington	MHSOP	12	8		2683.67	102.34	4%									
Oakwood	Forensics	FLD	8	8	33.75	2047.75	142	7%									
Bankfields Court	Teesside	LD	19	7		7637.7	245.32	3%						27		36	36
Cedar Ward	Durham & Darlington	AMH	10	10		3784.67	1075	28%					2	23	2	46	48
Fulmar Ward.	Forensics	FMH	12	7		2817.92	658.08	23%					1	1		1	1
Jay Ward	Forensics	FMH	5	7		2818.87	369.5	13%						4		9	9
Robin	Forensics	FLD	6	7	22.5	2589.42	640.67	25%									

Nightingale Ward	Forensics	FMH	16	8		2871.08	337.5	12%					1				
Sandpiper Ward	Forensics	FMH	8	8		3867.25	614.25	16%					1	27	2	70	72
Springwood Community Unit	North Yorkshire	MHSOP	14	9	403.5	3298	135.67	4%						22		24	24
Thistle	Forensics	FLD	5	7		3004.98	271.5	9%					2	1		1	1
Ward 15 Friarage	North Yorkshire	AMH	14	8		2537	381.5	15%						1		1	1
Overdale Ward	Teesside	AMH	18	7		2597	166	6%					1	2		2	2
Linnet Ward	Forensics	FMH	17	7		2695.75	601	22%						5		5	5
Swift Ward	Forensics	FMH	10	9		4652.63	1512.75	33%						20		41	41
Ayckbourn Unit Esk Ward	North Yorkshire	AMH	13	7		2382.75	341	14%						3		3	3
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	13	7		2690.48	334.48	12%					1				
Clover/Ivy	Forensics	FLD	12	9		4232.67	1027.75	24%					1	2		5	5
Kirkdale Ward	Teesside	AMH	16	9		3333	345	10%						1		1	1
Roseberry Wards	Durham & Darlington	MHSOP	15	7		2813.76	295.33	10%						1		1	1
Lark	Forensics	FMH	15	7		2895.18	225.68	8%					1				
Wingfield Ward	Teesside	MHSOP	10	7		2357.25	209.5	9%									
Kestrel/Kite.	Forensics	FLD	16	7	78.75	4254.01	1245.75	29%				1		19		36	36
The Orchards (NY)	North Yorkshire	AMH	10	8		2167	36	2%									
Mandarin	Forensics	FMH	16	7		2844.38	459.25	16%						1		3	3
Rowan Lea	North Yorkshire	MHSOP	20	9		3784.06	99.02	3%			1			11		24	24
Newtondale Ward	Forensics	FMH	20	7		3687.53	145.5	4%						1		1	1
Harrier/Hawk	Forensics	FLD	10	7	168.75	3927.67	245	6%						4		4	4
Meadowfields	York & Selby	MHSOP	14	6		3045.75	368.5	12%					2	5		5	5
Oak Rise	York & Selby	LD	8	8		4226.06	146.25	3%						2		3	3
Worsley Court	York & Selby	MHSOP	14	9	798	3844	22	1%						7		11	11
Cherry Tree House	York & Selby	MHSOP	16	8		3513.08	253	7%						2		2	2

August 2016 Data

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	13	63.7%	105.3%	100.0%	98.4%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	13	72.9%	110.0%	100.0%	96.8%
Bedale Ward	Teesside	Adults	10	97.6%	211.8%	139.8%	147.0%
Bilsdale Ward	Teesside	Adults	14	100.2%	114.6%	100.3%	103.8%
Birch Ward	Durham & Darlington	Adults	15	68.3%	108.0%	100.2%	103.2%
Bransdale Ward	Teesside	Adults	14	80.8%	112.8%	84.4%	103.8%
Cedar Ward	Durham & Darlington	Adults	10	101.7%	160.8%	100.0%	154.0%
Cedar Ward (NY)	North Yorkshire	Adults	18	93.6%	96.3%	104.5%	100.3%
Elm Ward	Durham & Darlington	Adults	20	105.7%	110.1%	109.7%	114.8%
Farnham Ward	Durham & Darlington	Adults	20	111.1%	95.5%	102.8%	102.2%
Kirkdale Ward	Teesside	Adults	16	85.6%	91.1%	91.5%	108.2%
Lincoln Ward	Teesside	Adults	20	106.3%	96.3%	92.6%	105.1%
Lustrum Vale	Teesside	Adults	20	99.0%	95.4%	110.5%	107.7%
Maple Ward	Durham & Darlington	Adults	20	102.5%	106.0%	99.6%	105.9%
Overdale Ward	Teesside	Adults	18	88.5%	113.4%	104.1%	100.3%
Primrose Lodge	Durham & Darlington	Adults	15	47.5%	145.2%	100.0%	100.0%
Stockdale Ward	Teesside	Adults	18	103.4%	108.8%	108.4%	94.1%
The Orchards (NY)	North Yorkshire	Adults	10	95.2%	80.6%	68.3%	119.4%
Tunstall Ward	Durham & Darlington	Adults	20	106.2%	105.6%	112.9%	100.0%

Ward 15 Friarage	North Yorkshire	Adults	14	72.8%	140.2%	87.1%	103.2%
Willow Ward	Durham & Darlington	Adults	15	88.9%	161.6%	96.8%	101.6%
Baysdale	Teesside	CYPS	6	141.0%	98.1%	100.2%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	107.1%	108.7%	99.8%	135.0%
Newberry Centre	Teesside	CYPS	14	70.7%	116.6%	106.1%	102.0%
The Evergreen Centre	Teesside	CYPS	16	94.4%	125.0%	101.4%	123.5%
Westwood Centre	Teesside	CYPS	12	99.8%	172.3%	115.0%	208.9%
Clover/Ivy	Forensics	Forensics LD	12	84.2%	114.4%	100.0%	148.2%
Eagle/Osprey	Forensics	Forensics LD	10	80.3%	91.4%	96.8%	100.0%
Harrier/Hawk	Forensics	Forensics LD	10	69.8%	108.0%	93.7%	146.9%
Kestrel/Kite.	Forensics	Forensics LD	16	74.5%	119.4%	90.3%	141.0%
Langley Ward	Forensics	Forensics LD	10	80.1%	133.6%	101.1%	196.6%
Northdale Centre	Forensics	Forensics LD	12	75.8%	91.6%	77.4%	100.2%
Oakwood	Forensics	Forensics LD	8	70.8%	203.4%	99.9%	100.0%
Robin	Forensics	Forensics LD	6	60.7%	118.1%	100.0%	98.4%
Thistle	Forensics	Forensics LD	5	80.0%	120.7%	96.8%	106.7%
Brambling Ward	Forensics	Forensics MH	13	72.4%	116.2%	93.5%	100.0%
Fulmar Ward.	Forensics	Forensics MH	12	55.8%	102.5%	100.0%	100.0%
Jay Ward	Forensics	Forensics MH	5	59.6%	114.4%	100.0%	108.1%
Lark	Forensics	Forensics MH	15	85.0%	104.4%	100.1%	98.0%
Linnet Ward	Forensics	Forensics MH	17	79.1%	113.2%	100.3%	98.4%
Mallard Ward	Forensics	Forensics MH	16	93.8%	108.6%	105.4%	133.8%
Mandarin	Forensics	Forensics MH	16	67.5%	127.8%	100.0%	111.3%
Merlin	Forensics	Forensics MH	10	92.4%	129.3%	79.0%	170.4%
Newtondale Ward	Forensics	Forensics MH	20	69.4%	101.7%	77.2%	104.8%
Nightingale Ward	Forensics	Forensics MH	16	85.7%	108.0%	126.4%	100.0%
Sandpiper Ward	Forensics	Forensics MH	8	82.4%	106.9%	71.6%	122.1%

Swift Ward	Forensics	Forensics MH	10	71.8%	116.5%	100.0%	125.8%
Aysgarth	Teesside	LD	6	108.9%	137.8%	101.0%	100.7%
Bankfields Court	Teesside	LD	19	82.3%	101.4%	98.2%	97.3%
Bankfields Court Unit 2	Teesside	LD	5	110.8%	105.5%	100.2%	113.1%
Bek-Ramsey Ward	Durham & Darlington	LD	16	101.7%	108.8%	100.0%	101.1%
Oak Rise	York and Selby	LD	8	127.4%	83.8%	100.0%	100.0%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	93.8%	160.2%	100.0%	103.2%
Cherry Tree House	York and Selby	MHSOP	16	88.0%	103.1%	96.7%	168.3%
Hamsterley Ward	Durham & Darlington	MHSOP	10	94.2%	219.1%	108.6%	142.2%
Meadowfields	York and Selby	MHSOP	14	85.5%	98.6%	46.6%	116.0%
Oak Ward	Durham & Darlington	MHSOP	12	98.5%	94.8%	100.0%	101.6%
Picktree Ward.	Durham & Darlington	MHSOP	0	41.1%	74.2%	37.5%	62.5%
Roseberry Wards	Durham & Darlington	MHSOP	15	89.3%	101.2%	100.1%	100.2%
Rowan Lea	North Yorkshire	MHSOP	20	90.4%	106.6%	94.7%	105.2%
Rowan Ward	North Yorkshire	MHSOP	16	101.1%	152.9%	106.7%	115.6%
Springwood Community Unit	North Yorkshire	MHSOP	14	76.7%	132.6%	100.0%	131.9%
Ward 14	North Yorkshire	MHSOP	9	87.9%	132.5%	103.5%	106.5%
Westerdale North	Teesside	MHSOP	18	104.5%	125.0%	101.7%	106.6%
Westerdale South	Teesside	MHSOP	14	128.6%	257.7%	96.8%	202.5%
Wingfield Ward	Teesside	MHSOP	10	63.0%	108.7%	99.7%	100.3%
Worsley Court	York and Selby	MHSOP	14	74.0%	99.4%	116.1%	142.9%

Scored Fill Rate compared to Quality Indicators - AUGUST 2016				Total score	Agency Usage Hours	Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers			Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Aysgarth	Teesside	LD	6	9		2343.94	449.25	19%						1		1	1
Tunstall Ward	Durham & Darlington	AMH	20	8		2837.67	156	5%			1			1		1	1
Westerdale South	Teesside	MHSOP	14	11		4681.74	1977.33	42%						2		2	2
Bankfields Court Unit 2	Teesside	LD	5	8		2363.8	418.57	18%									
Holly Unit	Durham & Darlington	CAMHS	4	9		1477.9	6.67	0%									
Lincoln Ward	Teesside	AMH	20	8		3108.58	275.42	9%									
Westerdale North	Teesside	MHSOP	18	9		2636.5	138.5	5%						3		3	3
Westwood Centre	Teesside	CAMHS Tier 4	12	10		5976.64	1687.75	28%			2		2	35	2	67	69
Farnham Ward	Durham & Darlington	AMH	20	8		2743.92	288	10%					3	5		6	6
Hamsterley Ward	Durham & Darlington	MHSOP	10	10		3521.59	429.67	12%						1		1	1
Mallard Ward	Forensics	FMH	16	9		3516.75	500.25	14%					1	5		7	7
Rowan Ward	North Yorkshire	MHSOP	16	9	719	3277.05	412.5	13%						7		9	9
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	9		3085.89	135.83	4%					1	1		1	1
Elm Ward	Durham & Darlington	AMH	20	8		2852.5	420	15%					1	1		1	1
Stockdale Ward	Teesside	AMH	18	8		2806.09	864	31%					1	8	1	15	16
Northdale Centre	Forensics	FMH	12	6		4231.5	364.75	9%						2		3	3
Bedale Ward	Teesside	AMH	10	11		4401.48	1251.5	28%						28		47	47
Bek-Ramsey Ward	Durham & Darlington	LD	16	8		4312.67	162	4%						2	1	1	2
Brambling Ward	Forensics	FMH	13	7		2817.87	447.25	16%						1		1	1

Bransdale Ward	Teesside	AMH	14	6		2561	383.5	15%						3		5	5
Lustrum Vale	Teesside	AMH	20	8		2923.31	391.5	13%						1		2	2
Bilsdale Ward	Teesside	AMH	14	8		2684.5	214.5	8%			1		1	1		1	1
Birch Ward	Durham & Darlington	AMH	15	7		2878.93	432	15%									
Cedar Ward (NY)	North Yorkshire	AMH	18	8		3306.68	349.75	11%			2		1	10		18	18
Eagle/Osprey	Forensics	FLD	10	7		3061.83	213.75	7%					1				
Maple Ward	Durham & Darlington	AMH	20	8		2878.84	502.08	17%			1		1	3		4	4
Picktree Ward.	Durham & Darlington	MHSOP	0	4		385.5	84	22%									
Primrose Lodge	Durham & Darlington	AMH	15	8		2631	120	5%									
Newberry Centre	Teesside	CAMHS Tier 4	14	7		3394.54	447.63	13%			2	1	1	6		9	9
The Evergreen Centre	Teesside	CAMHS Tier 4	16	10		5001.85	524	10%				1	3	51		88	88
Ward 14	North Yorkshire	MHSOP	9	8		2624	30.5	1%						7		15	15
Willow Ward	Durham & Darlington	AMH	15	8		2976	132	4%									
Baysdale	Teesside	CAMHS	6	9		2881.9	45.93	2%									
Langley Ward	Forensics	FLD	10	9		2789.5	691.5	25%					1				
Merlin	Forensics	FMH	10	9		4214.16	1155.5	27%					1	3		7	7
Oak Ward	Durham & Darlington	MHSOP	12	8		2710.51	139.6	5%									
Oakwood	Forensics	FLD	8	8	89.2	2019.28	164	8%									
Bankfields Court	Teesside	LD	19	7		8159.69	474.53	6%						36		50	50
Cedar Ward	Durham & Darlington	AMH	10	10		3941	1610	41%				1	3	13		21	21
Fulmar Ward.	Forensics	FMH	12	7		2860.1	212	7%						1		1	1
Jay Ward	Forensics	FMH	5	7		2774.3	474.25	17%						1		1	1
Robin	Forensics	FLD	6	7	45	2613.25	708.5	27%					1				
Nightingale Ward	Forensics	FMH	16	8		2975.2	462.5	16%									
Sandpiper Ward	Forensics	FMH	8	7		3789.9	577.5	15%				1		33	3	90	93
Springwood Community Unit	North Yorkshire	MHSOP	14	9	356	3217.01	0	0%						29		34	34

Thistle	Forensics	FLD	5	8		3093.58	300.5	10%				1	1	13		26	26
Ward 15 Friarage	North Yorkshire	AMH	14	7		2468.75	439.5	18%						1		1	1
Overdale Ward	Teesside	AMH	18	7		2557.5	230	9%					1	1		1	1
Linnet Ward	Forensics	FMH	17	7		2859.63	434.83	15%					4	1		1	1
Swift Ward	Forensics	FMH	10	8		3367.17	797.5	24%						3		4	4
Ayckbourn Unit Esk Ward	North Yorkshire	AMH	13	7		2553	290.5	11%					1	6		7	7
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	13	7		2374.25	354.75	15%									
Clover/Ivy	Forensics	FLD	12	8		4210.34	766.92	18%			1			2	1	4	5
Kirkdale Ward	Teesside	AMH	16	7		2997.44	279	9%									
Roseberry Wards	Durham & Darlington	MHSOP	15	7		2863.4	228.66	8%	2	2		1					
Lark	Forensics	FMH	15	7		2790.15	434.75	16%									
Wingfield Ward	Teesside	MHSOP	10	7		2315.5	129.5	6%									
Kestrel/Kite.	Forensics	FLD	16	6		4486.22	1086.84	24%					1	19	1	39	40
The Orchards (NY)	North Yorkshire	AMH	10	4		2053	36	2%									
Mandarin	Forensics	FMH	16	8		3007.25	588.75	20%					1	5		6	6
Rowan Lea	North Yorkshire	MHSOP	20	8		3674.48	215.53	6%					2	15		22	22
Newtondale Ward	Forensics	FMH	20	6		3554	349.75	10%					1				
Harrier/Hawk	Forensics	FLD	10	8		4034.38	659.17	16%					2	2		2	2
Meadowfields	York & Selby	MHSOP	14	6		3062.82	305.75	10%						3		3	3
Oak Rise	York & Selby	LD	8	8		4223.65	285.25	7%						1		1	1
Worsley Court	York & Selby	MHSOP	14	8	861	3501.26	155	4%					2	4		4	4
Cherry Tree House	York & Selby	MHSOP	16	8		3351.5	292	9%					1	3		4	4

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 27th September 2016**
TITLE:	**To consider the report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 1, 2016-17.

Recommendations:

The Board of Directors is asked to receive and note the assurance report and conclusions

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 27th September 2016**
TITLE:	**To consider the report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

1.1 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, 2016-17; through consideration of the work of the Mental Health Legislation Committee, which is a Standing Committee of the Board.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The background to the purpose of this report is held at Appendix 1.

3. KEY ISSUES:

At the meeting held on 25 July 2016

3.1 The minutes of the Committee meeting held on 25 April 2016 were reviewed and agreed as an accurate record. (See Appendix 2 for information).

3.2 It was noted from the summary report for CQC MHA inspections that there were 7 visits in the quarter compared to 10 in the previous quarter. There were 1 to AMH, 3 to MHSOP and 3 to Forensic services (MH and LD). Of the 7 visits, reports had been received for all of them and the report for Springwood in the previous quarter was also received in this quarter and the outcomes included in this report. There were issues identified around section 17 leave relating to the absence of risk assessments and evidence of the patient having been given a copy of the leave form. Continuing issues in the reiteration of patients' rights under section 132 and recording of comprehension were identified. A comment was made in one report that care plans appeared to be prescriptive rather than collaborative. Where issues were raised, all completed Provider Action Statements have been approved by EMT and returned to CQC

3.3 The Section 136 report was presented. In total there were 196 uses of section 136 across the whole Trust area (a slight increase in this quarter from 183 in the previous quarter) of which 177 (90%) were brought to a Mental Health Based Place Of Safety (MHBPOS). Cleveland Police use of section 136 appears to have plateaued; use of section 136 across North Yorkshire has increased slightly in comparison to last quarter by 7% and those taken to a Trust place of safety in North Yorkshire is 86%. Within Durham and Darlington the numbers have increased by 37% from 35 to 48 episodes in the quarter and that includes missing data for those taken to police custody in June. North Yorkshire total use of section 136 is now 39% higher than Cleveland Police compared to 31% last quarter. There were 9 children or young people brought

to a TEWV place of safety in the quarter including one 13 year old and one 14 year old. All were either admitted or discharged with follow-up.

In terms of Street Triage activity there were 136 contacts in the quarter in Teesside compared to 111 in the previous quarter, of which 0 resulted in the use of section 136, and in York there were 78 compared to 57 last quarter contacts of which 3 resulted in the use of section 136. Scarborough had 84 contacts of which none resulted in section 136 but data was not available in the previous quarter.

Within the Crisis Assessment Suite at Roseberry Park activity continues to be significant with 487 assessments compared to 577 assessments undertaken in the previous quarter, (this does not include those assessed subject to section 136). The numbers attending 'voluntarily' with the police and not subject to section 136 continues to be high and far exceeds the number subject to section 136 – in the quarter there were 127 attending voluntarily with the police compared to 59 brought subject to section 136. Of the total 487 assessments 71, approximately 15%, were discharged without mental health follow up or sign-posting to other services.

3.4 The Discharge from Detention Report was presented. This report focusses on discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. No patients were discharged by the Associate Hospital Managers this quarter. Of the FTTs held the Tribunal ordered 19 discharges in total, 6 discharged from section 2, 3 discharged from section 3 and 5 discharged from Community Treatment Orders. There were 2 conditional and 1 absolute discharges of restricted patients (all with the agreement of the clinical team) and 1 section 37N (with the agreement of the clinical team) and 1 section 37. It appears that although 4 of the patients had the same RC, and a further 2 also had the same RC, all had different Care Coordinators and their cases were heard by different Tribunal Panels. Of those discharged from detention /CTO, most remained informally for varying periods of between 3 days and 4 weeks, with 1 still informal. Only 1 patient was readmitted after approx 3 weeks and re-detained on a section 2, which was subsequently re-graded to a section 3.

3.5 The seclusion report, which has been unavailable for a while was presented. There are still difficulties in obtaining 'clean' data from Paris. Significant manual work is required and there are still some missing data issues. From the information available, there were 23 patients secluded in this period, with 46 reported episodes of seclusion; several patients were secluded on only one occasion, others were secluded between 2 and 6 times

3.6 Under any other business the question was raised again regarding the difficulty AMHPs have in obtaining second doctors to carry out formal MHA assessments. It was explained that the Trust provides the first doctor through PA and on-call arrangements but that the Trust could not also provide the second doctor. This is an issue nationally and the Trust, through its function of hosting the North of England Approval Panel, was considering making

available the names and contact details of doctors who wish to gain the necessary experience to become section 12 approved but who cannot do so in order that they may be contacted to assess alongside a section 12 approved doctor to gain experience. The DH are supportive of this suggestion.

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:**
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:**
No implications.

6. CONCLUSIONS:

At their meeting in July 2016, the MHL Committee received 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.

7. RECOMMENDATIONS:

The Board of Directors is asked to receive and note the assurance report and conclusions.

Author: Mel Wilkinson
Title: Head of Mental Health Legislation

Background Papers:
Appendix 1 – Background Information
Appendix 2 – Approved minutes of the 25 April 2016 MHL Committee Meeting

Appendix 1

Background Information

The Mental Health Act 1983 is the primary legislation that directs and regulates the management, including the assessment and treatment under compulsion, of those whose mental disorders may cause risk to their own health or safety or where the protection of others is necessary.

The Mental Capacity Act 2005 is the primary legislation which provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. This includes decisions around care and treatment, accommodation and financial matters. Within Schedule 1 of the Mental Capacity Act are the Deprivation of Liberty Safeguards (DoLS) which further allow for people who lack capacity to be deprived of their liberty in order to provide care and treatment in their best interests.

The Board of Directors, who may be defined as the Hospital Managers for the purposes of the Act, require assurance that the Trust is compliant with Mental Health Act legislation and regulation. Following the implementation of the Trust Integrated Assurance Framework in 2008, the Mental Health Act Committee was approved as a Standing Committee of, and directly accountable to, the Board of Directors. The quarterly committee is chaired by a non-executive director and the committee receive regular themed performance reports from the corporate Mental Health Legislation administrative team.

The Trust is registered with the CQC for the regulated activity of 'Assessment or medical treatment for persons detained under the 1983 Act'. CQC therefore have a programme of regulatory inspection visits to areas with detained patients and to community teams to assess compliance with the Essential Standards that apply to that regulated activity. Those inspections also feedback intelligence into the CQC compliance processes for all Essential Standards further to observations in clinical areas. Since the review of the MHL Committee in April all reports, including the MHA specific visit reports, are now received and managed by the CQC Registration and Assurance Team.

In addition any areas of concern relating to detained patients or issues related to implementation of the Act are brought to the Committee. Quarterly assurance reports are made to the Board of Directors and forwarded to the Quality and Assurance committee for information in relation to monitoring of CQC registration compliance.

Appendix 2

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 25 APRIL 2016 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 11.00AM.

Present:
Mrs L Bessant, Chairman of the Trust
Mr R Simpson, Non-Executive Director, (Chairman of the Committee)
Mr B Kilmurray, Director of Operations
Dr N Land, Medical Director
Mr K Marsden, Public Governor
Miss J Clark, Public Governor.

In Attendance:
Ms P Griffin, Mental Health Legislation Advisor
Dr H Griffiths, Non-Executive Director
Mr H Gibson, Public Governor, Harrogate
Mrs C McCann, Deputy Associate Director of Nursing & Governance
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation
Apologies: Apologies for absence were received from Mr K Marsden, Public Governor, Mrs Janice Clark, Public Governor, Mrs E Moody, Director of Nursing and Governance and Mrs J Illingworth, Director of Quality Governance.

16/09 MINUTES
Agreed – *That the minutes of the last meeting held on 25 January 2016 be approved as a correct record and signed by the Chairman, …"*
The Chairman offered thanks and appreciation to Mr Keith Marsden, Public Governor for his term supporting the Mental Health Legislation Committee and wished him well for the future.

16/10 ACTION LOG
The Committee updated the Action log, taking into account the relevant reports provided to the meeting.
15/30(d) "Update around funding for street triage to come back to Committee following discussion with Commissioners".
It was noted that a further 12 months funding had been received for Scarborough street triage service and discussions continued with NY around placing staff in the control room.
Completed
15/30(b) "Compare Mental Health Tribunal discharge rates for TEWV against national rates"
The Trust's discharge rates were at 8%, compared to a national picture of 10%.
Completed
16/03 "Discuss with Matrons and Ward Managers training around the updates to the Code of Practice"
Completed
16/04 "Look at overall rates, completed with 2015 on individuals going into police custody"
Completed
16/04(iii) "Include in Section 136 report figures around York Street Triage"
Completed
16/06 "Raise at Audit Committee on 12 May 2016 that Audit North had picked only 3 patient case files to be reviewed and reconciled from PARIS".
It was confirmed that this would be raised at the 12 May 2016 Audit Committee meeting.

Completed
16/08 “Seek further clarity around the definition “medical escort” from the Department of Health”
Clarification had not been available from the Department of Health, however Dr Land confirmed that the Trust’s definition of a medical escort meant that it did not mean a Doctor of Consultant Psychiatrist had to be present, it could be a Health Care Assistant.
Completed

16/11 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT
The Committee considered and noted the Care Quality Commission (MHA) visit feedback summary report
Arising from the report it was noted that:
1. There had been 10 visits in the quarter, compared to 16 in the previous quarter, 3 to AMH, 3 to MHSOP 3 to Forensic services (MH and LD) and 1 to LD services. Of the 10 visits, reports had been received for 9 of them and the report for Springwood was still awaited.
2. There had been no issues identified following the visit to Westerdale North.

The Committee congratulated Westerdale North on this result.
3. Some gaps had been identified in the reiteration of patients’ rights under section 132 and also some issues around the absence of RCs assessments of capacity regarding medication.
4. Where issues had been raised, all completed Provider Action Statements had been approved by EMT and returned to CQC

16/12 (i) SECTION 136
The Committee considered and noted the Section 136 report.
Arising from the report it was highlighted that:
1. In total there had been 183 uses of section 136 across the whole Trust area (a slight decrease from 186 in the previous quarter) of which 164 (90%) were brought to a MHBPOS.
2. Cleveland Police total use of section 136 had decreased by 1.5% compared with the previous quarter and appeared to have plateaued.
3. The use of section 136 across North Yorkshire had decreased slightly in comparison to last quarter by 4.5% and those taken to a Trust place of safety in North Yorkshire was 85%.
4. Within Durham and Darlington the numbers had been relatively static, though use of the police station had increased from 6% to 14%, however the numbers were still small.
5. North Yorkshire’s total use of section 136 had been 31% higher than Cleveland Police
6. In terms of Street Triage activity there had been 111 contacts in the quarter in Teesside, compared to 146 in the previous quarter, of which 0 resulted in the use of section 136.
7. In York there had been 57 contacts, of which 1 had resulted in the use of section 136. Scarborough information had not been available at the time of reporting.
8. Within the Crisis Assessment Suite at Roseberry Park activity continued to be significant with 577 assessments compared to 481 assessments undertaken in the previous quarter, however the quarter prior to that had been 597, (this did not include those assessed subject to section 136).
9. The numbers attending ‘voluntarily’ with the police and not subject to section 136 continued to be high and far exceeded the number subject to section 136 – in the quarter there had been 194 attending voluntarily with the police, compared to 61 brought subject to section 136.
10. Of the total 577 assessments 73, approximately 13%, had been discharged without mental health follow up or sign-posting to other services.

Following discussion it was noted that:

i) There had been no seclusion report this quarter since the Information Team were producing a report to enable the extraction of the data from Paris since the recording of seclusion became part of the electronic care record and no longer a manual record.
ii) There was at present no on call psychiatrist working at Scarborough. Should someone be admitted under a Section 136 aged 10 years, then a CAMHs out of hours on call psychiatrist could be contacted for assessment.

16/12 (ii) MHA DISCHARGES FROM DETENTION
The Committee considered and noted the MHA Discharges from Detention Report.
Arising from the report it was highlighted that:
1. The report focused on discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers.
2. No patients had been discharged by the Hospital Managers in the quarter.
3. Of the FTTs held the Tribunal had ordered 7 absolute discharges and 1 deferred discharge, (5 of which had been subject to section 2, 2 subject to section 3 and 1 CTO). None of the patients had the same RC or Care Coordinator.
4. 4 patients had remained informally for several days following discharge from detention.
5. None had been re-admitted to date.

16/13 UPDATE ON YORK & SELBY
Miss Wilkinson gave a verbal update on York & Selby and highlighted the following:
1. The Mental Health Officer post had been filled from February 2016 and good working relationships had been established with the staff and Consultant body at York.
2. The TEWV version of Paris had gone live and patients were being moved across onto the system. It was anticipated that going forward more competent information would be available.

16/14 AVOIDABLE MHA DETENTIONS CQUIN
The Committee considered and noted the outcome of the CQUIN relating to Avoidable Mental Health Act Detention.

Miss Wilkinson highlighted the following:
1. There had been some suggested parameters proposed and the CQUIN would include all those within services, across all localities over the age of 18 years, including LD and MHSOP services, however excluding Forensic MH and LD, who had been detained on multiple occasions subject to Sections 2 and 3 over the past 2 years dating back from 31 March 2016.
2. The MHL Committee would be updated quarterly on the progress of the CQUIN.

16/15 POLICING AND CRIME BILL
The Committee considered and noted the outcome of the Policing and Crime Bill.
Miss Wilkinson highlighted the following:
1. The Policing and Crime Bill was currently progressing through Parliament and one of the areas within it would be to amend the powers of the Police under the Mental Health Act 1983'.
2. The key changes were:

- To reduce the amount of time a section 136 could be in place from 72 hours to 24 hours, with the ability to extend by a further 12 hours in specific circumstances.
- To remain at a private dwelling as a place of safety to conduct the assessment when a section 135(1) warrant is executed, if it is agreed as a 'suitable place' on application of set criteria.

 Removal of the requirement to be found in a place to which the public have access for section 136 purposes, (other than private dwellings) and to provide a power of entry.

 To prohibit the use of police stations as places of safety for those aged under 18 years.

 To set down in regulations when an adult could be taken to a police station as a place of safety and make arrangements with regard to the review of their detention there.

 requirement for police to consult, where practicable, with a doctor, nurse, AMHP or other before using powers under s136

3. The Trust had prepared a response to the request for views in the consultation stage of the Bill, which included a proposal to amend Section 136(2) to state the purpose of s136 as …. *enabling examination by a Section 12(2) approved registered medical practitioner and interview by an appropriately qualified and registered professional, or AMHP, and of making any necessary arrangements for treatment or care. Where the RMP examination and registered professional interview indicates that admission to hospital is required, the person must also be interviewed by an AMHP.*

On this matter it was noted that:
i) This would remove the necessity for every section 136 detainee to be interviewed by an AMHP, which could cause significant delays, particularly out of hours, and would still allow for necessary follow-up to be arranged.
ii) Unfortunately the consultation had closed 2 days early on 12 April 2016 and the Trust submission had been submitted on the original end date of 14 April 2016.

16/16 ANNUAL SCHEDULE OF MEETINGS
The MHL Committee noted the annual schedule of reporting for 2016/17.

16/17 ANY OTHER BUSINESS
Mrs J Clark had submitted a question to the MHL Committee around AMHPs having significant problems getting section 12 doctors for MHA assessments. The following response had been provided:

AMHPs do quite often have difficulty in identifying the second doctor, both able and willing, to provide a medical recommendation for detention, particularly out of hours. The first medical recommendation is usually provided by the Trust's on-call consultant psychiatrist as part of their role when on-call and the timeliness of this is not an issue raised by the AMHPs. The second medical recommendation, if not provided by the service users GP who does not need to be s12 approved as they have previous acquaintance with the service user, needs to be provided by a doctor not precluded by the conflict of interest regulations. This is usually a doctor carrying out this role independently on a fee paid basis which, of course, means it is for them to decide whether they accept the 'work' or not. It is very unusual these days for a patient's GP to be involved in a MHA assessment and almost unheard of out of hours. There are a number of s12 approved doctors available and AMHPs have access to the database which has all of the s12 approved doctors contact details, however, as outlined above it is up to the individual doctor when contacted by the AMHP as to whether they carry out the MHA assessment or not. The fee is paid to the second doctor by the CCG and we are aware anecdotally that there are some issues with the timeliness of this payment which may have led to some doctors being reluctant to take on this fee paid 'work'.

It was noted that:
1. The Trust was currently in conversation with the lead AMHP in Durham to seek ways to address this issue, however, the Trust was limited in what it could do regarding the provision of a second doctor, due mainly to the conflict of interest regulations and the Code of Practice at Para 39.4 which states – "*It is also good practice for doctors on the staff of an NHS*

Trust or NHS Foundation Trust to ensure that one of the recommendations is given by a doctor not on the staff of that Trust.."

2. This was an issue not only in Durham but also in some other areas of the Trust and also nationally.

3. The Code of Practice states re availability of second medical recommendation at paras 15.9 and 15.10:

"It is the responsibility of clinical commissioning groups (and the NHS Commissioning Board) to ensure that doctors are available in a timely manner to examine patients under the Act when requested to do so by AMHPs and in other cases where such an examination is necessary.
If AMHPs find themselves having to consider making emergency applications because of difficulties in securing a second doctor, they should report that to the local authority on whose behalf they are acting (or in accordance with other agreed arrangements, if they are different). The local authority should review this issue promptly with the relevant NHS commissioner".

The meeting concluded at 12.45pm

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Dr Hugh Griffiths
Acting Chairman – Mental Health Legislation Committee
25 July 2016

ITEM NO 9

FOR GENERAL RELEASE

Trust Board Meeting

DATE:	**27th September 2016**
TITLE:	**Progress on Management of Waiting Times in Children and Young People's Services**
REPORT OF:	**Brent Kilmurray**
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 Board has received previous reports regarding the work under way to address concerns about excessive waits within CAMHS services. This report includes details from each locality and provides the position reported up to August together with a narrative regarding the key areas of action that have been completed and/or are under way.

There has been a significant improvement in services on Tees and within Durham and Darlington. There are ongoing pressures within North Yorkshire. York and Selby has recently developed plans to address the significant issues that are now known as a result of the Paris implementation in April 2016.

Performance Improvement Group maintains a watching brief across all services and specifically is reviewing progress with plans in North Yorkshire and York and Selby.

Recommendations:

The Board is asked to receive this paper and give comment and direction as appropriate.

MEETING OF:	**Trust Board**
DATE:	**27th September 2016**
TITLE:	**Progress on Management of Waiting Times in Children and Young People's Services**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to update the Board on progress made in minimising waiting times for children & young people accessing our CAMHS services.

2. BACKGROUND INFORMATION AND CONTEXT:

2.2 The Board has received previous reports regarding the work under way to address concerns about excessive waits within CAMHS services. This report includes details from each locality and provides the position reported to August and a narrative regarding the key areas of action that have been completed and/or are under way.

2.3 Consistent themes across the Trust have been regarding levels of referrals, the numbers of assessments undertaken for children that were not converted onto the caseload and staffing pressures – including sickness and vacancies.

2.4 The localities are at different stages in their response to the pressures. However it is clear that some of the elements of the Purposeful and Productive Community Services (PPCS) programme have been critical to enabling the service to make progress.

2.5 It is clear that Trustwide there is still much to do. Tees has made good progress and has delivered and exceeded the 90% target. Durham and Darlington, which for a long time has been the most significant concern, is demonstrating signs of making a sustained improvement. North Yorkshire is now in the position of consistently struggling to make progress towards the target. Whilst York and Selby, having migrated to Paris, is showing a more transparent position, enabling the full extent of the challenge to be understood.

2.6 There is commentary within the report from each locality explaining what has been and is being done to address the issue.

3. KEY ISSUES:

3.1 Durham and Darlington

	August 16	June 16	March 16
% seen in 4 wks	77.04%	32.65%	31.25%
Numbers waiting more than 4 wks	51	232	519

3.1.1 Sickness levels and staff turnover levels had a significant impact on the ability to meet an increased demand. The service recognised that low staffing levels impacted on capacity to meet demand. The service reviewed budgets and utilised slippage money to recruit additional Band 5 nurses to provide additional capacity in the teams.

3.1.2 The service implemented a Social Emotional Wellbeing Pathway in 2012. This supported open access with all referrals being offered a face to face assessment. For Durham & Darlington this resulted in 28% of initial face to face assessments being subsequently signposted to other providers. It was recognised that the service needed to review this element of the pathway.

3.1.3 There was an assumption that, within the locality, there was very little support within universal services for those young people with low level emotional needs, which resulted in an increase in referrals to CAMHS. The service mapped out other agencies and their provision to support effective signposting for children and young people with low level emotional difficulties and developed a clearer criteria aligned to redirect these young people to services where their needs would be better met.

3.1.4 The overall recovery plan was underpinned with QIS methodology and the phase one Purposeful & Productive Community Services tools. Key factors that influenced progress included: cells and huddles, caseload management, activity planning, daily lean management. There was also the introduction of the Single Point of Access (SPA). This was developed through an RPIW and has introduced: a single contact point for referrers; open access; telephone assessments on the day the referral is received; priority referrals are seen the same day as referral face to face; standard face to face assessment with SPA within 5 days; appointment with their local CAMHS team within 28 days; and more senior clinical involvement in initial assessments to offer coaching and supervision; a directory of other providers offering universal provision to support signposting and onward referral.

3.1.5 The Recovery Plan has been closely monitored by the Performance Improvement Group, alongside a waiters paper that is updated monthly.

3.1.6 The service is currently achieving the 9 week waiting KPI and is working towards achieving the Trust internal target of 4 weeks. Following the introduction of the SPA, all young people waiting will have had a telephone assessment which ensures we have considered risk and the young person is waiting for ongoing assessment and interventions at the right place.

3.2 Tees

	August 16	June 16	March 16
% seen in 4 wks	97.92%	97.55%	59.01%
Numbers waiting more than 4 wks	2	4	75

3.2.1 Following a period of investment it took a long time for the service to get up to full recruitment. During this time there was considerable pressure on waiting times. The service developed a comprehensive plan to proactively address waiting times. This had the full engagement and support of team managers, which has been critical to its success.

3.2.2 The plan comprised of:

- Identifying number of referrals received into the team/locality (per week/month)
- Calculating number of new assessment appointments required to meet the referral need (per week/month)
- Team Managers held job planning sessions with individual Clinicians
    - to incorporate agreed number of new assessment slots
    - to embed a standard diary format (25 slots x 1 ½ hours per 1.0wte)
- Visual Control Board (VCB) format was devised and Team Managers and an identified member of admininistrative staff agreed a process for daily reporting and management of referrals – these are sent to the Head of Service & Service Manager (daily)
- Daily huddles established in teams
- Alongside the above - Team Manager incorporated daily checks of IIC
- Weekly report out for Team Managers with Head of Service and Service Manager

3.2.3 Performance has been tracked through the locality and Trust Performance Improvement Group for several months and it is felt that there is now a well established model that has delivered a sustained improvement over the last 3 months. This will continue to be reviewed.

3.3 North Yorkshire

	August 16	June 16	March 16
% seen in 4 wks	50.63%	53.15%	58.77%
Numbers waiting more than 4 wks	57	42	76

3.3.1 Staff vacancy levels, particularly in the Scarborough team, have had a significant impact on the ability to meet an increased demand. Plans are in place to recruit into vacant posts although 2 posts remain vacant at this point in time. A steering group has been established to support recruitment across all specialities within the Scarborough area.

3.3.2 Across the service there are a number of complex patients on the caseload. To provide the most appropriate care all teams have stepped up to provide intensive intervention to meet individual patient needs. This is having an impact on team capacity and as a result patient appointments have been cancelled by the service. The Team Managers are realigning diaries to plan capacity across the teams where possible to minimise the impact.

3.3.3 The implementation of the PPCS tools has had a positive impact on the team performance against the waiting times performance. As this is embedded and refined performance will continue to improve.

3.3.4 The Head of Service has reviewed the current daily lean management processes in place and from 1 October 2016 will implement a revised process. This will support the review and monitoring of key performance indicators and facilitate proactive management of issues.

3.3.5 During October the Assistant Corporate Performance Manager is providing some dedicated IIC training to the team managers and team administration to support the revised daily management process. This will create a greater awareness of position against the key performance indicators and support improvement in performance.

3.4 York and Selby

	August 16	July 16	March 16
% seen in 4 wks	23.61%	25%	N/A
Numbers waiting more than 4 wks	390	429	N/A

3.4.1 York and Selby CAMHS transferred to TEWV Paris in April 2016. Since that time there have been data quality issues. IIC reflects greater numbers of long term waiters than is accurate. Contacts that occurred with Primary Mental Health Workers (PMHWs) and were recorded on LYPFT Paris have not been pulled through and have therefore not 'stopped the clock'. To rectify this, clinical and administrative staff will need to manually check all cases, cross referencing with LYPFT paper notes and TEWV Paris. This is a very time consuming process. The admin team has been chronically understaffed and we have not been able to prioritise this work. We are now fully recruited and all new starters have completed their induction. This will be addressed now as a priority.

3.4.2 There will be a Single Point of Access Service for all referrals from January 2017. In order to prepare for this, all waiting, unassessed PMHW referrals and new to service referrals received from September have been offered a telephone consultation and a face to face assessment, if required, in November 2016. Whilst this will still exceed the 4 week waiting target in October and November, it will release capacity in the PMHW team to complete pieces of work on their existing caseloads. From November, the PMHWs will offer the SPA telephone consultation service and will book families into the Multi Disciplinary Team (MDT) assessment slots. The number of MDT slots available has been staffed to higher than previous levels. This will be reviewed after 3 months to ensure that we are targeting clinical resources to the most appropriate part of the clinical pathways.

3.4.3 The service undertook an RPIW event in June 2016 focussing on improving flow and discharge processes within the service. One outcome of this event was the introduction of a CAMHS specific caseload management tool for all Clinicians (PPCS phase 1 product). The majority of Clinicians are now using

this tool. We are reviewing the supervision structures within the service and the role of the new Team Managers within this new structure. It is anticipated that this will provide greater rigour and focus on the direction and quality of the casework offered to families.

3.4.4 The introduction of the CAMHS Hospital Liaison Workers into York Hospital between 1pm - 9pm, 365 days a year, is now providing an urgent point of contact for young people and families in crisis in A&E and support to the Paediatric ward. The workers conduct the majority of post-overdose assessments and provide the majority of 7 day follow-up appointments (as per NICE guidelines). This has improved the consistency of care for young people and has also reduced the demand on the MDT Duty Clinician system. From this reduction in demand we can now commit fewer resources to the Duty Clinican offer, releasing time back into the clinical pathways.

3.4.5 York and Selby CAMHS hosted a pilot project during the last 12 months. School well-being workers worked into various primary and secondary schools in City of York (CYC), promoting emotional health and well-being in schools and offering consultation to school staff on children they have concerns about. The workers also offered time limited group interventions and individual work for children and young people exhibiting low level emotional well-being issues. The pilot demonstrated a reduction of referrals to CAMHS from the schools participating in it. In one school referrals are reported to have dropped by 24%. The CCG and CYC have agreed to roll out this model to all schools in the City of York, using Future in Mind monies. The CAMHS team will provide clinical supervision to the well-being workers and will ensure seamless pathways are in place to support young people transitioning in and out of the CAMH service.

3.4.6 The CCGs are currently running a tendering process within North Yorkshire for the provision of a similar service. NY and Y&S CAMHS have submitted an application and we are awaiting the outcome of the tender process.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no implications on Compliance with the CQC Fundamental Standards.

4.2 **Financial/Value for Money:**
There are no direct financial implications of this paper

4.3 **Legal and Constitutional (including the NHS Constitution):**
There are no legal or constitutional implications of this paper.

4.4 **Equality and Diversity:**
There are no equality or diversity implications of this paper.

4.4 **Other implications:** None identified.

5. RISKS: These matters are covered within the locality risk registers.

6. CONCLUSIONS:

Waiting time pressures are a key priority for clinical teams across the Trust. The position within CAMHS services over the last year or so has been a significant cause for concern. Much effort has gone into addressing these pressures. The results have been impressive on Tees and more recently within the Durham and Darlington service. North Yorkshire, after a period of improvement late last year, has experienced significant challenges with staffing. Previous papers to the board have demonstrated that there is a lack of resilience within the North Yorkshire service. As a result of recruitment and a more rigorous approach to daily management it is expected that there will be a an improvement in this position from the New Year. York and Selby services have been in a state of flux, and now Paris has been implemented there is a clearer line of sight regarding the extent of the challenges there. The team has enthusiastically embraced QIS methodology and the PPCS agenda and an improvement should be evident over coming months.

7. RECOMMENDATIONS:

The Board is asked to receive this paper and give comment and direction as appropriate.

Brent Kilmurray
Chief Operating Officer / Deputy Chief Executive

ITEM 10

FOR GENERAL RELEASE

TRUST BOARD

DATE:	**Tuesday 27 September 2016**
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 led 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:

Trust Board is 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:	**Trust Board**
DATE:	**Tuesday 27 September 2016**
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 the 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 October 2016.

3.3 As can be seen by reference to Appendix 1 of the standards that apply to the Trust we have assessed ourselves as fully compliant with all but two standards which are assessed as not compliant but evidencing progress towards it. This results in the Trust compliance level being 'Substantial', that is arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve.

3.4 Actions for the two standards rated as Amber have been agreed and implementation commenced.

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 Trust Board that the Trust can demonstrate it can effectively respond to emergency planning and business continuity incidents whilst maintain services to patients.

7. RECOMMENDATIONS:

Trust Board is requested to accept the self assessment prior to submission to NHS England in October 2016.

Brent Kilmurray
Chief Operating Officer

Attachments:
Appendix 1 : EPRR Core Standards
Appendix 2 : EPRR Statement of Compliance 2016/17

STATEMENT OF COMPLIANCE **Appendix 2**

Tees, Esk and Wear Valleys NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v4.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board or Governing Body has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body 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 or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the organisation has undertaken the following exercises on the dates shown below:

A live exercise (required at least every three years)	Three Cathedrals Exercise 09/09/15
A desktop exercise (required at least annually)	Forensic Tees Locality table top 04/11/15
A communications exercise (required at least every six months)	Exercise Temenos 22/04/16 Exercise Three Cathedrals 09/09/15

I confirm that the above level of compliance with the core standards has been confirmed by the organisation's board / governing body.

_____

Signed by the organisation's Accountable Emergency Officer

_____ _____

Date of board / governing body meeting Date signed

NHS England Core Standards for Emergency preparedness, resilience and response

v4.0

The EPRR Core Standards spreadsheet has 7 tabs:

Introduction - this tab,. outlining the content of the other 6 tabs and version control history

EPRR Core Standards tab - with core standards nos 1 - 37 (green tab)

Business Continuity tab:- with deep dive questions to support the review of business continutiy planning for EPRR Assurance 2016-17 (blue tab) with a focus on organisational fuel use and supply.

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and NHS ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard (NHS Ambulance Services only): designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards (NHS Ambulance Services only): designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V4.0. The following changes have been made :

- Inclusion of Business Continuity questions to support the 'deep dive' for EPRR Assurance 2016-17, replacing the Pandemic Influenza tab
- Inclusion of the HART service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Inclusion of the MTFA service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Updated the requirements for primary care to more accurately reflect where they sit in the health economy

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs
Governance												
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
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.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
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.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
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 it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity;	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
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	Y	Y	Y	Y	Y	Y	Y	Y	Y
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.	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
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):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y	Y			
		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y			Y	Y	Y	Y	Y
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y			Y		Y	Y	
		Mass Casualties	Y	Y	Y			Y		Y	Y	
		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Infectious Disease Outbreak	Y	Y	Y			Y	Y	Y	Y	Y
		Evacuation	Y	Y	Y			Y	Y	Y	Y	Y
		Lockdown	Y	Y	Y			Y	Y			
		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y	Y	Y	Y	Y
		Excess Deaths/ Mass Fatalities	Y	Y	Y					Y	Y	
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			Y							
		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y							
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	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.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
11	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.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y			Y	Y			
13	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	Y	Y	Y	Y	Y	Y	Y	Y	Y
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Command and Control (C2)												
15	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.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Y	Y		Y	Y	Y	Y	Y	Y

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs
17	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 .	This should be proportionate to the size and scope of the organisation.	Y	Y	Y		Y	Y	Y	Y	Y	Y
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
19	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	Y	Y		Y	Y	Y	Y	Y	Y
20	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.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y							
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y							
Duty to communicate with the public												
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	Y	Y			Y	Y	Y	Y	Y

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y		Y	Y	Y	Y	Y	Y
Information Sharing – mandatory requirements												
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	Y	Y		Y	Y	Y	Y	Y	Y
Co-operation												
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	Y	Y			Y	Y	Y	Y	Y
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and main	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y	Y	Y			Y	Y	Y	Y	Y
28	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.				Y					Y	Y	
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y						Y	
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y	Y	Y			Y	Y			Y
31	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										Y	
32	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									Y	Y	
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y			Y	Y	Y		Y
Training And Exercising												
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y			Y	Y	Y	Y	Y
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y		Y	Y	Y	Y	Y	Y

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 standard.	Action to be taken	Lead	Timescale
• Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	COO Director level accountability. EP BCM in post			
	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.			
	COO Director level accountability.Version controlled policies and plans in place. Exercises and tabletops undertaken to test plans Plans amended with lessons learnt			
	COO reports to the Trust Board on significant incidents and an Audit report by an outside agency has been undertaken to ensure Compliance			
• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	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			
	LHRP plans available and accessible. Meetings attended by COO and EPBCP Manager. Suppliers information on their plans are documented within their contract			
	Risks are shared in the working groups of the LHRP and the LHRP eg MOU			
Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	Internal Emergency and External Major Incident Plans in place and plans to manage identified risks			
	Corporate and Service Business Continuity Plans in place			
	HAZMAT/CBRN action cards included in plans			
	Summer and Winter Preparedness Plan in place			
	Pandemic Influenza Plan in place			
	Trust Fuel Plan in place			
	Summer and Winter plans in place			
	Pandemic Plan in place and discussed and assessed through the LHRP sub group			
	Evacuation action cards in place			
	Lock down procedures in place			
	Action cards for loss of critical services in place			
• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	Plans are updated on an annual basis, of 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.			
• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	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			
	All Critical services have BCP's in place which document how to keep these services at an acceptalbe level in the event of disruption			
	There are plans in place to ensure that VIP patients are managed appropriately within the services and also for Media interest.			
• Specifiy who has been consulted on the relevant documents/ plans etc.	LHRP minutes will evidence the external stakeholder engagement			
	Incidents / debrief events are discussed at the Emergency planning group to identify any learning outcomes			
Explain how the emergency on-call rota will be set up and managed over the short and longer term.	24/7 on call rota in place and tested howver there are two separate number as opposed to one. This is presently being reviewed	**Contact numbers being reviewed as part of on-call moving to CAS**	**LP**	Dec-16
Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	All Directors and on call Managers have attended or will be attending EPRR training as well as being part of all the exercises undertaken throughout the year			

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 standard.	Action to be taken	Lead	Timescale
Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	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.			
	Trained loggists and administrative support are available for Control Room			
	Situations reports are part of every BCP and tested in exercises			
	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 within the Action cards relating to HAZMAT.			
	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.			
• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and	Communications BCP in place as well as good communication links with NHS England and the LHRP			

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 standard.	Action to be taken	Lead	Timescale
• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	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			
• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	There is an agreement through the LHRP to share information which would be in the interest of the Patient and the General public.			
• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	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.			
	LHRP attended for each of the two NHS England areas			
	Multi agency discussions discussd in LHRP sub groups			
	The communications to the LHRP is within the Emergency Policy			
	Sitreps completed when required by the Trust for NHS England and Unify2			
	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			
	The communications to the LHRP is within the Emergency Policy			
	NHS England and PHE communicate tot the Trust in the event of any incident			
	COO attends LHRP meetings			
• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	Training needs analysis Training plans approved EP working group			
	Exercise programme approved EP Working Group Report from exercises			
	Directors and Senior managers take part in exercises anually			
	Not all Directors and On call Managers have been trained	Directors and Senior Managers to attend Incident Management Training	NP	Feb-17

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	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 standard.	Action to be taken	Lead	Timescale
2015 Deep Dive																	
DD1	Organisation has undertaken a Business Impact Assesment	• The organisation has undertaken a risk based Business Impact Assessment of services it delivers, taking into account the resouces required against staffing, premises, information and information systems, supplies and suppliers • The organisation has identified interdependencies within its own services and with other NHS organisations and 3rd party providers • Risks identified thought the Business Impact Assessment are present on the organisations Corporate Risk Register	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• updated Business Imact Assessment • corporate risk register	Business Impact Analysis have been undertaken to ensure that all Critical areas are supported by non critical areas and are updated. A Corporate Risk Register is in place and is reviewed at Emergency Planning meetings.			
DD2	Organisation has explicitly identified its Critical Functions and set Minimum Tolorable Periods of disruption for these	• The organisation has identified their Critical Functions through the Business Impact Assesment. • Maximum Tolerable Periods of Disruption have been set for all organisational functions , including the Critical Functions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity plan explicitly details the Critical Functions • Business Continuity plan explicitly outlines all organisations functions and the maximum tolerable period of disruption	All Critical areas have maximum tolerance of time and staffing requirements to undertake their functionality			
DD3	There is a plan in place for the organisation to follow to maintain critical functions and restore other functions following a disruptive event.	• The organisation has an up to date plan which has been approved by its Board/Governing Body that will support staff to maintain critical functions and restore lost functions • The plan outlines roles and responsibilities for key staff and includes how a disruptive event will be communicated both internally and externally	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• an organisation wide Business Continuity plan that has been updated in the last 12 months and agreed the Board/Governing Body	The Trust Business Continuity Plan is in place and works in conjuction with the Critical Locality BCPs and Corporate BCPs.			
DD4	Within the plan there are arrangements in place to manage a shortage of road fuel and heating fuel	• The plan details arrangements in place to maintain critical functions during disruption to fuel. These arrangements include both road fuel and were applicable heating fuel.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• detail within the plan that explicitly makes reference to shortage of fuel and its impact of the business.	There is a Fuel Plan which identifies Critical staff who would be able to access Fuel in an emergency situation			
DD5	The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsecuent guidance which may supersede this	EPRR Framework 2015 requirement, page 17	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		All PFI organisations take part in exercises within the Trust to test their plans are in place and ensure Continuity of service			
DD6	Review of Critical Services Fuel Requirement Data Collection Programme (F1F18)	Please complete the data collection below - this data set does not count towards the RAG score for the organisations. Please provide any additional information in the "Other comments" free text box.	Y	Y		Y	Y	Y	Y				• NHS Ambulance Trusts have already provided this information in a national collection in May 2016.	Data information is below.			

Fuel Demand Summary

When providing information on the fuel requirements for both business as usual and to operate a critical service please ensure the supply and demand balances whereby:

Total Daily fuel use (F3) = own bunkered fuel use (F5) + any 3rd party bunkered fuel use (F6) + any forecourt fuel use (F9)

Section 1: Business as Usual Demand

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F1	How much fuel do you use daily when providing a business as usual service? (litres)	588	1,230	19

Section 2: Bunkered Fuel

Please state answeres to the questions below in column 'D' onwards.

1) What happens if I have mutual aid agreements with another Critical Service provider to utilise their bunkered stock, do I need to record the bunkered stock or will they?
DECC is requesting that the supplier records the bunkered stock holdings and the user records the demand. As the user of these bunkered fuels in this instance, please record the use of these stocks under the section referring to access to third party bunkered stock.

2) Should we assume that in the build up to an emergency our bunkered stocks would be full, as we would be prioritising deliveries and therefore the days' stock held calculations should be based on full capacity and not average daily stock holdings?
The prioritisation of supply will be dependent on the facts of any fuel shortage scenario, and will be a decision taken at the time. Data provided in the template should provide DECC with a sufficient evidence base to make decisions based on capacity and BAU bunkered stocks. Therefore please fill out the template as requested, providing notes where you think that estimates are required, or where you have had to average data in order to fit the template.

3) Our choice of bunkered fuel supplier varies depending on supply cost or availability. Who do I record as the primary supplier?
Please provide the supplier you get most of your fuel from, but also note that this varies and provide details of the other suppliers and average quantities.

4) The terminal our bunkered fuel is supplied from varies depending on who our supplier is. What should we report?
Please report your largest supplier based on average BAU, but also provide notes on any secondary service providers and average quantities obtained from those providers.

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F2	Do you hold bunkered fuel (No) If no go to F6	No	No	No
F3	What is the total bunkered fuel capacity? (litres)			
F4	On average, what volume of bunkered fuel do you hold? (litres)			
F5	Do you use your own bunkered fuel when providing a business as usual service? If "Yes", how much bunkered fuel do you use daily? (litres) If no go to F6			
F6	Do you access a 3rd party or another service's bunkered fuel when providing a business as usual service? If "Yes", how much bunkered fuel do you use daily? (litres) If no go to F8			No
F7	If you have answered "Yes" to F6 or have bilateral supply agreements to operate a business as usual service, please provide a description of any agreement(s), amount of supply and companies / organisations involved.			

Section 3: Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F8	Do you use forecourts to operate a business as usual service? (Yes/No) If no go to F10	Yes	Yes	Yes
F9	What is the average daily forecourt fuel use to operate a business as usual service? (litres)	588	1,230	19

Critical Service Operation Only

Please refer to question 4 of the guidance notes for further information on how to identify the fuel requirements of a critical service.
During an emergency it is expected that organisations will not be operating as normal and will only be delivering those essential services that are Critical.
Low fuel consumption alternatives should also be explored as part of the Critical Service identification process. For example, if there is the possibility that a Critical Service activity can be carried out remotely, and therefore does not require the use of fuel, this should be removed from the supply requirements to deliver a Critical
The below section refers to the fuel requirements to deliver a Critical Service only.

Section 4: Critical Service Demand

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F10	How much fuel would you use daily if you were providing a critical service? (litres)	19	82	3

Section 5: Critical Service Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F11	Do you have access to either your own or 3rd party bunkered fuel if you were providing a critical service (either from general access or mutual supply agreements)? (Yes/No) If no go to F14	No	Yes	No
F12	What volume of your own bunkered fuel would you use daily if you were providing a critical service? (litres)		82	
F13	What volume of 3rd party or another service bunkered fuel (either from general access or mutual supply agreements) would you use daily if you were providing a critical service? (litres)		82	
F14	If you have answered "Yes" to F13 or have bilateral supply agreements to operate a critical service, please provide a description of any agreement(s), amount of supply and companies / organisations involved. If no go to F15	NEAS and YAS		

Section 6: Critical Service Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F15	Will you need access to Designated Filling Stations (DFS) if you were providing a critical service? (Yes/No) If no go to F17	Yes	Yes	Yes
F16	What volume of fuel would you use daily from Designated Filling Stations (DFS) if you were providing a critical service? (litres)	19	82	3

Critical Service Operation Only

F17 To ensure that there are adequate Designated Filling Stations* (DFS) to meet the demands of all critical users , please detail in the table below the number of vehicles required to operate a critical service
A Designated Filling Station (DFS) is a retail filling station with the purpose of only supplying road fuel for critical use only. The DFS list will be compiled to provide sites giving a good geographic coverage of the UK to meet the predicted regional demand for fuel for critical services.

Vehicles	Number of Vehicles required to operate a critical service		
	Petrol	Diesel	Other (inc LPG)
With NHS Logo		19	
Without NHS Logo		90	
Private vehicles			
Total		109	

F18 If you have answered "Yes" to question 2 (Do you hold bunkered fuel?) please detail which company primarily supplies your bunkered fuel and where known which local or regional supply depot or terminal does the fuel gets delivered from. Please select from drop down list provided or select "other" and please detail.

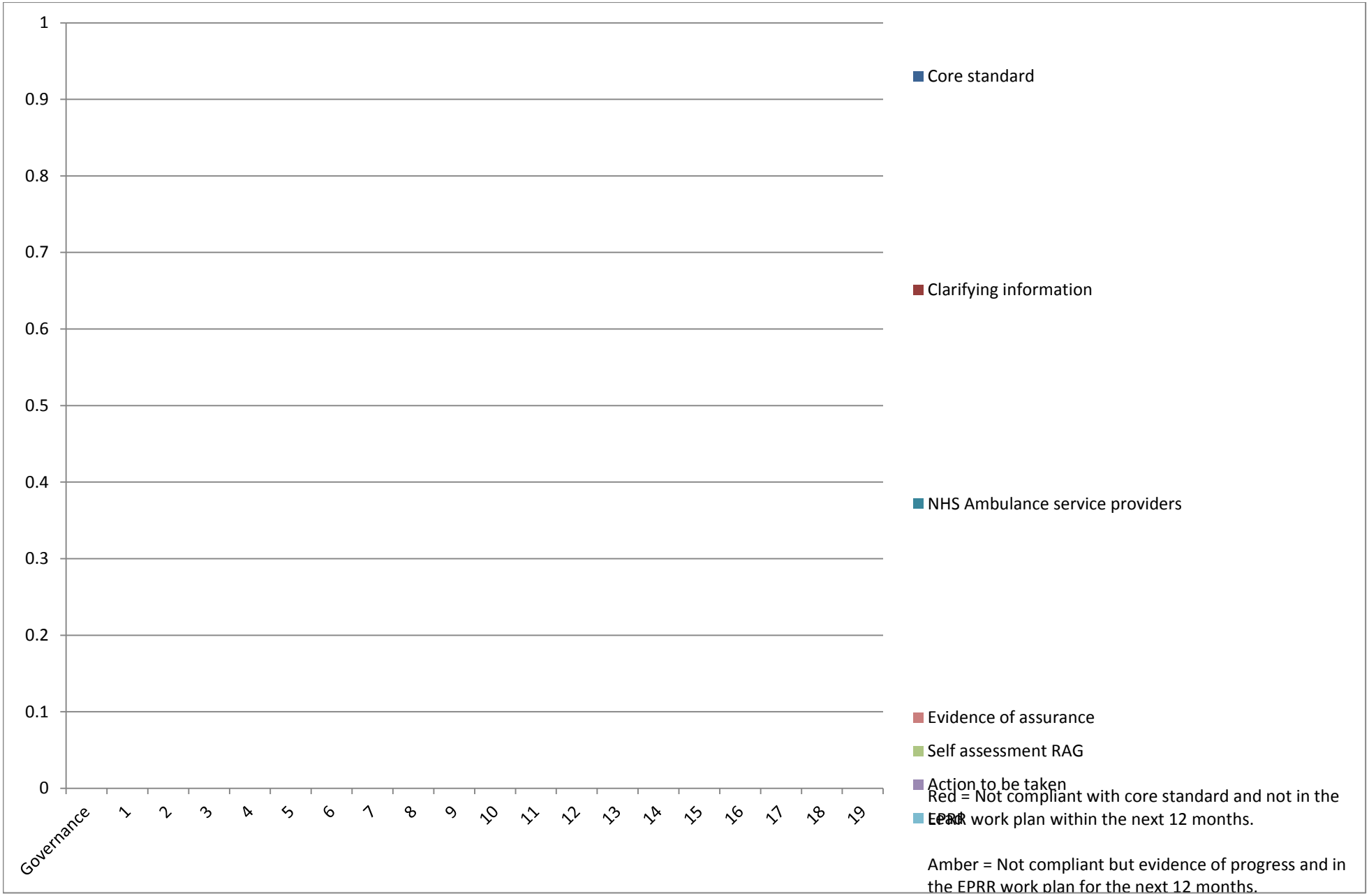
Who primarily supplies your bunkered fuel? Please Select from drop down list:	If other or multiple suppliers please state:	Which Terminal is your bunkered fuel supplied from? Please Select from drop down list:	If other please state:	Average Number of Deliveries per Month

The Trust has a Fuel Policy which was follows the National and Local Health Resilience Partnership guidance.
Within the Policy it identifies the Critical users who would be able to access fuel. It also identifies the logged vehicles which can be used in the event of a fuel crisis
The Local Health Resilience Parnership plan was Chaired by the Trust E P Manager.
The formulation for the fuel was undertaken by Finace to ensure that it was correct as per guidance .

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	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	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
	Preparedness											
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	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			
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	• Site inspection • IT system screen dumo	All Critical areas and reception areas have plans in place			
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	Appropriate Dry decontamination action cards are in place throughout all 24 /7 areas of the Trust			
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements	N/A			
42	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.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness	Action Cards identify the Line Managers responsibility to contact the relevent agencies. Exercises assist in the staff awareeness.			
	Decontamination Equipment											
43	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.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	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 with.			
44	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)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y				N/A			
45	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	There is a named role responsible for ensuring these checks take place	Y		Y				**N/A**			
46	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		Y		Y				N/A			
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y				N/A			
	Training											
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y				N/A			
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	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			
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme		Y		Y				N/A			
51	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.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y		Action Cards identify actions to be taken and exercises assist in raising staff awareness			

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) 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).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		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Core standard
Clarifying information
NHS Ambulance service providers
Evidence of assurance
Self assessment RAG
Action to be taken
Lead
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.

Core standard	Clarifying information	NHS Ambulance service 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 standard.	Action to be taken	Lead	Timescale
ce							
Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.	Y					
Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.	Y					
Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.	Y					
Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.	Y					
Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.	Y					
Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.		Y					
Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.		Y					
Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y					
Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.		Y					
Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).		Y					
In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.		Y					
Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.		Y					
Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.		Y					
Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.		Y					
Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.		Y					
Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.		Y					
Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.		Y					
FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.	Y					
Organisations ensure that staff view the appropriate DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.	Y					

	Core standard	Clarifying information	NHS Ambulance service 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 standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organisations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organisations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organisations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organisations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART.	Y					
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.		Y					
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.		Y					
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.		Y					
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.	Y					
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.		Y					
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.	Y					
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.		Y					
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.		Y					
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.		Y					
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).		Y					
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.		Y					
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.		Y					
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.		Y					
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.		Y					
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).		Y					
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.		Y					
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.		Y					
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.		Y					
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.		Y					
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.		Y					

STATEMENT OF COMPLIANCE **Appendix 2**

Tees, Esk and Wear Valleys NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v4.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board or Governing Body has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body 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 or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the organisation has undertaken the following exercises on the dates shown below:

A live exercise (required at least every three years)	Three Cathedrals Exercise 09/09/15
A desktop exercise (required at least annually)	Forensic Tees Locality table top 04/11/15
A communications exercise (required at least every six months)	Exercise Temenos 22/04/16 Exercise Three Cathedrals 09/09/15

I confirm that the above level of compliance with the core standards has been confirmed by the organisation's board / governing body.

_____

Signed by the organisation's Accountable Emergency Officer

_____ _____

Date of board / governing body meeting Date signed

Item 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27 September 2016**
TITLE:	**Finance Report for Period 1 April 2016 to 31 August 2016**
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 2016 is a surplus of £6,706k, representing 4.9% of the Trust's turnover. The Trust is ahead of plan by £1,084k largely due to vacancies and staff turnover, active recruitment is ongoing.

Identified Cash Releasing Efficiency Savings at 31 August 2016 are in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

The Financial Sustainability Risk Rating for the Trust is assessed as 4 for the period ending 31 August 2016 and is in line with plan.

Recommendations:

The Board of Directors are 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:	**27 September 2016**
TITLE:	**Finance Report for Period 1 April 2016 to 31 August 2016**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2016 to 31 August 2016.

2. BACKGROUND INFORMATION

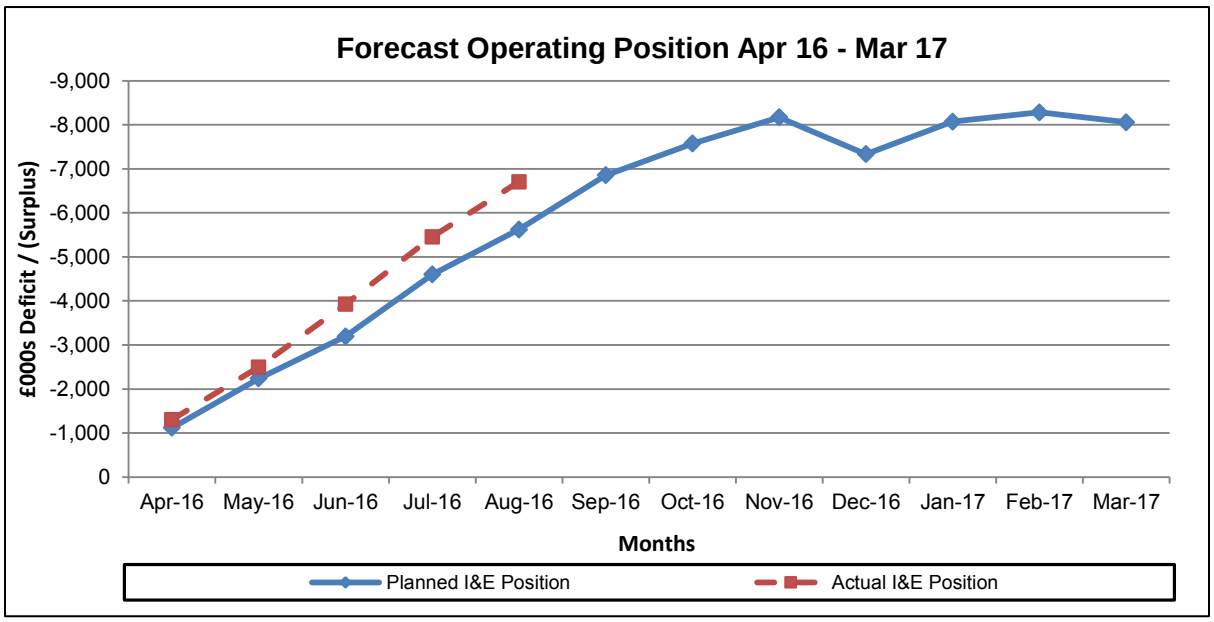
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis on a quarterly basis.

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

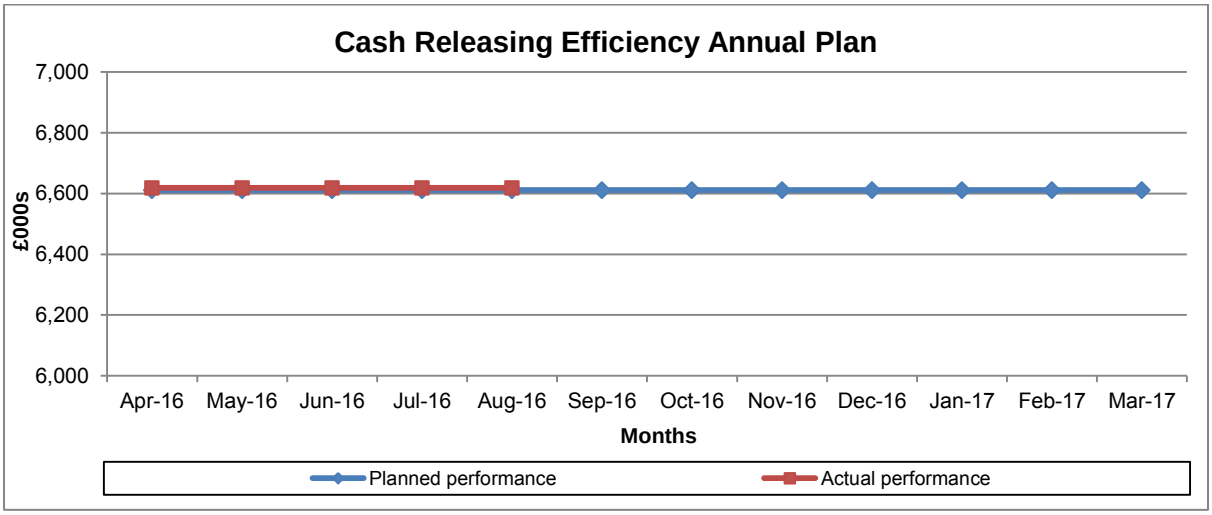
The comprehensive income outturn for the period ending 31 August 2016 is a surplus of £6,706k, representing 4.9% of the Trust's turnover. The Trust is ahead of plan by £1,084k largely due to vacancies across the majority of staffing groups.

The graph below shows the Trust's planned operating surplus against actual performance.

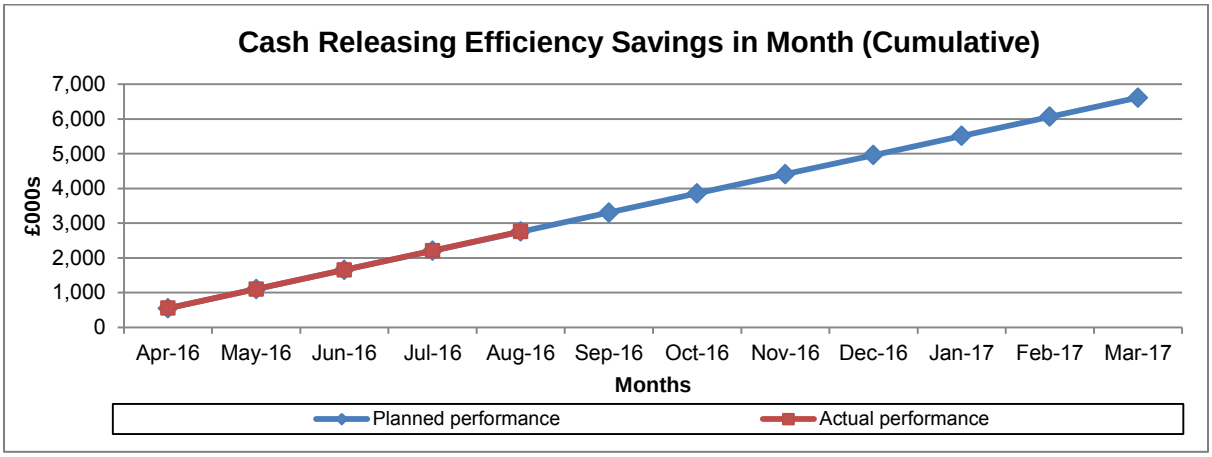


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 August 2016 is £6,618k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

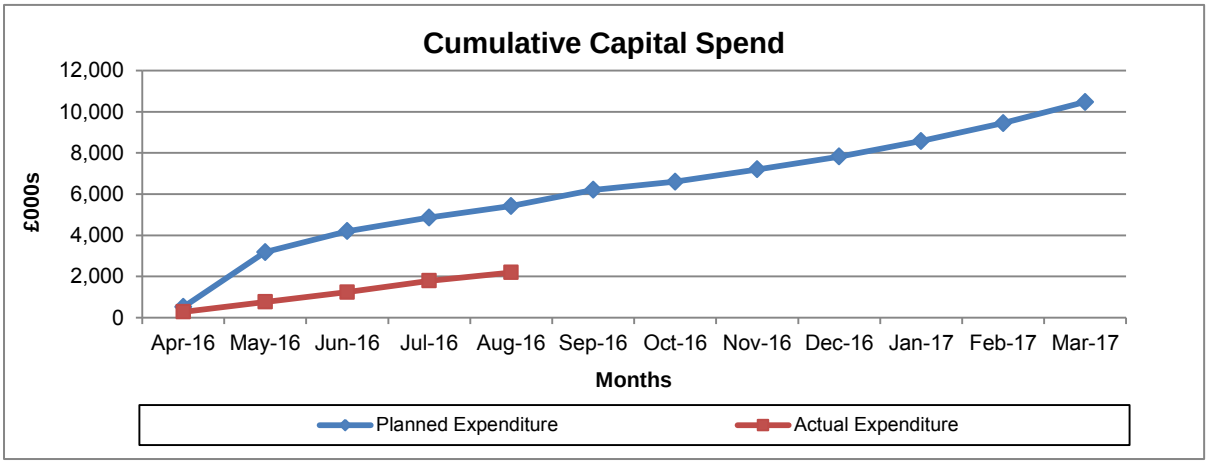


The monthly profile for CRES identified by Localities is shown below.



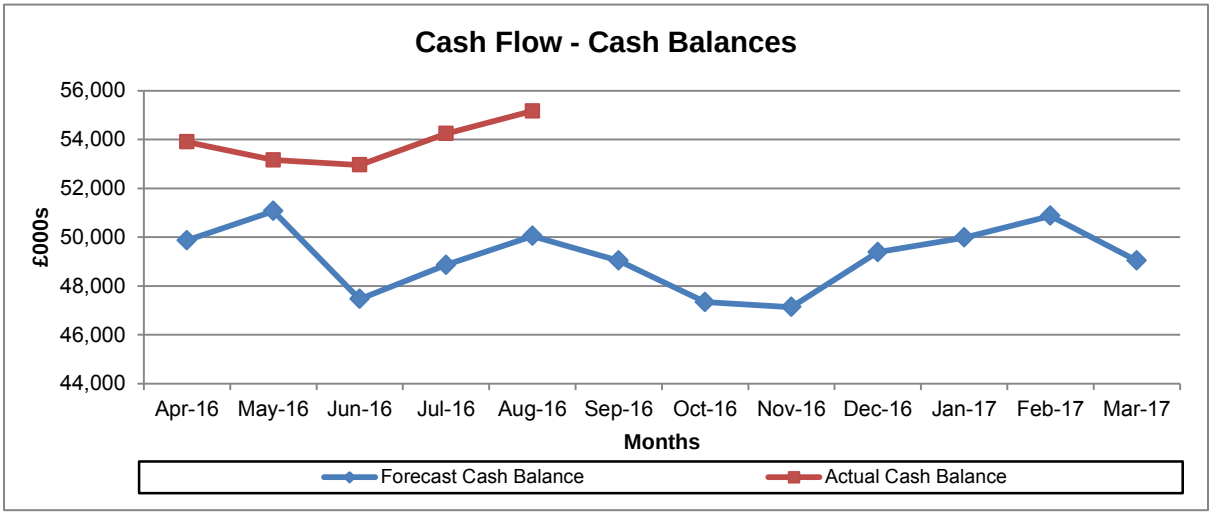
3.3 Capital Programme

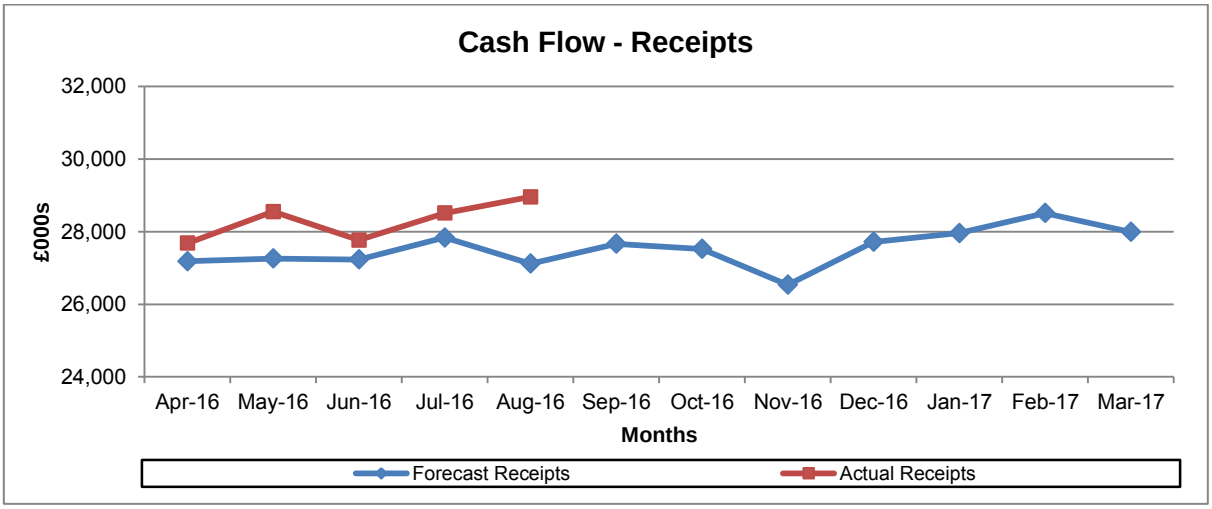
Capital expenditure to 31 August 2016 is £2,193k and is behind plan largely due to the Trust's decision to defer a material scheme.

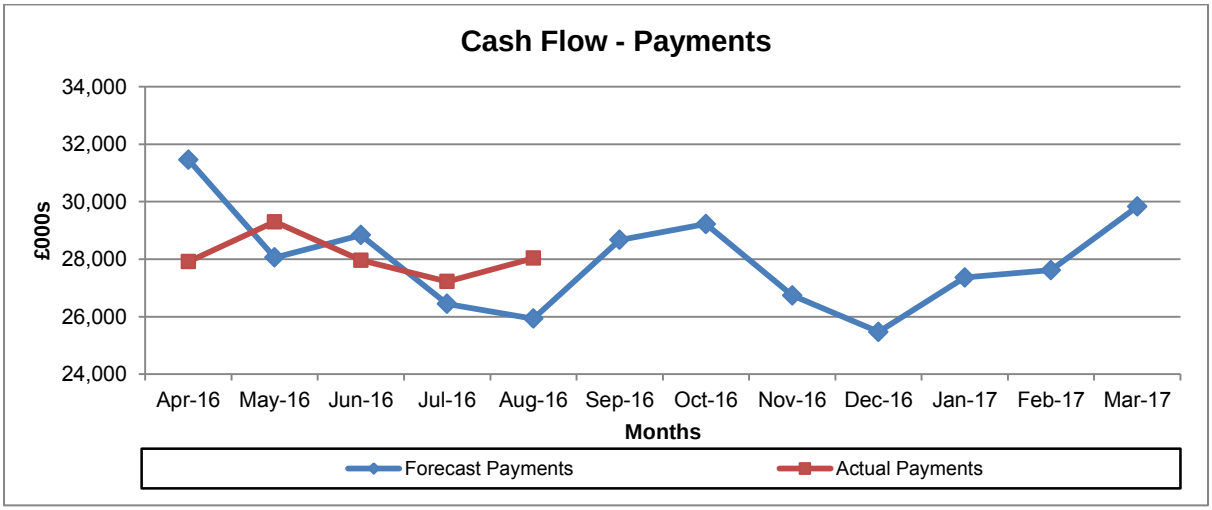


3.4 Cash Flow

Total cash at 31 August 2016 is £55,165k and is ahead of plan due to variances against the planned working capital cycle and planned delays in the capital programme.



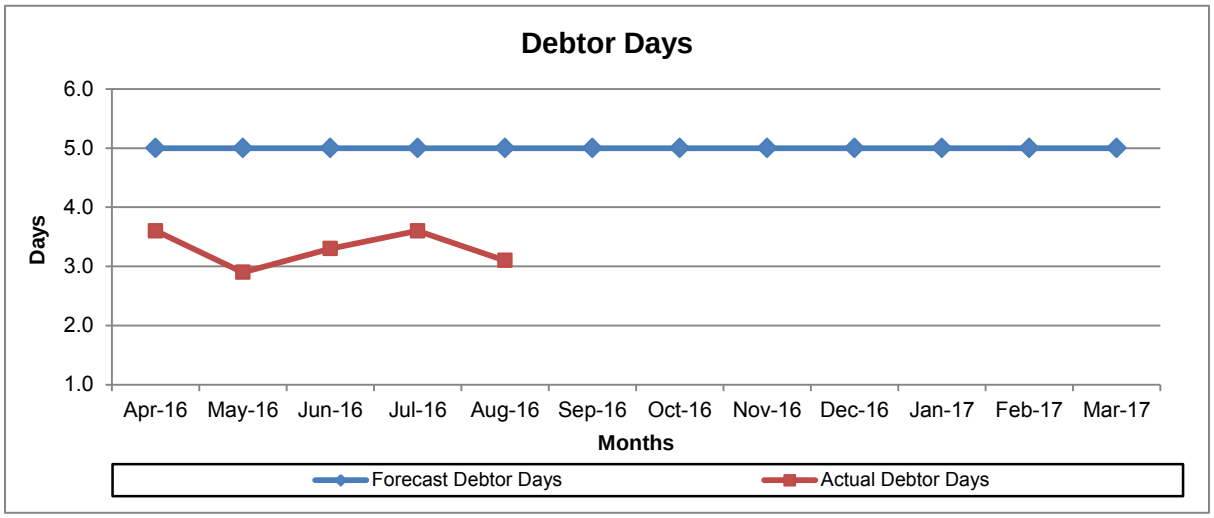




The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

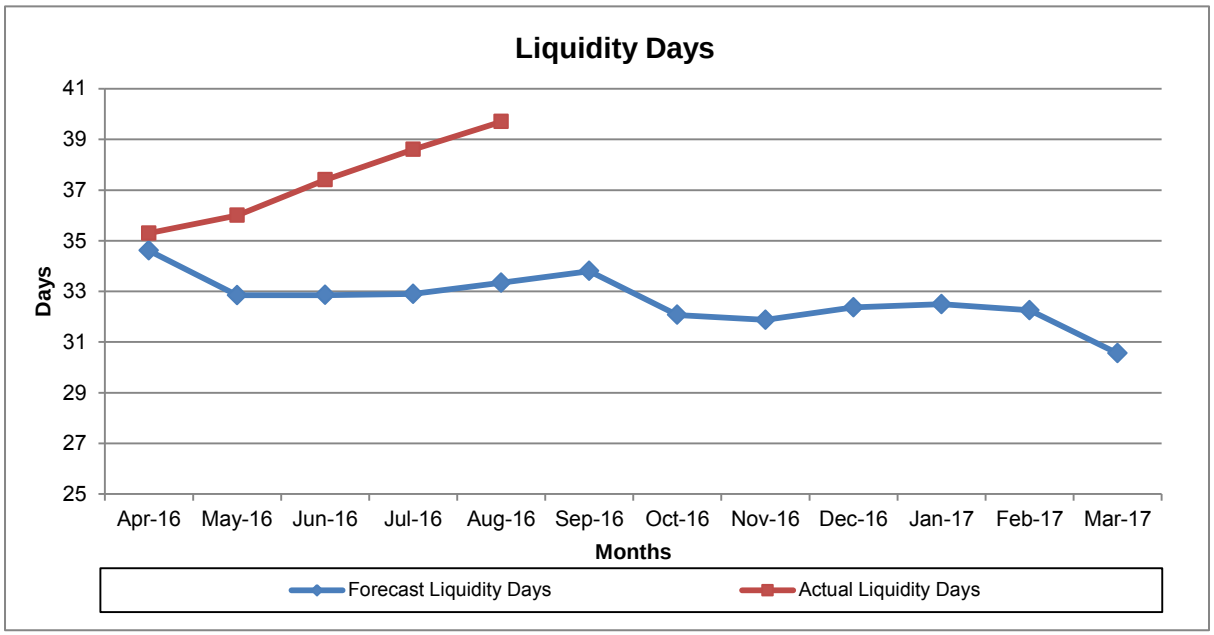
Working Capital ratios for period to 31 August 2016 are:

- Debtor Days of 3.1 days
- Liquidity of 39.7 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 52.21%
  Non NHS 30 Days – 98.31%



The Trust has a debtors' target of 5.0 days, and actual performance of 3.1 days for August, which is ahead of plan.

The liquidity days graph below reflects the metric within NHS Improvement's risk assessment framework. The Trust's liquidity day's ratio is ahead of plan.



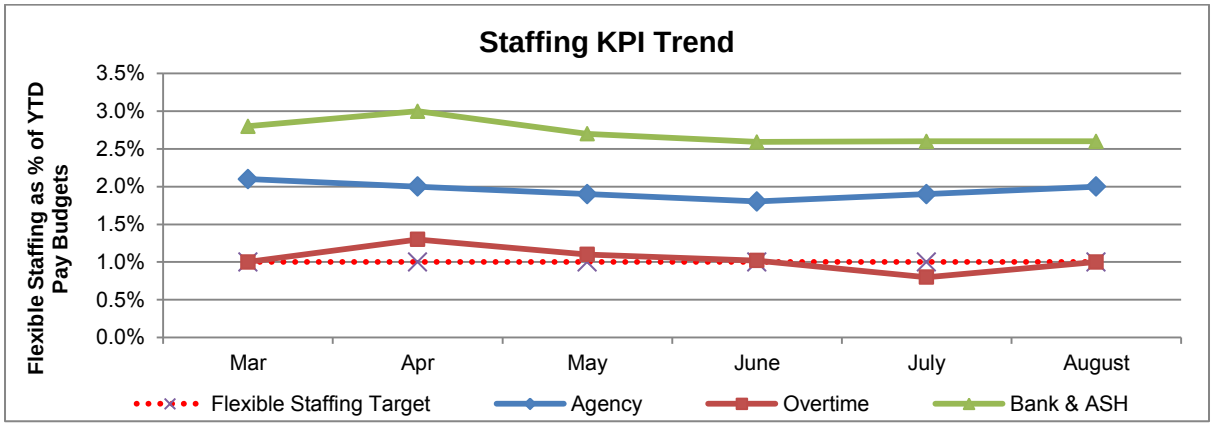
3.5 Financial Drivers

The following table and chart show the Trust's performance on some of the key financial drivers identified by the Board.

Tolerance	Apr	May	Jun	Jul	Aug
Agency (1%)	2.0%	1.9%	1.8%	1.9%	2.0%
Overtime (1%)	1.3%	1.1%	1.0%	0.8%	1.0%
Bank & ASH (flexed against establishment)	3.0%	2.7%	2.6%	2.6%	2.6%
Establishment (90%-95%)	94.5%	93.9%	93.8%	94.5%	94.6%
Total	100.8%	99.6%	99.2%	99.8%	100.2%

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 & additional standard hours (ASH). For August 2016 the tolerance for Bank and ASH is 3.4% of pay budgets.

The following chart shows performance for each type of flexible staffing.



Additional staffing expenditure is 5.6% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (58%), enhanced observations (17%) and sickness (10%).

3.6 Risk Ratings and Indicators

3.6.1 The Financial Sustainability Risk Rating is assessed as 4 at 31 August 2016, and is in line with plan.

3.6.2 Capital service capacity rating assesses the level of operating surplus generated, to ensure a Trust is able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.91x (can cover debt payments due 1.91 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 39.7 days, this is ahead of with plan and is rated as a 4.

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 4.9% and is rated as a 4.

3.6.5 The variance from plan assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. The Trust surplus is 0.8% ahead of plan and is rated as a 4.

The margins on Financial Sustainability Risk Rating are as follows:

- Capital service cover - to increase to a 4 a surplus increase of £3,675k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £32,906k is required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £5,327k is required.
- Variance from plan – to reduce to a 3 an operating surplus decrease of £1,093k is required.

Financial Sustainability Risk Rating at 31 August 2016

NHS Improvement's Rating Guide	Weighting %	Rating Categories 4	3	2	1
Capital service Cover	25	2.50	1.75	1.25	<1.25
Liquidity	25	0.0	-7.0	-14.0	<-14.0
I&E Margin	25	1%	0%	-1%	<=-1%
Variance from plan	25	0%	-1%	-2%	<=-2%

TEWV Performance	Actual Achieved	Actual Rating	YTD Plan Planned	YTD Plan Rating	RAG Rating
Capital service Cover	1.91x	3	1.73x	2	
Liquidity	39.7 days	4	34.3 days	4	
I&E Margin	4.9%	4	4.1%	4	
Variance from plan	0.8%	4	0.0%	4	
Overall Financial Sustainability Risk Rating		**4.00**		**4.00**	

3.6.7 12.5% of total receivables (£414k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as discussions are ongoing to resolve material debts.

3.6.8 3.4% of total payables invoices (£368k) held for payment are over 90 days past their due date. This is below the 5% finance risk tolerance.

3.6.9 The cash balance at 31 August 2016 is £55,165k and represents 66.3 days of annualised operating expenses.

3.6.10 The Trust does not anticipate the Financial Sustainability Risk Rating will be less than 3 in the next 12 months.

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 2016 is a surplus of £6,706k, representing 4.9% of the Trust's turnover. The Trust is ahead of plan by £1,084k largely due to vacancies and staff turnover with ongoing recruitment.

6.2 Total CRES identified at 31 August 2016 is £6,618k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

6.3 The Financial Sustainability Risk Rating for the Trust is a 4 for the period ending 31 August 2016 which is in line with plan.

7. RECOMMENDATIONS:

7.1 The Board of Directors are 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 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th September 2016**
TITLE:	**Board Dashboard as at 31st August 2016**
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 2016 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. The dashboard is now inclusive of performance relating to York and Selby. The report also provides proposals on some amendments to the current target following a review at the end of Quarter 1.

As at the end of August 2016, 9 (43%) of the indicators reported are not achieving the expected levels and are red, which is a decline on the July figure of 6 (33%). Of those red indicators, 8 are showing an improving trend over the previous 3 month period and some are performing better than in previous years. There is a further 1 indicator which whilst not completely achieving the target levels are within the amber tolerance levels.

The report also contains performance relating to one of the three indicators that has not previously been able to be report. It also contains recommendations from EMT of changes to targets following a review which was undertaken at the end of Quarter 1.

Whilst not included in the Trust Dashboard the Corporate Performance Department continue to monitor the indicators within Monitor's Risk Assessment Framework and as at the end August all the targets for these indicators were being achieved.

The key issues/risks continue to be:

- Bed Occupancy – (KPI3)
- Access – Waiting Times (KPI 7)
- Out of Locality Admissions (KPI 9)
- %age registered healthcare professional jobs advertised 2 or more times(KPI 15)
- Appraisal (KPI 16)

Recommendations:

It is recommended that the Board consider the content of this paper and:

- Raise any areas of concern/query.
- Discuss whether they wish the indicator on cancelled appointments to continue to be reported given its limited coverage or whether they would prefer for the indicator to be removed from the Dashboard until such time as we can report all cancellations by the Trust.(see Section 2.2)
- Approve the recommendations to revise the targets for KPI 14 and 15 as set out in Section 2.3.
- Approve a further review of the targets as at the end of September when further information in terms of the performance in York and Selby will be available.

MEETING OF:	**Board of Directors**
DATE:	**27th September 2016**
TITLE:	**Board Dashboard as at 31st August 2016**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st August 2016 in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 The key issues are as follows:

- As at the end of August 2016, 9 (43%) of the indicators are not achieving the expected levels and are red, which is a decline on the July figure of 6 (33%). Of those red indicators 8 are showing an improving trend. There is a further 1 indicator which whilst not completely achieving the target levels is within the amber tolerance level and the trend for this is also one of improvement.

- The Dashboard includes for the first time KPI 2 'Caseload Turnover' KPI2'. This indicator compares the caseload at the end of August with that three months ago and shows the difference between the two. The indicator target is set such that we would not want to see a growth of >1.99% between the two points in time. The indicator is linked to the Purposeful and Productive Community Services (PPCS) work and is an indicator that caseloads are not growing which could be as a result of service users remaining on caseloads unnecessarily whilst also putting pressure on the resources within community teams. Through the PPCS work we will in the future be able to identify what optimum caseloads are and this will influence this indicator and target in the future. Work is continuing on developing the reaming two outstanding indicators on Outcomes

- The Data Quality Scorecard is included in Appendix B.

- Appendix C includes the breakdown of the unexpected deaths actual.

2.2 The key risks are as follows:

- Bed Occupancy (KPI 3) – The actual performance is worse than the target by 9.84 percentage points which is a slight deterioration on the position in July. All localities are failing to achieve the target level with all showing levels of over 90%. The delay to the opening of Peppermill Court in York (due to a fire) is impacting on the position however it is expected that when the 24 beds open at the end of September that the overall levels of occupancy across the Trust will reduce.

- External Waiting Times (KPI 7) – the Trust has not achieved the 90% target it set itself for the number of people seen within 4 weeks in August; however this is the best performance so far this financial year and the 3 month trend continues to be one of improvement. The figure reported in August 2016 is also higher than that reported in both August of the two preceding years. The main area of concern continues to be Children and Young Peoples services, and in particular in North Yorkshire and York & Selby.

    - The position in North Yorkshire is linked to a number of urgent and complex cases that have consumed more of the teams resources together with vacancies. The service is holding an event in September to consider what it can do to increase recruitment. The number of children still waiting for more than 4 weeks as at the end of August has remained the same as that at the end of July.

    - In York & Selby the service has identified a shortfall in capacity to meet the demands on the service which has been logged on the Service Risk Register and the action plan which was developed in July is now being implemented. The number of children still waiting over 4 weeks at the end of August was slightly less than at the end of July.

    - The position in Durham and Darlington continues to improve with 51 children still waiting over 4 weeks at the end August compared to 72 as at the end of July.

- Percentage of appointments cancelled by the Trust (KPI 8) – This KPI is slightly worse than target. However extensive work has been undertaken following the work done by Internal Audit and it is now clear that the figures reported only relate to those appointments which are scheduled to take place in clinics by a medic rather than the more generic appointments undertaken by other members of the community teams, which are by far the greater number of appointments. This is due to the use of different modules in PARIS. Therefore the figure reported is not a true reflection of the position across all appointments within the Trust, in fact only relating to approximately 10% of all appointments. Work is ongoing to investigate if this can be rectified in the short term or if this can only be achieved when the planned introduction of staff diaries within PARIS is in place (expected in Quarter 1 2017/18. **The Board are asked to discuss whether they wish this indicator to continue to be reported given its limited coverage or whether they would prefer for the indicator to be removed from the Dashboard until such time as we can report all cancellations by the Trust.**

- Out of Locality Admissions (OoL) (KPI 9). The Trust has continued not to achieve the target in August; however there is a further improvement compared to July 2016 and the 3 month trend is one of improvement. North Yorkshire are significantly worse than target. It is anticipated that

the opening of Peppermill Court and the 'reboot' of the Purposeful Inpatient Admissions processes should have a positive impact on performance.

- %age of registered healthcare professional jobs advertised 2 or more times (KPI 15) - the actual performance is significantly worse than the target set and despite an deterioration in August the three month trend is still one of improvement.

- Appraisal (KPI 16) – The Trust is not achieving the target of 95% as at the end August however the trend continues to be one of improvement. The position in August 2016 is considerably better than that in August of the two previous years. The development work on the production of more detailed reports via the IIC is now in the user testing phase and it is planned that these will shortly become available to managers.

2.3 Review of Targets

At the time of setting the targets for the KPIs within the Dashboard it was recognised that this had included some assumptions made due to either the fact that the indicators were new and previous years data was not available or because of the inclusion within the Dashboard of the performance of the York and Selby Locality. It was therefore agreed that the targets would be reviewed at the end of June in order to assess if they remain appropriate given we would have 3 months data covering the whole Trust. EMT has therefore reviewed the targets and recommends that these remain as they currently are with the exception of the following:

- **KPI 14 Actual Number of Workforce in month**. EMT felt that on reflection the RAG thresholds weren't set correctly in that we would want to see higher levels of the actual workforce as a %age of establishment. Therefore EMT recommend that the following amendments should be made:

    - Target should be 95-100% (currently 90-95%)
    - Amber is 90-95% or 100-102% (currently no amber thresholds)
    - Red would be <90% and >102% (currently <90% and >95%

- **KPI 15 %age registered healthcare professional jobs that are advertised two or more times.** Given that there had not be any previous data available when the target was set and performance has consistently been worse than target EMT felt it was appropriate to ask the Workforce Development Group to discuss whether a more appropriate target should be established. The Workforce Development Group has recommended that the target be reset at 15% for the current year. This is based on a review of the monthly performance figures for the period April to August 2016 inclusive which show that there was variable performance with a best figure of 13% in July and a worst figure of 21% in June. The average figure over this time period was 17%. A revised performance figure of no more than 15% seemed to us to represent a target the achievement of which

would constitute real improvement but still be stretching. It is proposed that the current amber tolerance would still be set at 2.5% over the target ie amber RAG rating would be set between 15% and 17.5% with anything over 17.5% being red.

In reviewing the targets EMT noted that the amount of data available for the York and Selby Locality is still limited therefore they recommend that the targets are reviewed further at the end of September when information for a further quarter will be available.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board consider the content of this paper and:

- Raise any areas of concern/query.
- Discuss and agree whether they wish the indicator on Cancelled Appointments to continue to be reported given its limited coverage or whether they would prefer for the indicator to be removed from the Dashboard until such time as we can report all cancellations by the Trust.(see Section 2.2)
- Approve the recommendations to revise the targets for KPI 14 and 15 as set out in Section 2.3.
- Approve a further review of the targets as at end September when further information in terms of the performance in York and Selby will be available.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Activity

	August 2016				April 2016 To August 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,339.00	7,509.00			36,220.00	41,034.00		86,407.00
2) Caseload Turnover	1.99%	-3.79%			1.99%	-3.79%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	94.84%			85.00%	95.65%		85.00%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	23.00	28.00			116.00	150.00		277.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.01%			15.00%	7.38%		15.00%
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	22.67			99.00	130.67		237.00

Quality

	August 2016				April 2016 To August 2016			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%	86.46%			90.00%	84.54%		90.00%
8) Percentage of appointments cancelled by the Trust	0.67%	0.68%			0.67%	0.79%		0.67%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	18.12%			15.00%	19.50%		15.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	93.07%			91.44%	92.04%		91.44%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.49			5.00	0.77		12.00

Trust Dashboard Summary for TRUST

Workforce

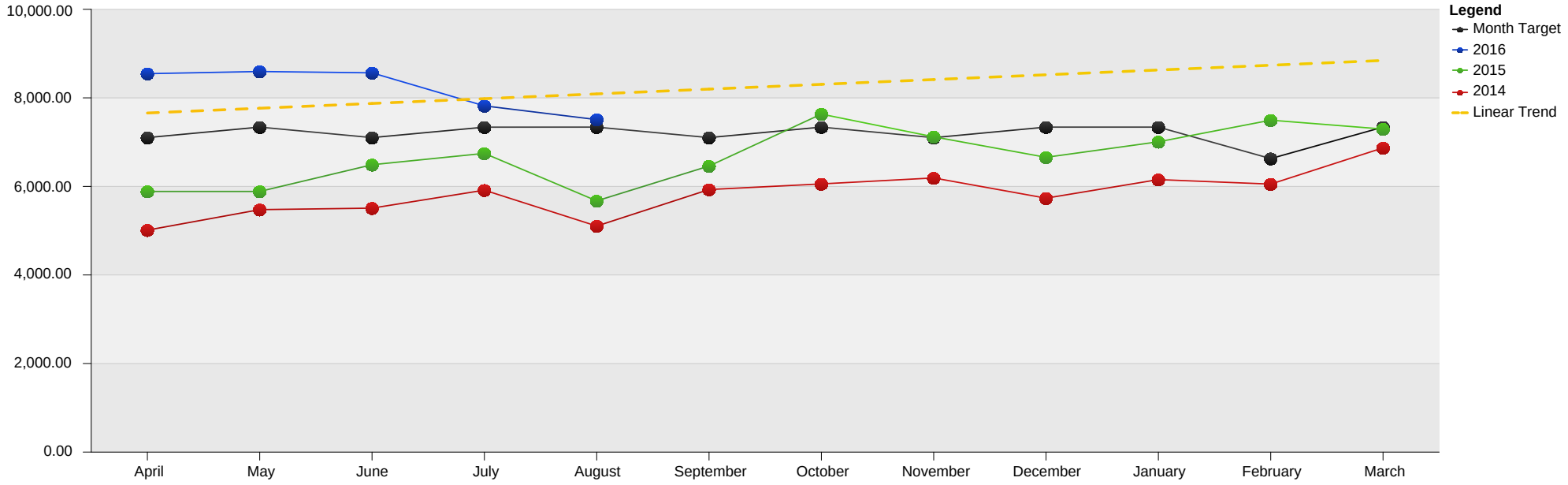
	August 2016				April 2016 To August 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 90%-95%)	95.00%	94.65%			95.00%	94.65%		95.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	5.00%	17.33%			5.00%	17.66%		5.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	89.04%			95.00%	89.04%		95.00%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.54%			95.00%	88.54%		95.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.80%			4.50%	4.73%		4.50%

Money

	August 2016				April 2016 To August 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-1,021,762.00	-1,250,000.00			-5,621,615.00	-6,706,000.00		-8,057,087.00
20) CRES delivery	550,854.00	551,538.00			2,754,271.00	2,757,690.00		6,610,251.00
21) Cash against plan	50,045,000.00	55,165,000.00			50,045,000.00	55,165,000.00		49,036,000.00

Trust Dashboard Graphs for TRUST

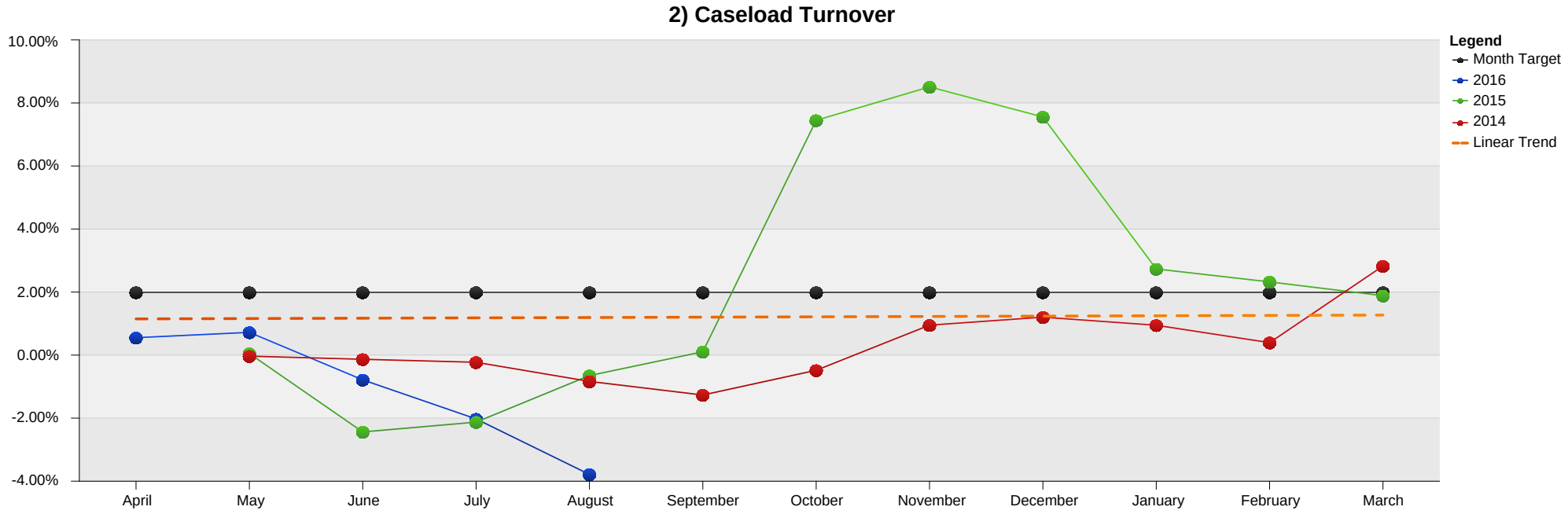
1) Total number of External Referrals into Trust Services



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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	7,509.00	41,034.00	1,791.00	9,842.00	1,757.00	9,562.00	1,952.00	9,921.00	539.00	3,182.00	1,470.00	8,515.00

Narrative
The Trust position for August 2016 is 7509 which is 170 above the Trust target of 7339 but less than that reported in July. Historically a reduction is seen in August as demonstrated in the graphs. The Trust position for the financial year to date is 41,034 which is 4814 above target.Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 6039 which is higher compared to the same period last year of 5586.Based on the increasing trend reported it is anticipated that we will exceed the annual target of 86,407 referrals by more than 10%.

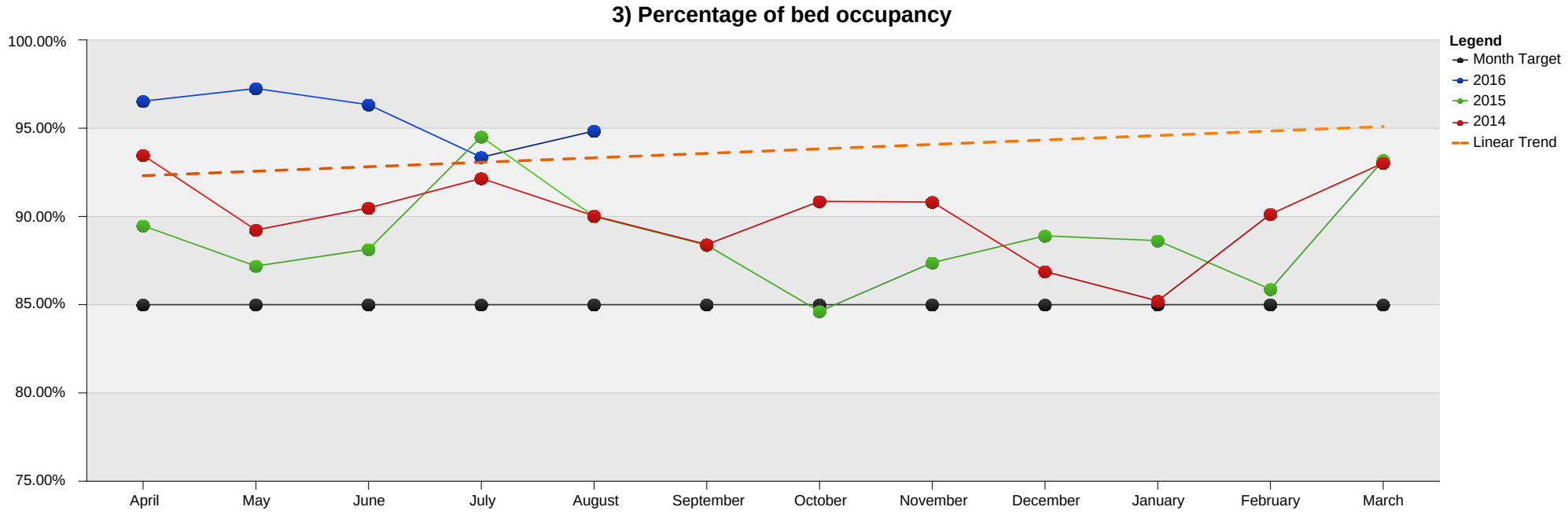
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Caseload Turnover	-3.79%	-3.79%	-4.07%	-4.07%	-1.16%	-1.16%	-8.28%	-8.28%	NA	NA	-1.94%	-1.94%

Narrative
This is a new indicator reported for the first time this month. It compares current caseload with that 3 months ago to ensure it remains within a suitable level. The Trust position for August is -3.79% which is within target. All localities are achieving the target. A peek in caseload was seen in 2015 from October – December as a result of the York and Selby locality joining the Trust and reviewing caseloads. Based on the current trend it is likely we will achieve the annual target of 1.99%

Trust Dashboard Graphs for TRUST

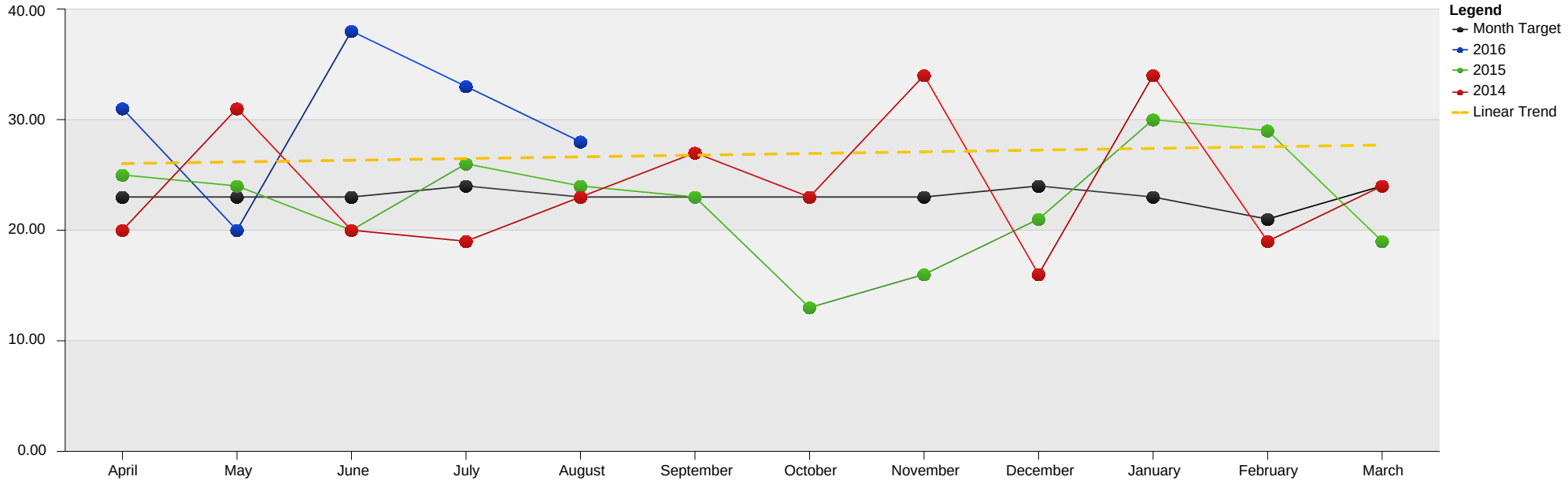


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	94.84%	95.65%	89.87%	90.84%	98.16%	98.91%	97.17%	97.45%	NA	NA	94.81%	96.49%

Narrative
The Trust position for August is 94.84% which is 9.84% over the Trust target of 85% and a deterioration on the July position. When compared to August 2015, the current position is also a deterioration. All localities are over target. The Trust position for the financial year to date is 95.65%, which is 10.65% above target.Comparative data is now included in the dashboard.A key factor contributing to this high level of occupancy is linked to the placement of York Adult Mental Health patients requiring inpatient care into beds in other localities within the Trust. It is expected that when the Adult Mental Health beds open at Peppermill in York in October, the levels of occupancy will move closer to the target set.

Trust Dashboard Graphs for TRUST

4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards



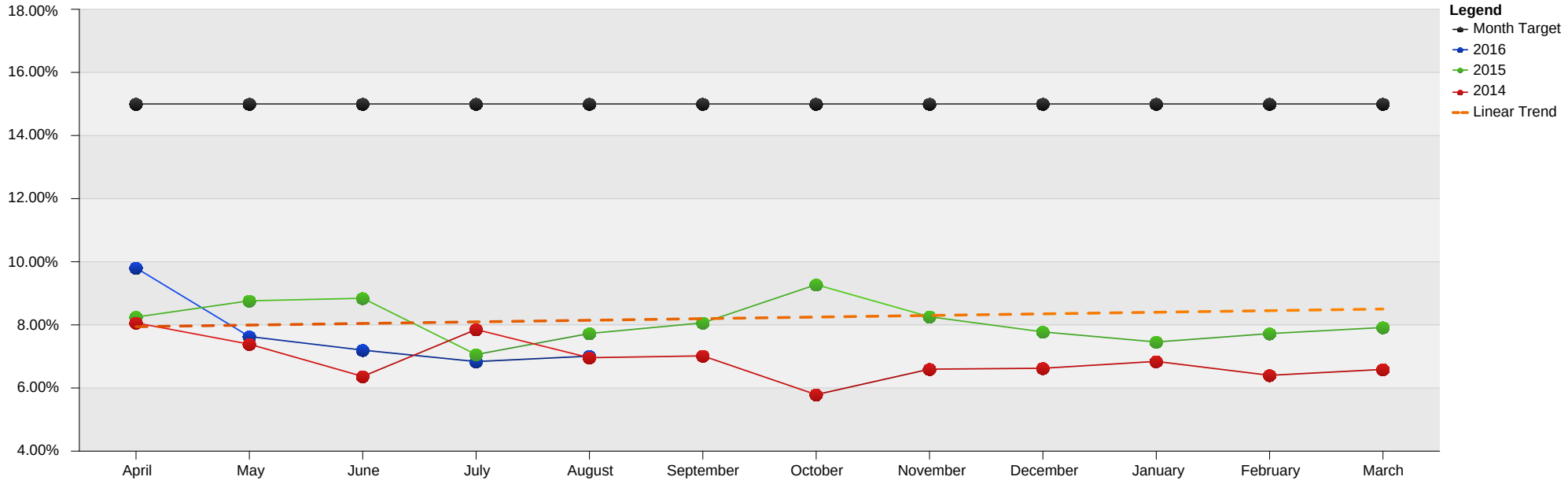
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	28.00	150.00	9.00	39.00	7.00	42.00	7.00	36.00	NA	NA	4.00	28.00

Narrative

The Trust position for August 2016 is 28 which is worse than the Trust target of 23 but an improvement on July's position. The lengths of stay ranged from 101-1295 days. The Trust position for the financial year to date is 150 which is worse than the target of 116.Of the 28 admissions with a LoS greater than 90 days:• 9 (32.14%) were within Durham & Darlington (3 AMH and 6 MHSOP) • 7 (25%) were within Teesside (3 AMH and 4 MHSOP)• 7 (25%) were within North Yorkshire (4 AMH and 3 MHSOP) • 4 (14.28%) were within York & Selby (4 MHSOP)• 1 (3.57%) was from an out of area CCG (1 MHSOP)Comparative data is now included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data given the indicator measurement is a number.The recent 'reboot' of the PIPA process in AMH should help to reduce the number of patients within AMH with a length of stay > 90 days. Based on the current trend it is unlikely we will achieve the annual target of 277.

Trust Dashboard Graphs for TRUST

5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)



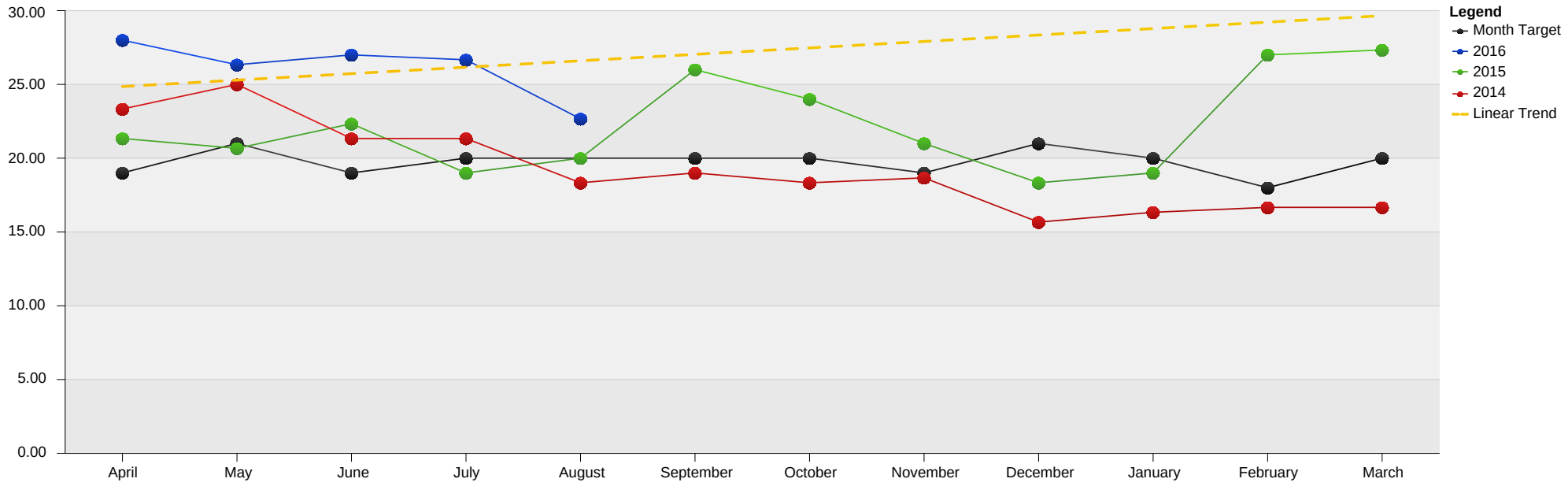
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	7.01%	7.38%	5.56%	6.12%	8.68%	7.42%	5.44%	7.32%	NA	NA	10.00%	12.30%

Narrative

The Trust rolling 3 month position ending August 2016 is.7.01%, which relates to 14.99 patients out of 214 that were readmitted within 30 days. This is better than the target of 15% and a similar level to the position reported in July 2016. The position is an improvement to that reported in August 2015. Of the 14.99 patients:• 3.99 were within Durham & Darlington (AMH) • 6.33 were within Teesside (5.33 AMH and 0.99 MHSOP).• 2.66 were within North Yorkshire (1.99 AMH and 0.66 MHSOP) • 1.99 were within York & Selby (1.33 AMH and 0.66 MHSOP)(*Please note data is displayed in decimal points due to the rolling position being calculated.)Comparative data is now included in the dashboard.Based on the improvement in performance reported earlier in the year despite the slight deterioration in August, it can be expected that we will achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

6) Number of instances of patients who have 3 or more admissions in a year (AMH and MHSOP)

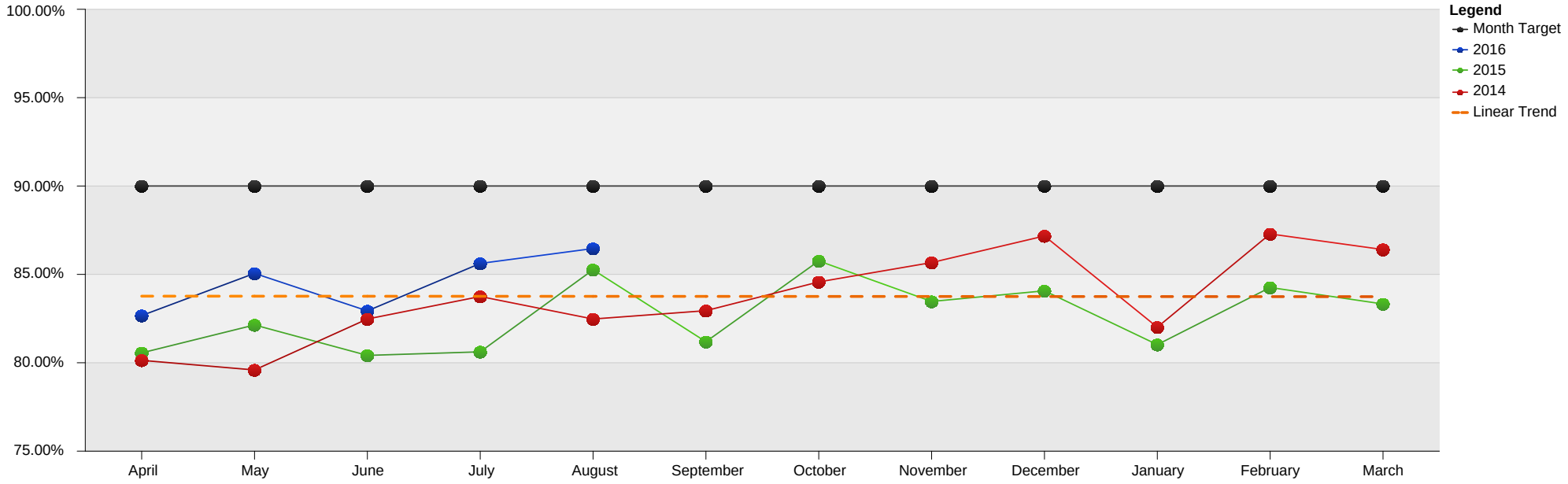


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	22.67	130.67	8.67	49.33	5.67	35.00	5.67	35.33	NA	NA	2.67	11.00

Narrative
The Trust rolling 3 month position ending August 2016 is 22.67, which is 2.67 worse than the target of 20 but an improvement on the position reported in July. The Trust position for the financial year to date is 130, which is worse than the target of 99.Of the 22.67 instances• 8.66 (38.20%) were within Durham & Darlington (AMH)• 5.66 (24.96%) were within Teesside (4.99 AMH and 0.66 MHSOP)• 5.66 (24.96%) were within North Yorkshire (5.66 AMH)• 2.66 (11.73%) was within York and Selby (AMH)(*Please note data is displayed in decimal points due to the rolling position being calculated.)Comparative data is now included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data given the indicator measurement is a number. Based on current and passed performance it is unlikely we will achieve the annual target of 237.

Trust Dashboard Graphs for TRUST

7) Percentage of patients seen within 4 weeks for a first appointment (external referral)

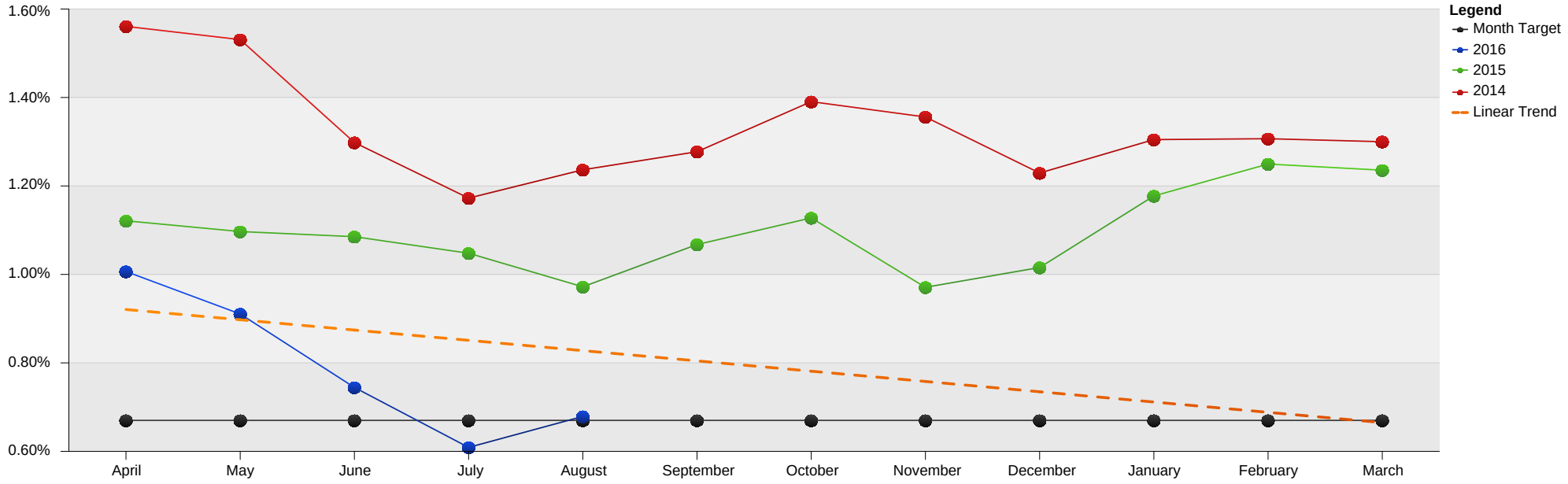


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	86.46%	84.54%	84.64%	77.67%	97.45%	95.86%	77.27%	76.70%	99.26%	99.49%	62.86%	71.04%

Narrative
The position for August 2016 is 86.46%, relating to 602 patients out of 4447 who had waited longer than 4 weeks for first appointment. This is 3.54% worse than target but an improvement on the position reported in July. The position for financial year to date is 84.54%, which is 5.46% worse than target.Areas of concern are:• Durham & Darlington CYP at 77.04% (198 of 257 patients), this is a 32.73% improvement on July 2016. The action plan is progressing and there has been a further improvement with the number still waiting over 4 weeks at the end August being 51 compared to 72 at end of July. Only 1 patient was waiting longer than 9 weeks at the end of August. Staff vacancies and sickness continue to impact. • North Yorkshire CYP at 50.68% (40 of 79 patients). This is linked to a continued number of urgent and complex cases and staff vacancies. An event is planned for September to look at recruitment challenges and options. • York & Selby CYP at 23.61% (17 of 72 patients). This is attributable to a shortfall in capacity to meet the demand which has been logged on the Risk Register, an action plan developed and implemented in August. In addition, following transition onto PARIS there are some data quality issues which are being corrected. Based on current performance there is a significant risk that we will not achieve the annual target of 90%, however if the improvement continues we could report the best annual position in the past 3 years.

Trust Dashboard Graphs for TRUST

8) Percentage of appointments cancelled by the Trust



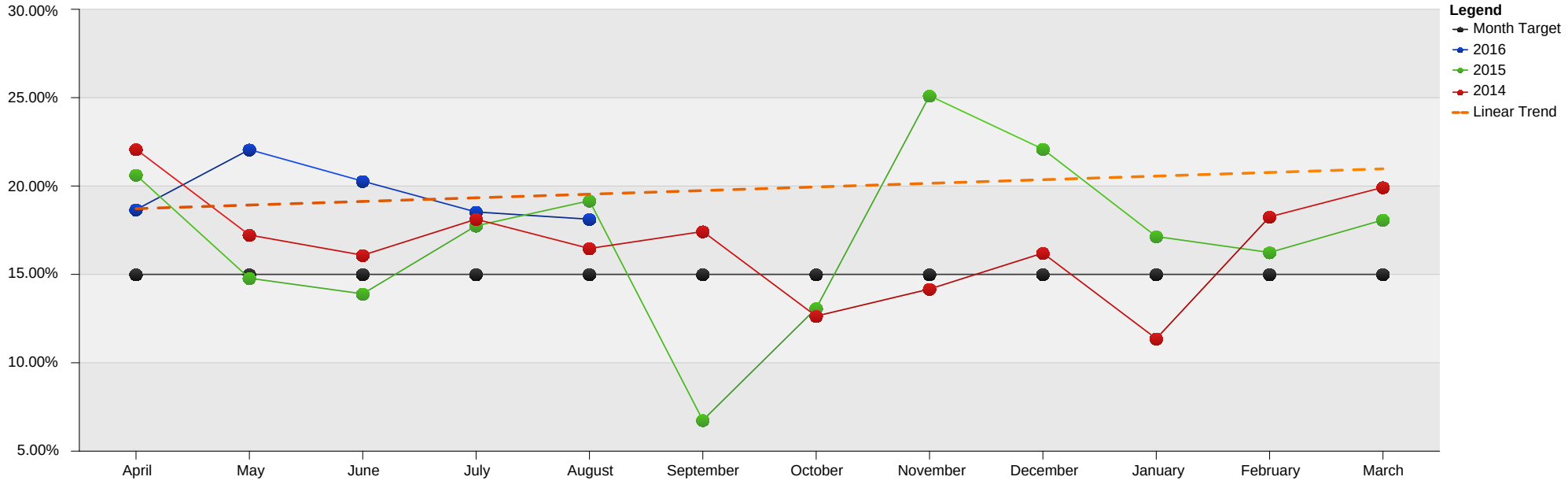
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of appointments cancelled by the Trust	0.68%	0.79%	0.91%	1.00%	0.45%	0.61%	0.80%	1.00%	0.00%	0.13%	0.64%	0.48%

Narrative

The Trust position for August 2016 is 0.68%, which relates to 578 appointments out of 85,140 that have been cancelled. This is 0.1% better than the target but a slight deterioration on the position reported in July. The Trust position for the financial year to date is 0.79%, which is 0.12% worse than the target.Only Durham & Darlington and North Yorkshire are worse than target.Based on quarter 1 and current performance it is possible that we could achieve the annual target of 0.67% if improvements continue.

Trust Dashboard Graphs for TRUST

9) Out of locality admissions (AMH and MHSOP) post validated



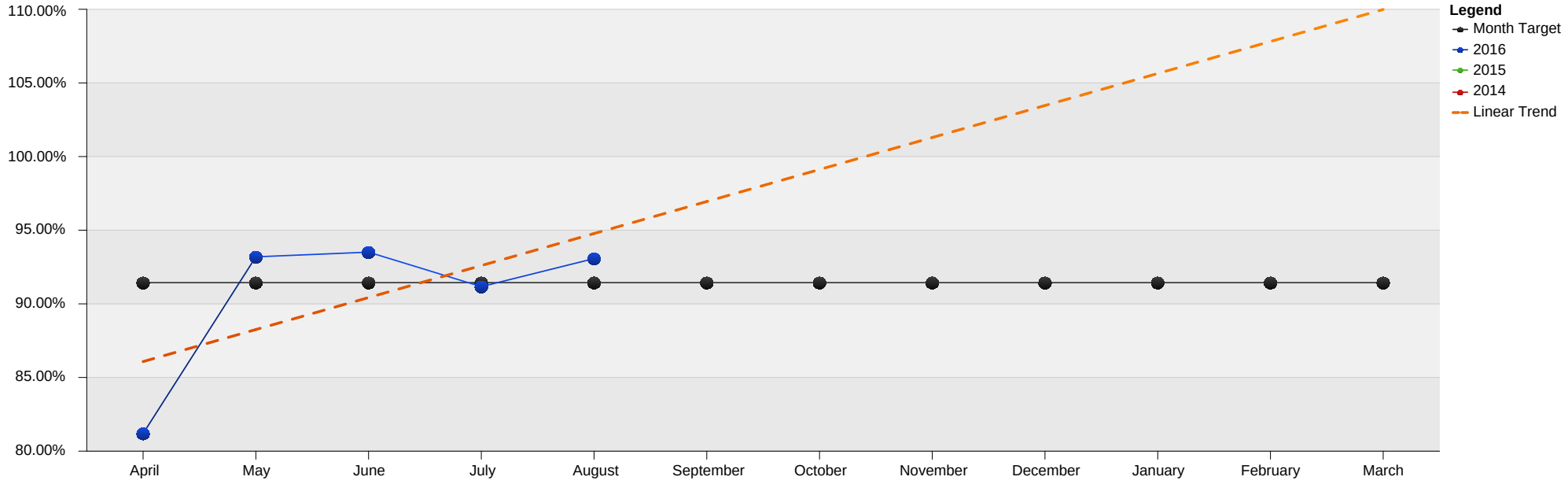
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	18.12%	19.50%	17.14%	18.06%	19.42%	16.63%	27.45%	31.82%	NA	NA	5.13%	10.05%

Narrative

The Trust position for August 2016 is 18.12%, which relates to 54 admissions out of 298 that were admitted to assessment and treatment wards out of locality. This is 3.12% worse than the target of 15% but an improvement on the position reported in July. The Trust position for the financial year to date is 19.50%, which is 4.50% worse than the target. Only York and Selby (5.13%) is better than target.Of the 54 patients (AMH 32, MHSOP 22) admitted to an 'out of locality' bed, all were due to no beds being available at their local hospital. The high occupancy rates described in KPI 3 continues to impact on this indicator. It is anticipated that the opening of Peppermill Court and the 'reboot' of PIPA could also have a positive impact in terms of performance in future months. Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 20.08% which is a deterioration of 0.91% compared to August 2015. Based on past performance there is a significant risk that we will not achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)

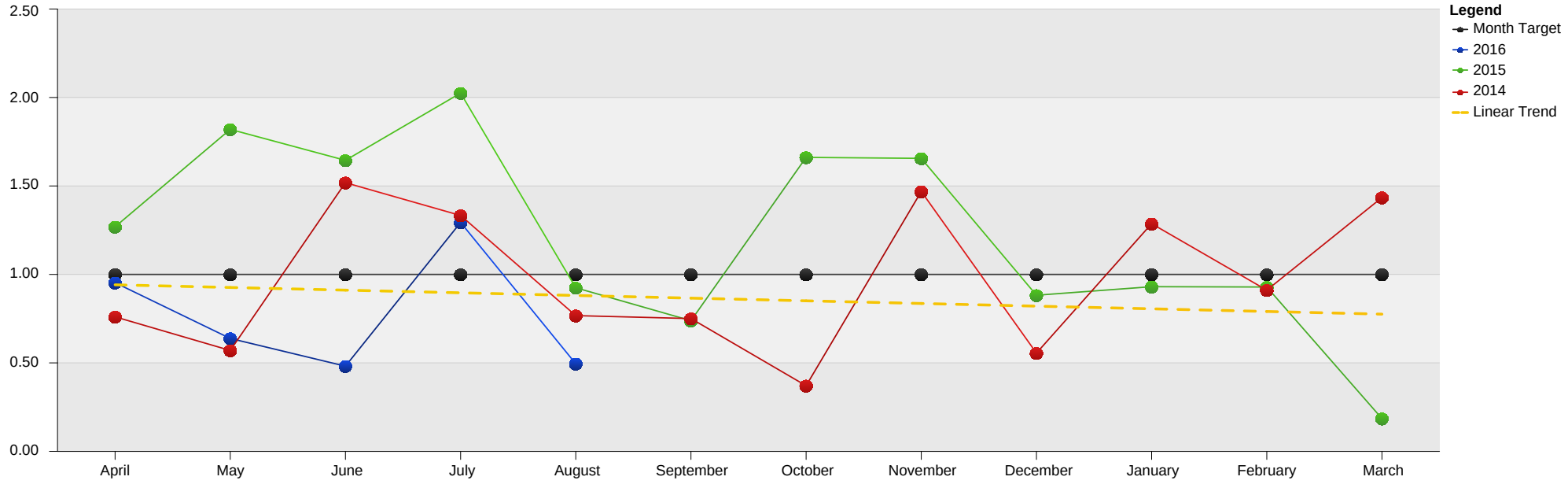


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	93.07%	92.04%	94.46%	94.32%	93.96%	92.97%	91.47%	91.81%	85.11%	79.35%	90.74%	90.13%

Narrative
The Trust position reported in August relates to July performance. The Trust position for July 2016 is 93.07% which is 1.63% better than the target of 91.44% but an improvement on the position reported for June. The Trust position for the financial year to date is 92.04%, which is 0.6% better than the 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. If performance continues at the levels achieved in quarter 1 and current, it can be expected that we will achieve the annual target of 91.44%.

Trust Dashboard Graphs for TRUST

11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated

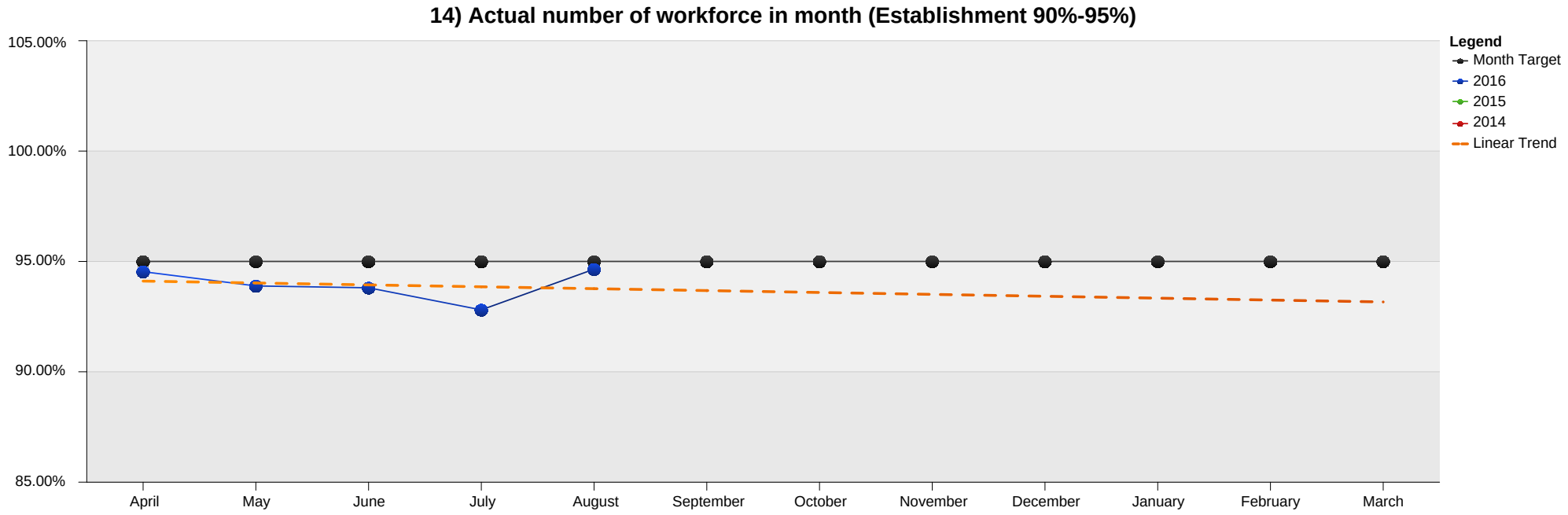


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.49	0.77	0.87	0.67	0.00	0.49	0.88	1.20	0.00	3.10	0.00	0.85

Narrative

The Trust position for August 2016 is 0.49, which is 0.51 better than the target of 1.00. This rate relates to 3 unexpected deaths. The Trust position for the financial year to date is 0.77 which is 4.23 better than the target.Of the 8 unexpected deaths:• 2 were in Durham & Darlington (AMH)• 1 was in North Yorkshire (AMH)Given the 2015/16 data did not include York and Selby data it is not possible to compare the position with previous years totals. However the number of unexpected deaths reported in August 2015 was 5 and therefore the figure of 3 across Durham and Darlington and North Yorkshire is lower. Based on past and current performance, it can be anticipated that we will achieve the annual target of 12.00.

Trust Dashboard Graphs for TRUST

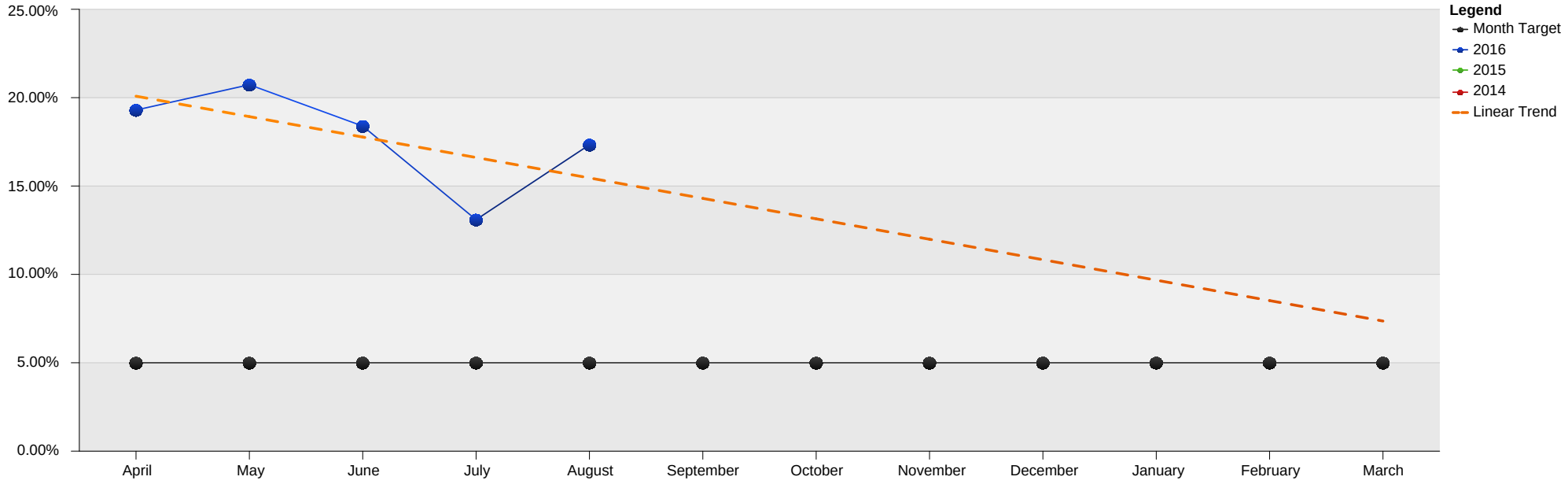


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 90%-95%)	94.65%	94.65%	95.09%	95.09%	98.26%	98.26%	95.54%	95.54%	92.87%	92.87%	90.42%	90.42%

Narrative
The Trust position for August 2016 is 94.65% which is within the expected establishment level of 90-95%, and a similar level to that reported in July.Data only started to be reported in the dashboard from April 2016; therefore no comparative data for 2015/16 is available currently in this dashboard. Based on the performance so far during 2016/17, it can be expected that we will achieve the annual target.

Trust Dashboard Graphs for TRUST

15) Percentage of registered healthcare professional jobs that are advertised two or more times



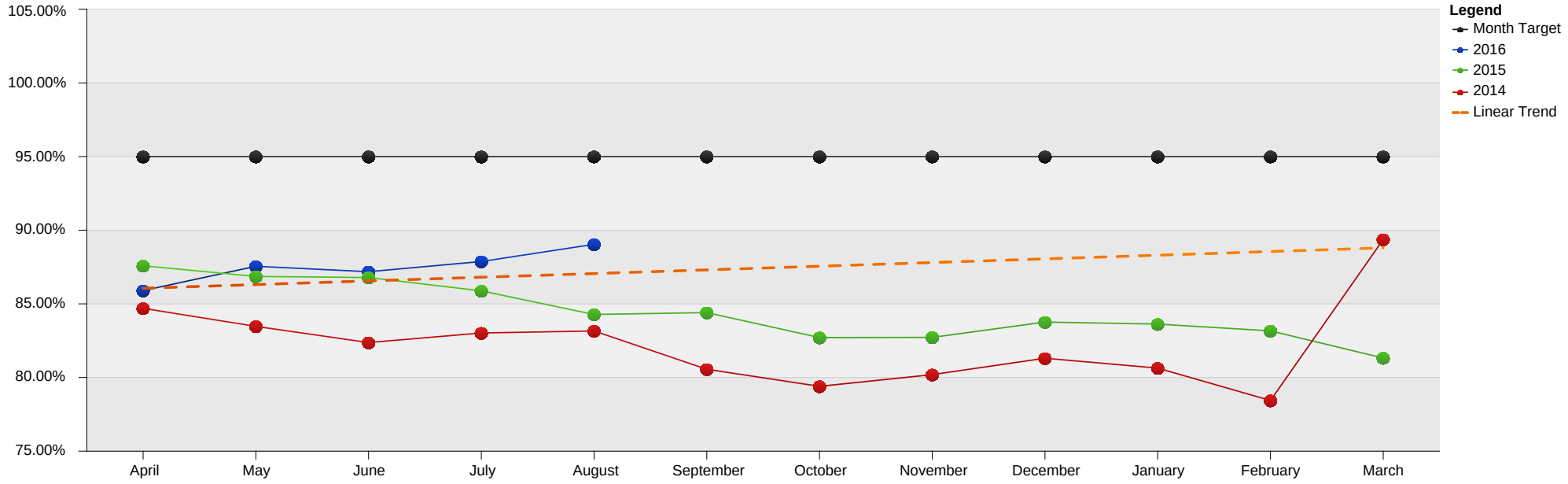
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	17.33%	17.66%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative

The Trust position for August 2016 is 17.33%, which is a decline on the figure of 14.29% previously reported and remains worse than target of 5.00%. The Trust position for the financial year to date is 17.66%, which is 12.66% worse than the target. There were 11 jobs re-advertised in August for registered healthcare professional jobs. Two of the posts were fixed term. The posts were primarily for a range of registered nurse vacancies across a number of specialities and bands throughout the Trust, with also an Applied Psychologist and a specialist Family Therapist.Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available.Based on quarter 1 performance there is a significant risk that we will not achieve the annual target of 5.00%.

Trust Dashboard Graphs for TRUST

16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)

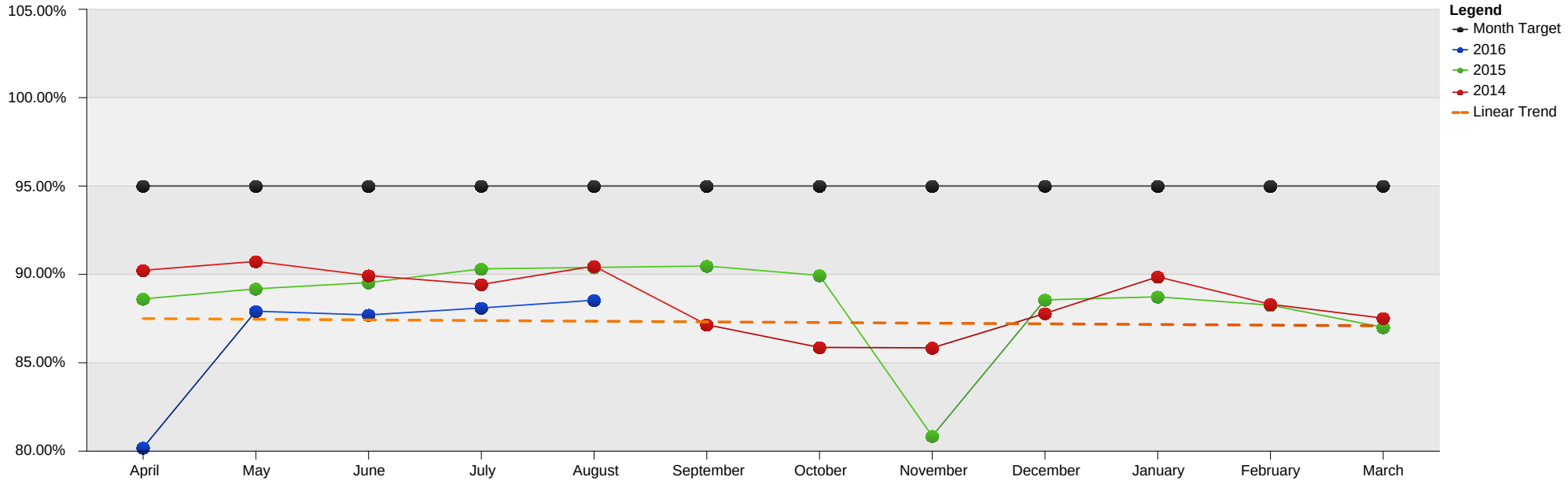


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	89.04%	89.04%	86.74%	86.74%	93.38%	93.38%	84.73%	84.73%	94.18%	94.18%	76.92%	76.92%

Narrative
The Trust position for August 2016 is 89.04% which relates to 562 members of staff out of 5128 that do not have a current appraisal, this is the highest position since March 2015. This is 5.96% below target of 95% but a continuing improvement on the position in previous months. A number of localities now have regular operational management huddles which include discussions on appraisal compliance levels, this has had a positive impact on performance levels being achieved. Development work to enhance HR related information available through the IIC is in the user testing phase and it is hoped will be available to managers by end of September. The enhancement will highlight to managers staff showing as non-compliant and those due to be appraised within the following three months. Managers are able to access compliance reports through the IIC to monitor performance against the target of 95% and this is reviewed at the Performance Improvement Group, where Directors of Operations provide details of actions being taken to improve compliance. Based on past performance and August's performance there is a risk that we may not achieve the annual target of 95%.

Trust Dashboard Graphs for TRUST

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

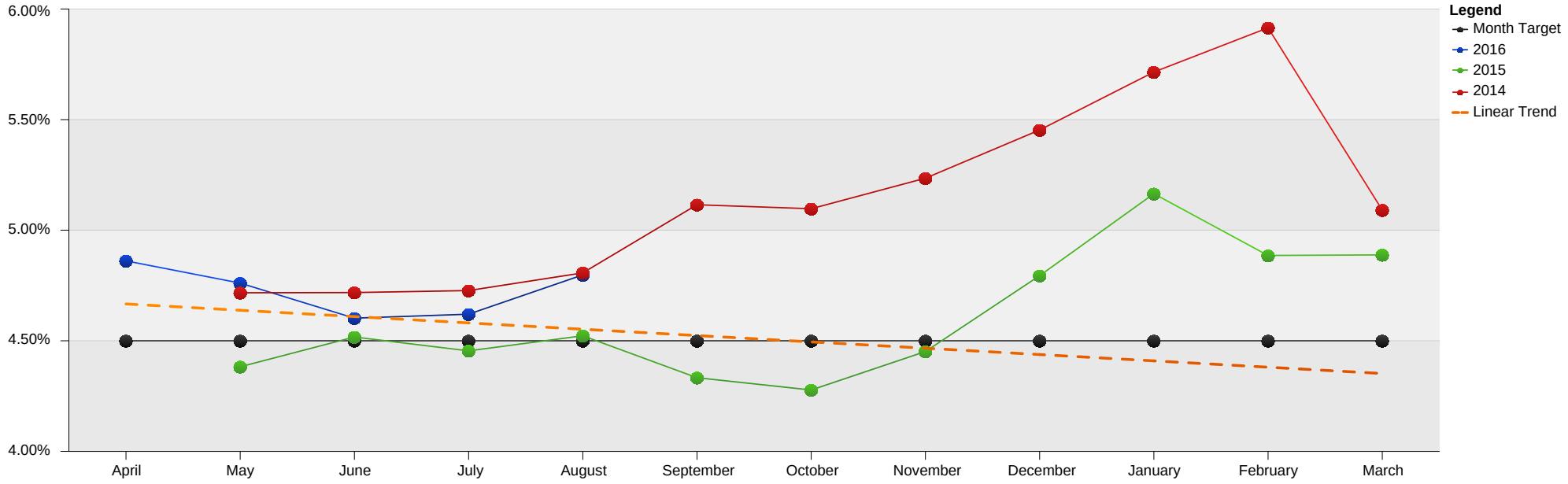


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with mandatory and statutory training (snapshot)	88.54%	88.54%	89.91%	89.91%	91.88%	91.88%	88.96%	88.96%	90.73%	90.73%	63.51%	63.51%

Narrative
The position for August 2016 is 88.52%. This is 6.48% lower than the target of 95% and is comparable with the position reported in July. The construction of this indicator has been amended from 1 April to ensure it more accurately reflects the Trust policy on Mandatory and Statutory Training compliance. Development work that has taken place on the IIC allows managers to monitor compliance against each individual training module and highlights staff who are due training within 3 months or who are non-compliant. This will help support proactive management of individuals in this area. Based on past performance and August's performance, there is a risk that we may not achieve the annual target of 95%.

Trust Dashboard Graphs for TRUST

18) Percentage Sickness Absence Rate (month behind)



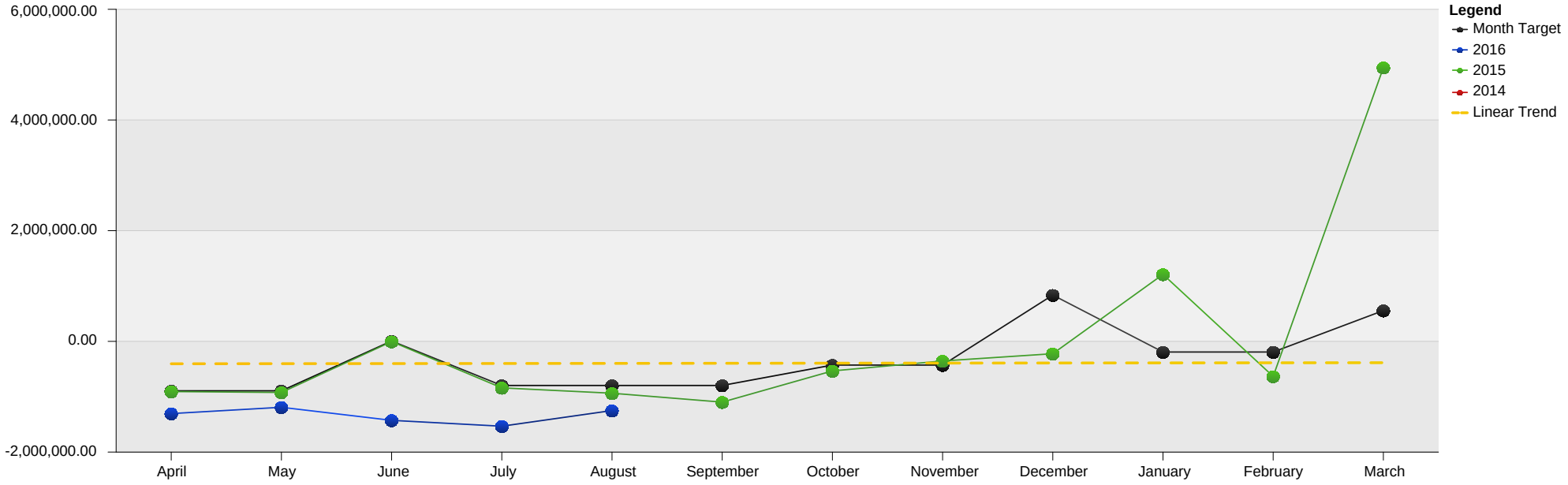
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	4.80%	4.73%	5.31%	5.10%	5.33%	5.27%	4.75%	4.55%	4.84%	5.12%	5.03%	4.67%

Narrative

The Trust position reported in August relates to the July sickness level. The Trust position reported in August 2016 is 4.80%, which is 0.30% worse than the Trust target of 4.50%. This figure also represents a deterioration on position reported in July. The Trust position for the financial year to date is 4.74%, which is 0.24% worse than the target. The figure reported is higher than the sickness rate recorded for the same period last year. Short term absence historically has averaged between 1.3% and 1.4% however this figure has risen to 1.7% this month. The Operational HR team are currently looking at how they can provide more focussed support to line managers to manage those staff experiencing excessive episodes of short term absence. The long term sickness absence team continues to manage staff on long term sickness, proactively facilitating staff back to work or ultimately to the ending of the employment. The number of staff on long term sickness absence being managed by the long term sickness team is between 150 and 200 at any point in time. 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).Based on past performance and August's performance it is still possible that we will achieve the annual target of 4.50%.

Trust Dashboard Graphs for TRUST

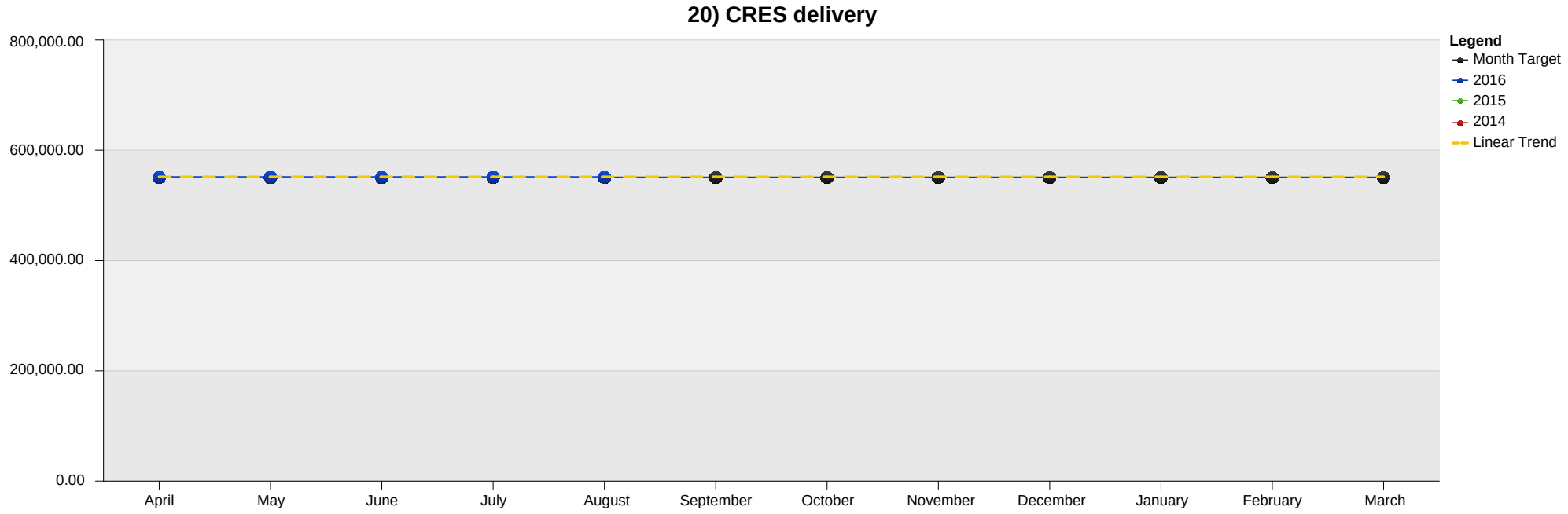
19) Delivery of our financial plan (I and E)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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)	-1,250,000.00	-6,706,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The comprehensive income outturn for the period ending 31 August 2016 is a surplus of £6,706k, representing 4.9% of the Trust's turnover. The Trust is ahead of plan by £1,084k largely due to vacancies.

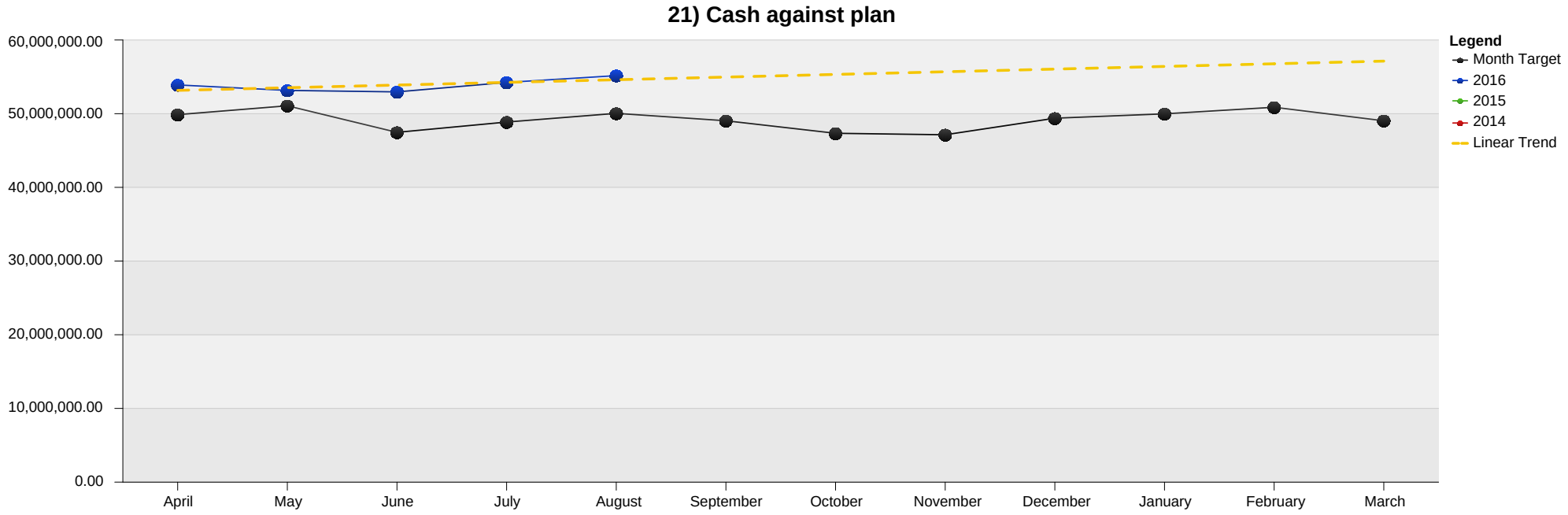
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	551,538.00	2,757,690.00	196,833.00	984,165.00	94,000.00	470,000.00	32,833.00	164,165.00	26,833.00	134,165.00		

Narrative
The Trust position for August is £551,538k. All localities continue to identify CRES schemes to ensure 100% is delivered recurrently in 2016/17.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	55,165,000.00	55,165,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The Trust position at 31 August 2016 is £55,165k and is ahead of plan due variances against the planned working capital cycle and delays in the capital programme, particularly in regard to the new hospital within Harrogate.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	August 2016												April 2016 To August 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		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
1) Total number of External Referrals into Trust Services	7,339.00	7,509.00	1,930.00	1,791.00	1,962.00	1,757.00	1,893.00	1,952.00	600.00	539.00	954.00	1,470.00	36,220.00	41,034.00	9,527.00	9,842.00	9,683.00	9,562.00	9,342.00	9,921.00	2,960.00	3,182.00	4,709.00	8,515.00
2) Caseload Turnover	1.99%	-3.79%	1.99%	-4.07%	1.99%	-1.16%	1.99%	-8.28%	NA	NA	1.99%	-1.94%	1.99%	-3.79%	1.99%	-4.07%	1.99%	-1.16%	1.99%	-8.28%	NA	NA	1.99%	-1.94%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	94.84%	85.00%	89.87%	85.00%	98.16%	85.00%	97.17%	85.00%	NA	85.00%	94.81%	85.00%	95.65%	85.00%	90.84%	85.00%	98.91%	85.00%	97.45%	85.00%	NA	85.00%	96.49%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	23.00	28.00	8.00	9.00	6.00	7.00	6.00	7.00	NA	NA	2.00	4.00	116.00	150.00	40.00	39.00	31.00	42.00	31.00	36.00	NA	NA	13.00	28.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.01%	15.00%	5.56%	15.00%	8.68%	15.00%	5.44%	NA	NA	15.00%	10.00%	15.00%	7.38%	15.00%	6.12%	15.00%	7.42%	15.00%	7.32%	NA	NA	15.00%	12.30%
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	22.67	5.00	8.67	5.00	5.67	7.00	5.67	NA	NA	6.00	5.33	99.00	130.67	27.00	49.33	27.00	35.00	33.00	35.33	NA	NA	24.00	22.00

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	August 2016												April 2016 To August 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		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
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	86.46%	90.00%	84.64%	90.00%	97.45%	90.00%	77.27%	90.00%	99.26%	90.00%	62.86%	90.00%	84.54%	90.00%	77.67%	90.00%	95.86%	90.00%	76.70%	90.00%	99.49%	90.00%	71.04%
8) Percentage of appointments cancelled by the Trust	0.67%	0.68%	0.67%	0.91%	0.67%	0.45%	0.67%	0.80%	0.67%	0.00%	0.67%	0.64%	0.67%	0.79%	0.67%	1.00%	0.67%	0.61%	0.67%	1.00%	0.67%	0.13%	0.67%	0.48%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	18.12%	15.00%	17.14%	15.00%	19.42%	15.00%	27.45%	NA	NA	15.00%	5.13%	15.00%	19.50%	15.00%	18.06%	15.00%	16.63%	15.00%	31.82%	NA	NA	15.00%	10.05%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	93.07%	91.44%	94.46%	91.44%	93.96%	91.44%	91.47%	91.44%	85.11%	91.44%	90.74%	91.44%	92.04%	91.44%	94.32%	91.44%	92.97%	91.44%	91.81%	91.44%	79.35%	91.44%	90.13%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.49	1.00	0.87	1.00	0.00	1.00	0.88	1.00	0.00	1.00	0.00	5.00	0.77	5.00	0.67	5.00	0.49	5.00	1.20	5.00	3.10	5.00	0.85

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	August 2016												April 2016 To August 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		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
14) Actual number of workforce in month (Establishment 90%-95%)	95.00%	94.65%	95.00%	95.09%	95.00%	98.26%	95.00%	95.54%	95.00%	92.87%	95.00%	90.42%	95.00%	94.65%	95.00%	95.09%	95.00%	98.26%	95.00%	95.54%	95.00%	92.87%	95.00%	90.42%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	5.00%	17.33%	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	17.66%	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	NA
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	89.04%	95.00%	86.74%	95.00%	93.38%	95.00%	84.73%	95.00%	94.18%	95.00%	76.92%	95.00%	89.04%	95.00%	86.74%	95.00%	93.38%	95.00%	84.73%	95.00%	94.18%	95.00%	76.92%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.54%	95.00%	89.91%	95.00%	91.88%	95.00%	88.96%	95.00%	90.73%	95.00%	63.51%	95.00%	88.54%	95.00%	89.91%	95.00%	91.88%	95.00%	88.96%	95.00%	90.73%	95.00%	63.51%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.80%	4.50%	5.31%	4.50%	5.33%	4.50%	4.75%	4.50%	4.84%	4.50%	5.03%	4.50%	4.73%	4.50%	5.10%	4.50%	5.27%	4.50%	4.55%	4.50%	5.12%	4.50%	4.67%

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	August 2016												April 2016 To August 2016									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		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
19) Delivery of our financial plan (I and E)	-1,021,762.00	-1,250,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	-5,621,615.00	-6,706,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
20) CRES delivery	550,854.00	551,538.00	183,500.00	196,833.00	168,250.00	94,000.00	117,595.00	32,833.00	92,909.00	26,833.00			2,754,271.00	2,757,690.00	917,500.00	984,165.00	841,250.00	470,000.00	587,977.00	164,165.00	464,545.00	134,165.00		
21) Cash against plan	50,045,000.00	55,165,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	247,314,000.00	55,165,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Data Quality Scorecarrd 2016/17

Appendix B

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at April 2016	Percentage	Notes	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 services	5					5					5					15	100%	100%		
2	Caseload Turnover	5					5					5					15		100%		
3	Number of patients with a length of stay over 90 days (AMH & MHSOP A&T wards)	5					5					5					15		100%		
4	Bed occupancy (AMH & MHSOP A&T wards)	5					5					5					15		100%		
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						4				5					14	93%	93%		York and Selby historic data is not in the system so any admissions prior to 1st April may not be on the system. As a result it may appear that Y&S locality position deteriorates as the year progresses.
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						4				5					14	100%	93%		York and Selby historic data is not in the system so any admissions prior to 1st April may not be on the system.
7	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					14	67%	93%		Data will be directly extracted from Datix into the IIC; however, this process is not fully embedded. IAPT caseload is currently a manual upload. Data reliability has improved following the introduction of the central approval team
8	Percentage of patients who have not waited longer than 4 weeks following an external referral	5						4				5					14	93%	93%		Data reliability is 4 due to issues over recording of Did not attends which would stop the clock. Actions to be developed through Data Quality working group to resolve this.
9	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated		4					4				5					13	87%	87%		Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches.
10	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					12		80%		All questionnaires are paper-based, except for some CAMHS units, where patients use a touch screen facility to record their comments. The manual questionnaires from Trust are sent to CRT and scanned into their system. Raw data files are received from CRT, which are accessed by IPT and uploaded into the IIC. TEWV are changing provider during the year. Procurement is currently underway. Transition from CRT to new system will be planned and closely monitored.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at April 2016	Percentage	Notes	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					
11	Percentage of appointments cancelled by the Trust	5									1				2		8	**87%**	**53%**		PARIS codes to be updated in May and indicator construction to change – this to be conducted through the KPI process. Audit conducted on this indicator and action plan in place to address concerns.
14	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5							3			5					13	**93%**	**87%**		Issues with appraisal dates being entered to ESR Issues with data being input correctly. York and Selby staff were transferred on 1st October, currently an issue with any appraisals carried out prior to this date. HR are monitoring this closely and identifying issues as they arise.
15	Percentage compliance with mandatory and statutory training – snapshot	5							3			5					13	**93%**	**87%**		Issues with training dates being entered to ESR Issues with data being input correctly. York and Selby staff were transferred on 1st October, currently an issue with any training carried out prior to this date. HR are monitoring this closely and identifying issues as they arise.
16	Percentage Sickness Absence Rate (month behind)	5							3			5					13	**87%**	**87%**		Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR and there are examples whereby managers are failing to end sickness in a timely manner or inaccurately recording information onto the system – this is picked up and monitored through sickness absence audits that the Operational HR team undertake. York and Selby services are in the process of implementing MSS. The current process implemented for capturing sickness activity is via email notification to payroll. There is the potential for activity to be inaccurate due to managers failing to inform payroll of absence or forgetting to inform payroll when an employee returns to work following a period of absence.
17	Actual number of workforce in month		4				5					5					14		**93%**		Data extracted elecronically but processed manually
18	Percentage of registered health care professional jobs that are advertised two or more times				2				3			5					10		**67%**		Mostly reliable Reliant on recruiting managers informing the recruitment team that the vacancy has been advertised on two previous occasions. 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%**		An extract is taken from the system then processed manually to obtain actual performance.
20	Delivery of CRES against plan				2		5					5					12		**80%**		Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4				5					5					14		**93%**		An extract is taken from the system then processed manually to obtain actual performance.

Number of unexpected deaths and verdicts from the coroner April 2016 - March 2017

	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	1	1																			**2**
Open																					**0**
Drug related death																					**0**
Drowning																					**0**
Misadventure																					**0**
Awaiting verdict	3	1	3	1	5	1						1	3			3	1	1			**23**
Total	**4**	**2**	**3**	**1**	**5**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**3**	**0**	**0**	**3**	**1**	**1**	**0**	**0**	**25**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
6	4	3	9	3							

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
8	4	7	1	5

Number of unexpected deaths and verdicts from the coroner 2015 / 2016

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	1																				**1**
Natural causes	1					1															**2**
Hanging	3	1	2								1						1		1		**9**
Suicides	7	3	6										1				1				**18**
Open	1		1																		**2**
Drug related death	1	2																			**3**
Drowning																					**0**
Misadventure	1		1																		**2**
Awaiting verdict	13	9	7	2		2		1			2	2	2			1	6	1	1		**49**
Total	**28**	**15**	**17**	**2**	**0**	**3**	**0**	**1**	**0**	**0**	**3**	**2**	**3**	**0**	**0**	**1**	**8**	**1**	**2**	**0**	**86**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
7	10	9	10*	5	4	9	9	7	6	8	2

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
35	25	22	4	0

Y&S recorded in old Datix not included

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th September 2016**
TITLE:	**Strategic Direction Performance Report – Quarter 1 2016-17**
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 the Board of Directors the Strategic Direction Performance Report as at Quarter 1 (30th June 2016/17).

The Trust has identified key performance indicators to monitor and report progress against its 5 year strategic direction in conjunction with the Trust Business Plan and other forms of intelligence.

Overall the position is positive however the Trust is not meeting some of its high ambitions given the number of reds against stretching metrics, this is a consistent position with the percentage reported as at quarter 1 2015/16. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

Recommendations:

Trust Board are asked to receive this report and provide comment/feedback as appropriate.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**27th September 2016**
TITLE:	**Strategic Direction Performance Report – Quarter 1 2016-17**

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) 2016/17.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report demonstrates progress against the Strategic Direction Scorecard, the Trust Business Plan as well as other forms of intelligence.

2.2 The 5 year targets for the Trust Strategic Direction Scorecard were agreed by the Board on the 18th August 2015.

3. KEY ISSUES:

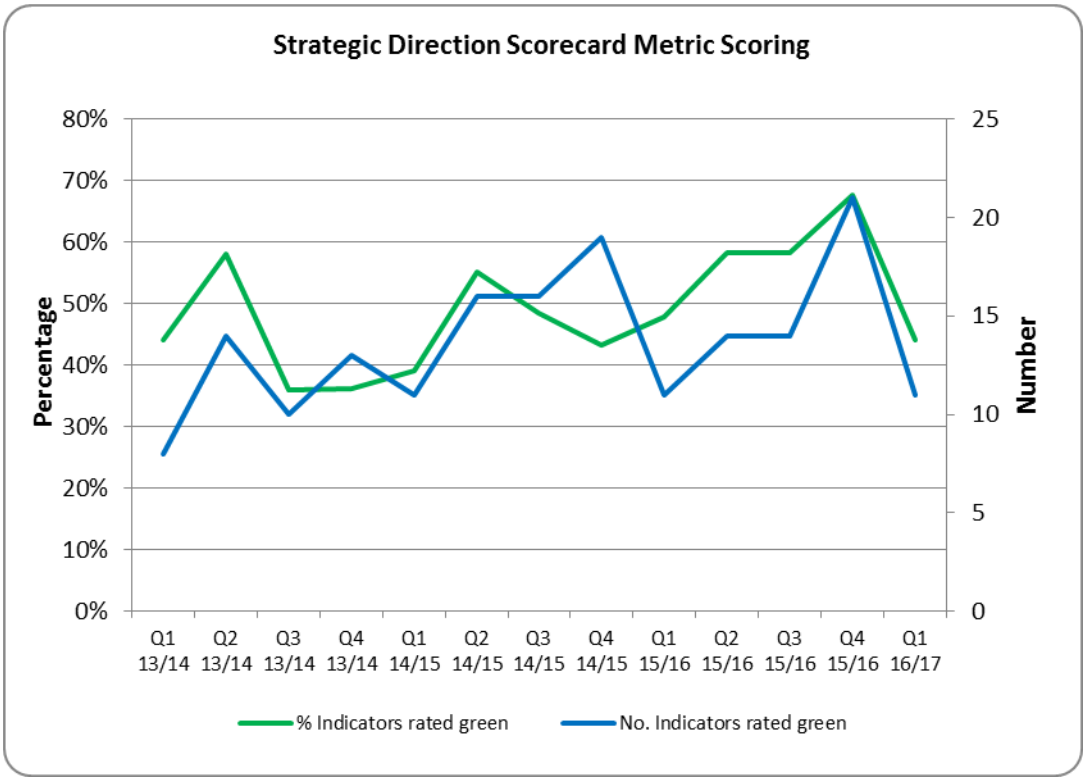
3.1 Trust Strategic Direction Scorecard

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) and the previous financial years 2014/15 and 2015/16. The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics; however this is consistent position with the percentage reported as at quarter 1 2015/16. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances

	2014/15 Actual		2015/16 Actual		Q4 201516		Q1 2016/17		2016/17 Actual YTD	
	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	18	42%	21	66%	21	68%	11	44%	11	44%
Indicators rated red	25	58%	11	34%	10	32%	14	56%	14	56%
Indicators with no target	2		3		3		2		2	
Indicators currently under development/being finaliased	1		1		1		0		0	
Indicators where data is not yet available/not applicable in qtr	0		4		5		12		12	

The percentage is based on the number of indicators that can be RAG rated (25 for quarter 1).



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, with 1 of those indicators showing an improvement on the quarter 4 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17							
	Indicator	Q1 Target 2016/17	Q4 2015/16	Quarter 1 Actual 2016/17	Change on previous quarter/year	Annual Target 2016/17	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	>91.37%	91.17%	92.59%	⇧	>15/16 out-turn= 91.37% tbc	>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	98.00%	81.76%	81.95%	⇧	98.00%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	81.36%	80.00%	⇩	85% tbc	TBC
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	YES	Results due in Q2	n/a	Surveys: Top 20% of MH Trusts	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	YES top MH/LD trust	Results due in Q4	n/a	Surveys: Top 10% of MH Trusts	Surveys: Top 10% of MH Trusts
6	Percentage of service users with a recovery focussed action plan (Adult Mental Health)	95.00%	93.00%	92.59%	⇩	95.00%	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 81.95% against a target of 98% which is an improvement on the quarter 4 position.

  Only Forensic Services (98.87%) are reporting above target for quarter 1, with Tees reporting the highest performance at 94.46% and York & Selby the lowest performance at 56.18%.

  Within York and Selby there are a number of issues, relating to both data quality, stemming from the migration of the data onto TEWV systems, and capacity issues within the locality. Capacity issues are a particular concern in CAMHS and the MHSOP memory service, where there is the largest number of waiters. CAMHS have produced an action plan which they are currently working towards, whilst MHSOP are reviewing the processes in other directorates and conducting a pathway review. This will be aligned with an operational plan to increase the memory service establishment to include additional resource to meet the demand for memory monitoring.

  Within Durham and Darlington locality (76.22%), the main area of underperformance is in relation to Children and Young People's Services (CYP). The waiting list had been impacted in Quarter 1 by low staffing levels, attributable to high sickness levels and poor retention rates. The Service has implemented a recovery plan and work has progressed over a number of months to improve staff wellbeing and accelerate recruitment to vacant posts. The Service has also implemented Purposeful Productive Community Services phase 1 products, which has improved caseload management and facilitated daily reporting to understand referrals received, ensuring capacity meets demand. In addition, the criteria for appropriateness of referrals into CAMHS have been reviewed and improvements made to support effective signposting to more appropriate services. The waiting times position has improved as the quarter has progressed with June reporting an improved position to that at the end of April.

  Within North Yorkshire locality (79.94%) all services are under performing, reporting issues relating to the levels of sickness and vacancies within the teams. This is particularly affecting the primary care teams within Hambleton & Richmondshire and Harrogate where it has been identified that staff have been operating an old practice sending 'opt in' letters to patients. There is a plan in place to address this as a matter of urgency.

- **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 80.00% against a target of 85% which reflects a small deterioration on the quarter 4 position.

All localities are performing below target, with Tees reporting the highest position at 82.89% and North Yorkshire reporting the lowest at 74.58%. Whilst all localities are reporting below target, Forensic Services have a generally lower position across more wards. All wards below target level are detailed in Appendix 1.

Forensic Services – due to the nature of the service and the patients within this service, difficult situations can occur which have an impact on other patients. Linnet and Mandarin wards have reported that there have been an increased number of incidents on the wards, which could have contributed to the feedback received on the survey. Brambling Ward is not aware of any particular issues; however the patient group has provided reassurance that no direct verbal reports were received that patients felt unsafe.

North Yorkshire – Whilst there have been no specific patients who have raised any concern directly with the ward manager or the staff, Cedar ward is a very busy environment within a general hospital, with highly complex and disturbed patients who are distressed and can be noisy for some of the other patients. The ward has action plans in place, which are used in their weekly patient group meetings to prompt discussions around patient safety.

- **KPI 6 - Percentage of service users with a recovery focussed action plan (Adult Mental Health)** – the Trust position for quarter 1 is 92.59% against a target of 95% which is a slight deterioration on the quarter 4 position of 93.00%.

  Only Durham and Darlington are not achieving target, reporting a position of 89.80%. The following should be noted:

  - All localities are achieving target for the Assertive Outreach teams of 95% but this is not the case for the psychosis teams.
  - There have been significant staffing issues experienced in some teams within Durham and Darlington locality which has impacted on performance. Work is ongoing to address this but recruitment is proving difficult. All leadership hubs are working with their teams to ensure that outstanding activity is planned and completed as soon as possible.

Other points to note

- **KPI 3 – Percentage of patients reporting "yes always" to the question "did you feel safe on the ward"** – Board of Directors are asked to approve the target used for this indicator is 85%, which is the same as last year.

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 (78%) and only 8% of the priorities / service developments in the Business Plan are at high risk of failure to deliver on-time or within budget.

The 8% represents 8 priorities / service developments. Of these:

- 2 required in-year timescale changes which EMT approved
- 1 required a change in action/metrics and in-year timescale change which EMT approved
- 1 required a change in timescale and a PM2a was approved by EMT
- 2 were due to delays in projects (KMS and Paris programme)
- 1 requires a change in timescale for which Board approval is needed
- 1 is recommended for removal from the Plan for which Board approval is needed

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 points should be noted:

- In April 2016, civil servants from the Cabinet Office visited the Durham and Darlington CAMHS eating disorders and crisis teams at the Mulberry Centre, Darlington Memorial Hospital. The visit was part of a number taking place across the country reviewing CAMHS service provision. The team, along with the Director of Operations, Head of CAMHS, Clinical Director and CYP IAPT project manager presented an update their work and how it supports the national policy agenda. TEWV received positive feedback from the cabinet office team.

- The unannounced inspection of HMP Frankland by HM Chief Inspector of Prisons in early 2016, praised the mental health services for improved psychological interventions, commented that care planning was good with evidence to support this. However there was recognition that hospital transfers take too long for secure hospital beds although it was acknowledged that is a national issue. The Inspection Team found the staff welcoming and helpful.

- Forensic learning disability services were recognised for their work by the British Institute of Learning Disabilities (BILD) in their positive behavioural support leadership awards, winning in the category of innovative practice in supporting people with intellectual disabilities through positive behaviour support.

- The crisis resolution and home based treatment teams in York and Selby and Hambleton and Richmondshire have both been accredited by the Royal College of Psychiatrists' Home Treatment Accreditation Service (HTAS).

3.2.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs, Business Plan and qualitative intelligence, the overall position is positive. However, further work is required around waiting times, patient experience and recovery focused action plans.

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 5 indicators rated red out of 8 as at quarter 1, with 3 of these indicators showing an improvement on the Q4 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17							
	Indicator	Q1 Target 2016/17	Q4 2015/16	Quarter 1 Actual 2016/17	Change on previous quarter/year	Annual Target 2016/17	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 SUIs and action points for safeguarding serious case reviews and domestic homicide reviews	0	**0**	**17**	⇩	0	0
8	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	**13**	**11**	⇧	0	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?"	>86.01%	**85.23%**	**85.96%**	⇧	>15/16 out-turn= 86.01% tbc	> previous year out-turn
10	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	**33.33%**	**37.50%**	⇧	50.00%	>=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	**79% and in top 20%**	Results due in Q4	n/a	>2015/16 (79%) and in top 20%ile of MH/LD trusts tbc	> 2018/19 and in top 20%ile for MH/LD Trusts
12	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"	>82.58%	**82.33%**	**81.04%**	⇩	>15/16 out-turn= 82.58% tbc	> 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) > national average PLACE (new PEAT) assessments.	80%	**80.00%**	Assessment due in Q2	n/a	80%	80%
14	Hospitality Assured Accreditation score*	83.00%	**Assessment now due Q1 16/17**	Assessment due in Q2	n/a	83.00%	86.00%

Indicators of concern are:

- **KPI 7 - Number of outstanding action points on action plans for more than 31 days for Level 5 SUI's and action points for safeguarding serious case reviews and domestic homicide reviews**– the Trust position for quarter 1 is 17 against a target of zero, which is a deterioration on the quarter 4 position when the target was met. All relate to Level 5 SUI's.

  An enhanced monitoring system is being introduced within the Patient Safety Team in response to action plan evidence not always being available or adequate when subject to testing by internal audit. The team have retrospectively reviewed the action plans from April 2016 onwards which has highlighted these areas of non-

compliance. These have been followed up with appropriate Heads of Service and at the time of writing this report they are complete.

- **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 11 against a target of zero, which is an improvement on the quarter 4 position. All relate to Clinical Audit.

  The 11 outstanding action points of more than 31 days at the end of quarter 1 are from 5 audits; 6 were outstanding 60 days past the target date. There are varied reasons for the delays. Of these, 9 are now complete and 2 have had an approved data change as the action owner has been changed. All outstanding action points are escalated to the Clinical Effectiveness Group.

- **KPI 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?"** – the Trust position for quarter 1 is 85.96% against a target of 86.01% which is a slight deterioration on the quarter 4 position.

  Only Forensic Services are failing to achieve target, reporting 80.08%.

  Due to the nature of the service it could be expected that a lower number of patients would recommend our ward/services as the patients are in a secure inpatient facility where they are resident not by choice.

- **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 37.50% against a target of 50%, which is an improvement on the quarter 4 position.

  There were 5 baseline assessment tools signed off by CEG; however not within 6 months of publication.
  - Two were extensive guidelines that directly impacted a number of Trust policies, projects and training programmes and their application. The delays were primarily attributable to key strategic issues requiring long term work streams including changes to policies and procedures and staff training programmes/systems.
  - One was delayed as LD Specialty representatives were unable to attend the NICE Facilitation Event to populate the baseline assessment.
  - One encompassed extensive guidance content that directly impacted upon clinical service delivery
  - One required corporate and clinical process changes that resulted in initial delays in undertaking the baseline assessment.

- **KPI 12 - FFT – Staff Friends and Family scores – 'How likely are you to recommend this organisation to friends and family if they needed care or treatment?'** – the Trust position for quarter 1 is 81.04% against a target of 82.58%, which is a slight deterioration on the quarter 4 position.

  Investigations have shown that the Trust-wide scores over the previous 12 months have been consistently around 82% and there are no patterns or trends that would identify any issues which have resulted in this slight deterioration on performance. Some of the reasons provided for not recommending the organisation for care or treatment include; inconsistent quality of care across localities, inadequate staffing, high caseloads, inadequate facilities and low staff morale.

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 (89%) and only 10% of the priorities / service developments in the Business Plan are at high risk of failure to deliver on-time or within budget.

The 10% represents 1 priority/service development. This required a change in action/metrics which EMT approved.

There is one action for which Board approval is required which is also contained in Appendix 2.

3.3.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The Trust won the award for Best Staff FFT Initiative and was highly commended in the Best FFT Initiative in Other-NHS Funded services category at the recent Friends & Family Test Awards 2016. The staff award was presented for the work the staff experience project manager has done to improve staff experience and the Trust's Patient and Carer Experience Team received a highly commended for their work developing a Trust wide system for collating, analysing and reporting back patient feedback.

- The Trust was shortlisted four times in the national Patient Safety Awards, which recognise and reward outstanding practice within the NHS and independent healthcare organisations. The Trust was a finalist for 'Best Organisation' and 'Best Board Leadership'; the physical healthcare and force reduction projects were also shortlisted in the 'patient safety in mental health' category.

- Recovery Focused Care Transfer (ReFleCT) service won the best service category award in the NHS Innovations North Bright Ideas in Health Awards. The ReFleCT service is a recovery focused pre-discharge intervention which has improved and supports the transfer of service users' ongoing care from mental health services to GP services.

- The Trust has received mainly positive feedback from stakeholders on the 2015/16 Quality Account. In accordance with the statutory guidance, the draft TEWV quality account was circulated to all Local Authorities, Healthwatch and Commissioners in our area, and their comments included in the published version of the document. Our commitment to patient, public and stakeholder engagement were widely praised, along with our Trust's achievements on last year's quality priorities. Areas where stakeholder hoped we could improve further included the format of the Quality Account document itself, and reducing / reacting to Serious Incidents. Notably the letter from York Healthwatch states that, "Although TEWV have only had responsibility for services in York since October 2015, it feels as though a lot has been achieved in a relatively short period of time. Healthwatch York particularly welcomes TEWV's commitment to promoting and strengthening patient and public involvement".

3.3.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs, the Business Plan and qualitative intelligence, the overall position remains positive. However further work is needed in terms of ensuring the completion of action points for Clinical Audit and Level 5 SUI's in a timely manner and the percentage of NICE guidance where baseline assessment tools are signed off by CEG within 6 months.

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 4 indicators rated red out of 12 as at quarter 1, with none of these indicators reporting an improvement on the quarter 4 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17							
	Indicator	Q1 Target 2016/17	Q4 2015/16	Quarter 1 Actual 2016/17	Change on previous quarter/year	Annual Target 2016/17	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 3 (To recruit, develop and retain a skillled, compassionate and motivated workforce)							
15	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"	>70.95%	**71.38%**	**70.68%**	⇩	>15/16 out-turn= 70.95% tbc	> previous year out-turn
16	Percentage of medical students and junior doctors reporting satisfaction with their placement	88.00%	**89.09%**	**95.24%**	⇧	88.00%	90.00%
17	Percentage of positive nursing placement evaluations received	95.00%	**94.26%**	**95.59%**	⇧	95.00%	95.00%
18	Excess cost of employing medical agency versus substantive	£75,000	**£283,500**	**£228,963**	⇧	**£300k**	zero
19	NHS Employers Assessment of Wellbeing	100%	**100.00%**	**100.00%**	⇔	100%	100%
20	Percentage of Culture Metrics showing improvement at year end*	100%	**To be discussed at July 16 Board**	due in Q2	n/a	100%	100%
21	Percentage of positive staff responses for training/development evaluations received	75% tbc	**no data for Q4**	**72.21%**	n/a	TBC	TBC
22	Quality of Appraisals	>3.36 TBC	**3.36**	Results due in Q4	n/a	>15/16 out-turn= 3.36 tbc	>= 2018/19 & in top 20%
23	Percentage of medical staff successfully revalidated	100%	**100.00%**	**100.00%**	⇔	100%	100%
24	The variation in percentage responses to the questions in NHS Staff Survey of those who identified themselves as disabled compared to those who did not identified themselves as disabled*	tbc	n/a	Results due in Q4	n/a	TBC	TBC
25	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	50%	**14.29%**	**8.70%**	⇩	50.00%	80.00%
26	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	<2015/16 outturn (28%)	**28% and top 20% (top MH/LD Trust)**	Results due in Q4	n/a	<2015/16 outturn (28%) & top 20%	< previous year out-turn

Indicators of concern are:

- **KPI 15 – FFT STAFF: How likely are you to recommend this organisation to friends and family as a place to work?'** – the Trust position for quarter 1 is 70.68% which is 0.27% below the target of 70.95%, which is a slight deterioration on the quarter 4 position.

Investigations have shown that the Trust-wide scores over the previous 12 months have been consistently around 72% and there are no patterns or trends that would identify any issues which have resulted in this slight deterioration on performance. Some of the reasons provided for not recommending the organisation as a place to work include low staff morale, too few staff with large caseloads, too focused on goals and targets and continuous change.

- **KPI 18 - Excess cost of employing medical agency versus substantive** - the Trust position for quarter 1 is £228,963, which is £153,963 worse than the target of £75,000.

    - As at the end of quarter 1, agency has been required to support vacancies in Durham and Darlington (4 AMH), Forensic (1 FMH), North Yorkshire (1 CYPS and 2 MHSOP), Teesside (1 AMH and 1 MHSOP) and York and Selby (1 AMH, 1 CYPS and 3 MHSOP).

    - A further 2 agency staff were used in North Yorkshire to cover sickness (1 AMH and 1 MHSOP) whilst 1 more agency staff was used in North Yorkshire to support mind the gap (1 MHSOP).

- **KPI 21 – Percentage of positive staff responses for training/development evaluations received** – the Trust position for quarter 1 is 72.21% against a suggested target of 75%. There is no comparable data as this is a new indicator.

  The Education and Training team has now created a process using survey monkey whereby all staff who have completed any training processed by the team will be sent a survey. As this process is embedded, this will be analysed for trends.

- **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 8.70% against a target of 50% which is a deterioration on the quarter 4 position.

  This relates to 2 advertised posts with at least 2 internal candidates out of 23 advertised posts. The number of posts at band seven and above with a people management responsibility where at least two internal candidates were appointable in quarter 1 is significantly below the target of 50% and this trend has been declining for some time. The rate of internal appointments versus external appointments in the last 18 months is 89:11 which is highlighting a risk of shortages of supply within this group. As yet, there appears to be no increase to the number of posts not recruited to. However, this trend should be seen as an early warning for these supply risks materialising in the future. Talent management is in a transitional phase where new approaches to accelerated development of internal staff or increased focus on supply of external staff have not been implemented fully.

The continued implementation of Talent Management within the Trust will support the delivery of this indicator. The importance of embedding this has been recognised in the Business Plan for 2016/17 to 2018/19.

Other Points to note –

- **KPI 21– Percentage of positive staff responses for training/development evaluations received** – the Trust position for quarter 1 is 72.21% against a suggested target of 75%. There is no comparable data as this is a new indicator but the Board of Directors are asked to approve the suggested target of 75% and consider increasing this to 80% next year.

- **KPI 22 – Quality of Appraisals –** this indictor replaces the indictor previously entitled **- Percentage** *of staff reporting that they have had a 'well structured' appraisal in the last 12 months* – as agreed by Board. For the previous indicator it had been agreed that the target would be an improvement on the previous year's outturn, which was 3.36 from a possible 5.00. The Board of Directors are requested to confirm that this target can remain for the new indicator.

- **KPI 24 – The variation in percentage responses to those questions in NHS Staff Survey of those who identified themselves as disabled compared to those who did not identify themselves as disabled** –As previously reported, the NHS Staff Survey has changed so that there are less metrics reported as a percentage and more reported using a sliding scale 1-5. Following acceptance by the Board, it was agreed, we would amend the scorecard to reflect the number of actual indicators where there is 'a noticeable or sufficient difference', which would mean that how it is recorded becomes irrelevant. As the sliding scale used is 1-5 and the remaining questions are a percentage, it is proposed to identify 'a noticeable or sufficient difference' as 1.0 or 20% difference. The Board of Directors are asked to consider this proposed target.

3.4.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 1 were rated green (89%) 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

- **NHS Workforce Race Equality Standard** - The NHS Workforce Race Equality Standard (WRES) for 2015 was introduced in April 2015 and for the first time was included in the NHS standard contract. The WRES aims to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. From July, NHS Trusts

submitted their WRES data against nine indicators and the first WRES annual report published on 26th May 2016 provides analysis and an overview of the data returns from NHS trusts relating to staff experience indicators derived from the national NHS Staff survey.

Key messages for the Trust are:

- % of staff who report experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months – FAVOURABLE results for BME staff (2014 Staff survey data used) – indicator 5 - white 29.9% and BME 27.3% (BME sample size was 2.5%)
- % of staff experiencing harassment, bullying or abuse from staff in last 12 months – UNFAVOURABLE results for BME staff (2014 Staff survey data used) – indicator 6 – white 13.6% and BME 36.4% (BME sample size 2.6%)
- % of staff who believe that trust provides equal opportunities for career progression or promotion – UNFAVOURABLE RESULTS.. (no bar shown? – 2014 Staff survey data used) - indicator 7 – white 93.3% and BME no position reported (BME sample size 1.7%)
- In the last 12 months have you personally experienced discrimination at work from any of the following – Manager/Team Leader or other colleagues? – UNFAVOUABLE RESULTS … (no bar shown? 2014 Staff survey data used) – indicator 8 – white 5.6% and BME no position reported (BME sample size 2.5%)

3.4.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs, the Business Plan and qualitative intelligence, the overall position is positive. However, Trust will continue to benefit from an increased focus on talent management and raising awareness of the NHS Workforce Race Equality Standard.

3.5 Strategic Goal 4 - *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing 1 indicator rated red out of 6 as at quarter 1.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17							
	Indicator	Q1 Target 2016/17	Q4 2015/16	Quarter 1 Actual 2016/17	Change on previous quarter/year	Annual Target 2016/17	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%	100.00%	77.78%	⇩	90%	90%
28	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	100.00%	⇔	98%	98%
29	Proportion of student nursing placements provided as a % of placements requested	90%	97.35%	100.00%	⇧	90.00%	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	412 (15/16 annual)	34	n/a	453	10% increase year on year
31	R&D Outcomes - Annual external R&D income (including external grants and commercial income)	n/a	616376 (15/16 annual)	£139,955	n/a	£678,014	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	Signed & Green	Signed & Green	Signed & Green	⇔	Signed & Green	Signed & Green

- **KPI 27 – Attendance rate at H&WB -** The Trust position for quarter 1 is 77.78%, which is 12.22% below the target of 90% and a deterioration on quarter 4 position.

  There were 2 occasions in the quarter when there was no representative from TEWV at H&WBB. On both of these occasions, the Member had to attend other meetings and the named Deputy was on annual leave. It should be noted that only the Member or Named Deputy can attend the meetings, no other representative can be sent.

3.5.2 Trust Business Plan

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

The organisation has worked closely with other partners to support draft Sustainability and Transformation Plans (STPs) by the national deadline in June 2016. This covers the following areas:

- Durham, Darlington, Teesside and Hambleton, Richmondshire & Whitby STP
- Humber Coast and Vale STP (includes Scarborough & Ryedale CCG and York & Selby)
- West Yorkshire STP (includes Harrogate CCG).

Feedback on the draft submissions was received in July with the next draft being required to be submitted nationally by October 2016.

In addition the Trust continues to play an active role in two national vanguards as follows:

- Harrogate New Model of Care Vanguard
- North East Emergency & Urgent Care Vanguard

3.5.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs and Business Plan the overall position remains positive.

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 1 indicator rated red out of 7 as at quarter 1, which is the same as the quarter 4 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17							
	Indicator	Q1 Target 2016/17	Q4 2015/16	Quarter 1 Actual 2016/17	Change on previous quarter/year	Annual Target 2016/17	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%	**57.14%**	**71.43%**	⇩	**<37.5% tbc**	<=6.25%
34	Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard	75% tbc	**5 yr Strategy & metrics approved EMT March 2016**	**87.50%**	n/a		**TBC**
35	Percentage change in income for Trust contracted services compared to previous year	1.10%	**1.28%**	**6.72%**	⇧	**1.10% TBC**	Better than deflator
36	Reference Cost Index score for in-scope PbR Services	<=95	**92**	Due in Q2	n/a	<=95 TBC	TBC
37	Reference Cost Index score for out of scope PbR Services	<=95	**95**	Due in Q2	n/a	<=95 TBC	TBC
38	EBITDA **	7.79%	**10.01%**	**8.57%**	⇧	6.33%	8.00%
39	Good Corporate Citizenship audit scores*	65.00%	**66.00%**	Due in Q4	n/a	65.00%	75.00%

Indicators of concern are:

- **KPI 33 - Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)** – the Trust position for quarter 1 is 71.43% which above the target of 37.50% and a deterioration on the quarter 4 position.

  The increase in reds is attributable to the increase in patients recorded on PARIS without a gender. This was 4% over the target of 20% in May and 1% over in June. This is linked to a range of data quality issues that have emerged following the migration of York & Selby service onto TEWV PARIS. There is a data quality action plan underway with the Information Department and the clinical services to address the issues. This is monitored at Trust Data Quality and at Trust Performance Improvement Group on a monthly basis.

Other points to note

- **KPI 34 - Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard –** following previous Board approval this indicator replaced the indicator entitled – "Percentage of Information Strategy outcomes achieved that are reported on Information Strategy Metrics Scorecard" – it is proposed that this new indicator should have a target of 75% .The Board of Directors are asked to consider this target proposal.

- **KPI 35 - Percentage change in income for Trust contracted services compared to previous year –** the target has been amended from -1.3% to 1.1% This is to reflect the net effect of inflation and efficiency target imposed by the commissioners on contracts, for 2015/16 this was a negative 1.3% and in 2016/17 this increased from a negative to a positive 1.1%.

  The Board of Directors are asked to confirm and approve the amendment.

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.

There is one action for which Board approval is required which is also contained in Appendix 2.

3.6.3 Other Qualitative Intelligence

The current position with 16/17 contracts for provision of services is as follows:

- NHS England Specialised Services – Contract agreed and signed. This is a 1 year contract term.
- Durham and Darlington CCGs – Contract agreed and signed. This is a 3 year contract term and the CCGs have agreed to a continuation of the ring fence current mental health spend and to increase it annually in line with CCG allocation uplifts. The Trust will work with the CCG to minimise pressures on the ring fence.
- Tees CCGs – Contract agreed and signed. This is a 3 year contract term. HaST CCG has agreed to continue with the ring fence on mental health budgets which has been in place for 5 years. South Tees CCG is not part of a ring fence agreement but continues to invest in mental health services; in 2016/17 the CCG has commitment to recurrently funding the delirium service.
- North Yorkshire CCGs – Contract agreed and signed. This is a 3 year contract term with an option to extend for a further 2 years.

- York and Selby CCGs – the Trust was awarded a contract following a tender process during 15/16. This is a 5 year contract term with an option to extend for a further 2 years from October 2015.

- Durham and Darlington IAPT – Commissioners are now looking to extend our current contract; however we are awaiting details of the contract offer.

- Offender Health Contract has been continued for 2016/17.

- **Managing the Budget for Tertiary Services** following a request for applications from secondary care providers to manage the tertiary care budgets for secure mental health services and CYP Tier 4 services the Trust submitted an application and was shortlisted for the CYP Tier 4 service initiative. Members of EMT, NHSE and HRW CCG attended a selection panel on the 27th June and it has now been confirmed that the Trust was successful in its application.

- **CQUIN 2015/16** IN Quarter 1 we received confirmation of the additional resources we had 'earned' via the CQUIN scheme for 2015/16. The total percentage achieved £6,452,068 (99.1%) was greater than the amount 'budgeted' (85%) for in the financial plan 2015/16.

- Formal notification has now been received of recurrent funding allocations totalling £1.08 million for **Eating Disorder Services** as part of Children's Transformation Plans:

CCG	£k
NHS Darlington CCG	60
NHS Durham Dales, Easington and Sedgefield CCG	172
NHS North Durham CCG	134
NHS Hartlepool and Stockton-on-Tees CCG	166
NHS South Tees CCG	175
NHS Hambleton, Richmondshire and Whitby CCG	73
NHS Harrogate and Rural District CCG	77
NHS Scarborough and Ryedale CCG	63
NHS Vale of York CCG	161

- Provisional agreement has been given by the North East Urgent and Emergency Care Vanguard for £1.00m additional income for **CYP Crisis and Intensive Home Treatment services in Durham**, Darlington and Teesside. However final receipt depends upon matched funding being found by the CCGs.

3.6.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs, the Business Plan and qualitative intelligence, the overall position remains positive.

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'. Qualitative Intelligence is also included within this report regarding the NHS Workforce Race Equality Standard.

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 2016/17 and reports progress against the Strategic Direction Scorecard and the Trust Business Plan whilst also considering other forms of qualitative intelligence.

Overall the position remains positive, however the Trust is not meeting some of its high ambitions given the number of reds against stretching metrics, reporting a deterioration on the percentage of greens reported compared to the previous quarter; however this is consistent with the percentage reported as at quarter 1 2015/16. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

7. RECOMMENDATIONS:

The Board is asked to:

- Note the changes to the Trust Business Plan that requires Board approval in Appendix 1.
- Note the suggested amendments for key performance indicator targets referenced in section 3.2.1 (KPI 3) and 3.4.1 (KPI's 21,22 and 24) and 3.6.1 (KPI 33 and 34) for approval.

Sharon Pickering
Director of Planning Performance and Communications

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	Q1 Metric Status	Comment and requests for decisions
1.6	Deliver agreed service developments - **Further improve Community Services and extended hours** (ends 16/17 Q1)	Durham and Darlington	AMH	Implement outputs from extended hours 3P event (held March 15) in AMH	Implementation of 3P newspaper complete	~~15/16 Q4~~ 16/17 Q1	Jo Dawson / Paul Walker		This priority has been superseded by PPCS and so it is requested **that Board remove this from the Business Plan as a separate service development because this is now within the scope of the PPCS Programme** (Priority 1.1)
1.6	Deliver agreed service developments - **Identify non LD Autism needs and develop business proposal in discussion with commission-ers** (ends 16/17 Q1)	Durham and Darlington	AMH	Implement the plan arising from Locality Director paper to EMT (Jan 15) to identify sites in Tees and Durham to develop individual TEWV placements/accommodatio n for people with autism	Implementation in line with project plan	16/17 Q4	Patrick Scott		This was a priority identified within the 15/16 plan, however as the BoD have identified autism as a Trust priority for 2016/17 **Board confirmation is sought that this can be deleted from the 16/17 Business Plan.**

Appendix 1

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
1.6	Deliver agreed service developments - **Trauma Centre of Excellence** (ends 16/17 Q1)	Durham and Darlington	AMH	Develop a business case for a Trauma centre of excellence	Business case submitted to EMT	~~15/16 Q3~~ ~~15/16 Q4~~ 16/17 Q1	Jo Dawson / Angela Kennedy		**Board Confirmation is requested that this Durham & Darlington specific action can be removed from the Business Plan** due to the approval of the Trust-wide Trauma PM3.
1.6	Deliver agreed service developments - **Establishing School Status for West Lane CAMHS Education Provision with new provider** (ends 16/17 Q1)	Tees	CYP Tier 4	Education Provider (Priory) obtained Registered School Status for West Lane Site	Department for Education Registration Complete	16/17 Q1	Jackie Ennis		Issues with commissioning of education provider by LA resulted in Priory no longer providing service. Middlesbrough Academy currently providing service. Procurement of a new provider will commence later this year. The final date of 17/18 Q4 for completion of the procurement and commencement of the new provider is indicative at this stage and will be firmed up in the production of the 17/18 – 20/21 Business Plan in the coming months. **Board is requested to agree to removal of this priority to be replaced with:**
				School inspected by Ofsted	Ofsted report published	16/17 Q1	Jackie Ennis		
				Identification of options for education provision within West Lane	Options identified	16/17 Q4	Chris Davis		

Appendix 1

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
				In liaison with Middlesbrough LA, ensure the procurement of a suitable provider to deliver the agreed model of education.	New provider commences operation	17/18 Q4	Chris Davis		**'Establish suitable education provision for patients within West Lane' and to delete the current actions and replace them with those highlighted in pink. This also requires an extension of the timescale for final completion to 17/18 Q4**
1.6	Deliver agreed service developments: **Personality Disorder – develop Trust-wide co-ordinated approach** (ends 15/16 Q4)	COO	AMH	Develop Business Case, including detailed Project Plan	Business Case produced and agreed by EMT	15/16 Q4	Malcolm Bass		Project Manager in discussion with Sponsor re PM3. Awaiting Sponsor approval to go to EMT following which further actions will be identified. **Board are requested to approve extension of this action and priority completion date to 16/17 Q2**
1.6	Deliver agreed service developments: - **Create capacity and process to**	COO	All	Conduct review of technology developments (both current and future)	Review of technologic developments produced for, and agreed at, EMT	15/16 Q3	Brent Kilmurray		This priority is now being delivered through the Purposeful and Productive Community Services Programme, and it is therefore proposed to remove the existing, "carry-over"

Appendix 1

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
	identify and test radical new approaches to service delivery, including the use of new technology (ends 16/17 Q4)			Identify where technology could be applied across Trust	Proposals for applying new technology discussed and agreed by EMT	16/17 Q1			actions/metrics from the 15//18 Business Plan as this is incorporated within priority 1.1 of the new Plan. **Board confirmation of removal of this service development is sought.**
				Report outcome of pilots and evaluate potential opportunities to roll out across services	Report, including roll out programme, produced for, and agreed at EMT	16/17 Q4			
5.1	Develop a range of interventions that will enable staff to use the technologies available to them more effectively (ends 17/18 Q2)	COO	NA	Complete assessments of technology requirements for clinical staff in clinical settings	Report presented to OMT	15/16 Q4	Brent Kilmurray		This priority is now being delivered through the Purposeful and Productive Community Services Programme, and it is therefore proposed to remove the existing, "carry-over" actions/metrics from the 15//18 Business Plan as this is incorporated within priority 1.1 of the new Plan. **Board confirmation of removal of this service development is sought.**
				Develop proposals for adoption of key technologies	Proposal report presented to EMT	16/17 Q2			
				If approved, implement proposals (including training)	Progress reported to OMT	16/17 Q4			
				Evaluate success/benefits	Evaluation report presented to EMT	17/18 Q2			
2.8	Improve the clinical effectiveness and patient experience at times of	Nursing & Governance	**Please refer to the table at the end of this Appendix** which sets out proposed replacements for the actions and metrics currently in the Business Plan by those agreed in the Quality Account / CQUIN.						

Appendix 1

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
	transition (ends 17/18 Q4)								
1.6	Deliver agreed service developments - **Agree a detailed, resourced plan to address gaps between current competenc-ies of staff and what they require to deliver effective patient care through model lines and pathways** (ends 16/17 Q1)	Human Resources	All	Produce report with recommendations	Present report and recommendation to Workforce Development Group	16/17 Q1	Judith Hurst		This 15/16 Business Plan carry-over is now being delivered as part of the PPCS priority so **Board are asked to confirm the deletion of this service development**

Appendix 1

Current Business Plan actions and metrics for priority 2.8 (Transitions)

Following approval of the Trust's Business Plan, the actions for this priority were developed further as part of the Quality Account process. Due to this, the actions have changed so that they align with the CAMHS Transitions CQUIN. This will allow for a streamlined process, avoid duplication and enable co-production to achieve this priority and the CQUIN. **Trust Board is requested to approve the alignment of the Business Plan to the Quality Account for this priority, replacing the current actions (highlighted in pale grey) with those highlighted in light pink on the subsequent page.**

Ref	Priority	Directorate	Action			
2.8	Improve the clinical effectiveness and patient experience at times of transition	Nursing and Governance	Baseline current experiences through a detailed review of transition e.g. patient feedback on their experience to identify issues	Baseline assessment completed.	16/17 Q1	Corinne Aspel
			Using baseline data identify the speciality with the most significant transition issues	Speciality identified	16/17 Q2	
			Develop and commence an action plan focusing on the speciality highlighted with the most significant issues	Action plan developed and commenced	16/17 Q3	
			Develop 'new state' patient flow and high level standard process for priority speciality	New state value stream map developed	16/17 Q4	
			Evaluate effectiveness of action plan implementation	Evaluation report on the effectiveness of action plan implementation completed	17/18 Q1	
			Develop a roll out programme in collaboration with relevant clinical services that will focus on one specialty and a selection of teams based on the priority area identified within year	Roll out programme in place	17/18 Q1	
			Agree communication strategy including agreement of reporting and feedback mechanisms	Communication strategy developed. Routine reports produced.	17/18 Q2	
			Remaining identified teams to implement new transition process	Implementation of new transitions procedures initiated within 100% of identified teams	17/18 Q3	
			Evaluate effectiveness of implementation and feedback to relevant stakeholders	Evaluation report on the effectiveness of implementation completed	17/18 Q4	

Appendix 1

Proposed New Actions and Metrics for Priority 2.8: Improve the clinical effectiveness and patient experience at times of transition

Proposed New Action	New Metric	Timeline	Lead	Comment
(i) Baseline current experiences through a review of transition in CAMHS	Review complete	16/17 Q1	Corinne Aspel/ Leanne McCrindle	For 2016/17 the Trust have been issued with a Local CQUIN for Children and Young Peoples Mental Health Services. The CQUIN aims to improve patient & carer involvement, experience and outcomes in transitions out of Child and Adolescent Mental Health Services (CAMHS). As the aims of the Quality Account priority and CQUIN objectives are the same, the Trust has therefore agreed to approach this work as an integrated project. The Quality Account Leads have been working with the CQUIN Lead and a dedicated Steering Group to deliver the objectives. The baseline of current experiences was reviewed including: A review of the national evidence base for young people's transitions experience and the effectiveness of those transitions. This showed that nationally many young people have a poor experience of transition and that this impacts upon the clinical effectiveness of their ongoing care and treatment - A review of the Trust audit data from the last three years, highlighting areas where improvements were required. Again audit data suggested inconsistent application of the transitions protocol. - Baseline survey performed which reviewed the experience of young people and their carers during and following the transition process. These experiences reflected the national evidence base and local audit findings.
(ii) Review and develop a Safe Transition and Discharge Protocol for CAMHS	Protocol reviewed and developed	16/17 Q1	Debbie Smith	The protocol has been reviewed and developed with key clinicians and was then distributed across the Trust for consultation and then approved by SDG and EMT. The protocol is also available on InTouch to enable access for all staff.

(iii) Implement Safe Transitions and Discharge Protocol	Protocol implemented within CAMHS	16/17 Q2	Debbie Smith	The protocol has been published on Intouch to enable all staff to access it. CYP QUAG members are being asked what support they need to implement the protocol as are SDMs in LD, Forensic and AMHS. Relevent support will then be put in place. Guidance is being developed for use by Team Managers to ensure that they can clearly describe the protocol, its contents and the differences compared to the previous version. A visual display format will be shared with CYPS - Heads of service to track those in transition. Learning from the earlier clinical audit will be used to highlight issues which may need additional attention.
(iv) Undertake an audit of the protocols to include further collection of carer and user experience	Audit complete	16/17 Q3	Corinne Aspel/ Leanne McCrindle	Systems established for ongoing collection of carer and user experience via service surveys. In addition an audit of the protocol is planned for Q3 to assess levels of implementation
(v) Review outcome of the audit, develop and implement an action plan	Review complete and action plan in place	16/17 Q4	Corinne Aspel/ Leanne McCrindle	An action plan will developed following completion of the Q3 audit
(vi) Using the audit action plan, further embed the Safe Transitions and Discharge Protocol	All actions completed within agreed timescales	17/18 Q2	Debbie Smith	The service will work with the audit subgroup to identify appropriate actions and utilise SDG to support the action plan implementation
(vii) Undertake an additional audit of the protocols to include further collection of carer and user experience	Audit complete	17/18 Q2	Corinne Aspel/ Leanne McCrindle	Systems established for ongoing collection of carer and user experience via service surveys. In addition an audit of the protocol is planned for Q2 17/18 to assess levels of implementation
(viii) Review outcome of the audit, updating current action plan	Action plan updated	17/18 Q3	Corinne Aspel/ Leanne McCrindle	An action plan will developed following completion of the Q2 17/18 audit
(ix) Complete an evaluation report on the effectiveness of implementation of the new protocol and feedback to relevant stakeholders	Evaluation complete	17/18 Q4	Corinne Aspel/ Leanne McCrindle	Cumulative evaluation will be collected throughout the 2 year project. This will be collated into a detailed evaluation report which will be presented to key stakeholders (via written report/presentation) by Q4 17/18.

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th September 2016**
TITLE:	**Annual Review of the Terms of Reference of the Board's Committees**
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 approval of the terms of reference of its committees is reserved to the Board under the Constitution.

The terms of reference were refreshed in 2014 and are reviewed annually.

Suggested amendments to the documents are provided in the Annexes to this report.

Recommendations:

The Board is asked to approve the proposed changes to the terms of reference as set out in this report.

MEETING OF:	**The Board of Directors**
DATE:	**27th September 2016**
TITLE:	**Annual Review of the Terms of Reference of the Board's Committees**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to enable the Board to review the terms of reference (TOR) of its committees.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Board has established the following committees under Standing Order 6.1 of Annex 8 to the Constitution.

- Audit Committee
- Commercial Oversight Committee
- Investment Committee including Charitable Funds
- Mental Health Legislation Committee
- Nomination and Remuneration Committee
- Quality Assurance Committee

2.2 The TOR of the Board's committees were refreshed in 2014 and are subject to annual review.

3. KEY ISSUES:

3.1 Copies of the TOR for each Committee are attached as Annexes 1 to 6 to this report with proposed amendments highlighted using tracked changes.

3.2 The Board is asked to note that it is proposed to change to the number of seats for Non-Executive Directors on the following Committees:

(a) Quality Assurance Committee – reduction of 1 seat
(b) Investment Committee – 1 additional seat
(b) Mental Health Legislation Committee – 1 additional seat.

These changes are required to support the allocation of seats to Non-Executive Directors under agenda item 15.

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 report supports compliance with 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 It is considered that, subject to minor amendments, the TOR of the Board's committees remain fit for purpose.

7. RECOMMENDATIONS:

7.1 The Board is asked to confirm the terms of reference of the Board's committees as set out in Annexes 1 to 6 to this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution (October 2015)

Annex 1

AUDIT COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION AND PURPOSE

1.1 The Audit Committee is established under Standing Order 6 of the Board of Directors.

1.2 The Committee exists to provide the Board of Directors with a means of independent and objective review of financial and corporate governance and assurance and risk management processes across the whole of the Trust's activities (both clinical and non-clinical) both generally and in support of the achievement of the Trust's Strategic Direction.

1.3 The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

1.4 The Standing Orders of the Board of Directors, as far as they are applicable and with any appropriate alterations, shall apply to meetings of the Committee.

2 FUNCTIONS

Governance, Risk Management and Internal Control

2.1 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's Strategic Goals.

. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with national standards/regulatory requirements), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

Internal Audit

2.2 To consider the Internal Audit Strategy and Operational Plan ensuring it is consistent with the needs of the organisation as identified in the Assurance Framework.

2.3 To oversee, on an ongoing basis, the effective operation of Internal Audit in respect of:

- Adequate resourcing
- Its co-ordination with External Audit
- Meeting mandatory NHS Internal Audit Standards
- Providing adequate and appropriate independent assurances
- Having appropriate standing within the organisation
- Meeting the internal audit needs of the Trust

2.4 To consider the major findings of Internal Audit investigations and management's responses and their implications and monitor progress on the implementation of agreed recommendations.

2.5 To consider the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

2.6 To conduct an annual review of the effectiveness of the Internal Audit function.

External Audit

2.7 To make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the External Auditor.

(Note: Where the Council of Governors does not approve the recommendation, the Audit Committee shall prepare a statement for consideration by the Board of Directors explaining its recommendation, for inclusion in the Annual Report.)

2.8 To oversee the conduct of a market testing exercise for the appointment of an External Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors in respect to the appointment of the External Auditor.

2.9 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit and to ensure coordination, as appropriate, with other External Auditors in the local health economy.

2.10 To review the work and findings of the External Auditor and to consider implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor ;

- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; and

- reviewing all External Audit reports, including agreement of the annual audit letter (if required) before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses.

2.11 To review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements and compliance with the Audit Code for NHS Foundation Trusts.

2.12 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the External Audit firm.

Annual Accounts Review

2.13 To review whether the Trust remains a "going concern" and to assure the Board accordingly.

2.14 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes.
- Areas where judgment has been exercised.
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having a material effect
- The schedule of losses and special payments
- Any adjusted misstatements
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved

2.15 To review the Annual Report and Annual Governance Statement prior to submission to the Board of Directors to determine their completeness, objectivity, integrity, accuracy and compliance with directions received from ~~Monitor~~ NHS Improvement.

2.16 To review the Trust's Quality Account/Report prior to inclusion in the Annual Report and submission to the Board of Directors to determine its completeness, integrity and accuracy. This review will include but is not limited to:

- Compliance with directions received from the Department of Health and ~~Monitor~~ NHS Improvement.
- The accuracy of mandatory and local performance indicators
- Any issues raised by stakeholders

2.17 To review all systems of accounting and financial reporting, including those of budgetary control, in order to provide assurance on the completeness and accuracy of information provided to the Board.

Other

2.18 To review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. NHS Improvement ~~Monitor~~, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

2.19 To review the work of other committees within the organisation and the Executive Management Team (*including recommendations from EMT and the other Committees)* whose work can provide relevant assurance to the Committee's own scope of work on the appropriateness, robustness and operation of the Trust's governance arrangements. This will particularly include the Quality Assurance Committee.

In reviewing the work of the Quality Assurance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

2.20 To review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ("The Whistle Blowing Policy").

In undertaking the review the Committee's objective will be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

2.21 To review the Trust's systems and processes for the prevention of bribery and receive reports on non-compliance.

2.22 To request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

2.23 To request and review specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

2.24 To commission and review value for money studies of the Trust's services and functions and to make recommendations to the Board accordingly.

3 MEMBERSHIP

3.1 The Committee shall be appointed by the Board from amongst the Non - Executive Directors/ Associate Non-Executive Directors of the Trust and shall consist of not less than four members. At least one Member of the Committee shall have recent and relevant financial experience.

3.2 The Chairman of the Committee shall be appointed by the Board of Directors.

3.3 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman. Nominated deputies may be appointed when appropriate.

4 ATTENDANCE

4.1. The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. .

4.2 The Chairman of the Trust shall not be a member of the Committee but may attend as an observer at the invitation of the Committee.

4.3 Any Non-Executive Director of the Trust may attend meetings should they wish and participate in discussions on all matters before the Committee. All Non-Executive Directors will receive Audit Committee agendas and papers.

4.4. The Chief Executive and other Executive Directors **may** be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

4.5 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

4.6 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary of the Committee.

5 QUORUM

5.1 A quorum shall not be less than three members of the Committee.

6 FREQUENCY

6.1. Meetings shall be held not less than three times a year.

6.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

6.3 The Committee shall meet privately at least once a year with the Internal and External Auditors.

7 DELEGATED AUTHORITY

7.1 Authority to investigate any activity within its terms of reference.

7.2 Authority to seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee.

7.3 Authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise at its meetings if it considers this necessary.

7.4 Authority to commission value for money and other studies.

7.5 Approval of the Internal Audit Strategy and Operational Plan.

7.6 Appointment and dismissal of the Internal Audit provider.

7.7 Approval of the External Audit Strategy.

8 REPORTING

8.1. The minutes of Audit Committee meetings shall be formally recorded by the Trust Secretary and submitted to the Board. The Chairman of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action, including any risks which the Committee considers should be included in the Board's Chapter of the Integrated Assurance Framework and Risk Register.

8.2. The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessments as required by ~~Monitor~~ NHS Improvement and/or the Care Quality Commission.

8.4 The Audit Committee may also make recommendations directly to the Council of Governors on any matters it deems appropriate within the Council of Governors roles and responsibilities.

9 REVIEW

9.1. The terms of reference of the Committee shall be reviewed, at least, annually.

Annex 2

COMMERCIAL OVERSIGHT COMMITTEE

TERMS OF REFERENCE

CONSTITUTION

The Commercial Oversight Committee is established under Standing Order 6 of the Board of Directors.

The Standing Orders of the Board of Directors, as far as they are applicable and with any appropriate alterations, shall apply to meetings of the Committee.

For the purposes of these Terms of Reference the term "Subsidiary" shall include any company, limited liability partnership, joint venture or other trading initiative which the Committee is designated as overseeing.

FUNCTIONS

1 To oversee and provide assurance to the Board on the performance of the Trust's Subsidiaries.

2 To ensure that all the Trust's Subsidiaries:

- (a) Are and remain established in accordance with the Companies Act 2006 and / or other relevant legislative requirements;
- (b) Have no functions other than those agreed by the Board of Directors of the Trust;
- (c) Adhere to all applicable laws and statutory guidance;
- (d) Ensure appropriate insurance is in place, in particular:
  - i. Employer Liability
  - ii. Public Liability
  - iii. If relevant, Directors and Officers insurance
  - iv. All other relevant insurance
- (e) Apply the proceeds of any trading activity to the benefit of the Trust.

3 To provide input on any matter related to the Trust's interest in a Subsidiary to:

- (i) The nominee(s) on the board or equivalent of that Subsidiary.
- (ii) If relevant, a person or persons appointed under Section 323 of the Companies Act 2006 to act as the Trust's representative or representatives at any meeting of the Subsidiary.

4 To receive and review the annual reports and accounts of Trust Subsidiaries.

5 To notify any material risks with regard to the operation of the Trust Subsidiaries to the Board of Directors.

6 To investigate any concerns it may have in relation to any Subsidiary and to report the outcome of any investigations, if it considers it appropriate, together with suggested recommendations to the relevant Subsidiary and the Board.

7 To take appropriate steps to ensure the Subsidiaries remain financially solvent and provide a positive financial return to the Trust.

DELEGATED AUTHORITY

1 In carrying out its duties the Committee may do anything which appears to it to be reasonably necessary or expedient for the purposes of or in connection with the functions set out above. In particular it may agree its requirements as to the information it requires from Trust Subsidiaries in order to maintain proper oversight of their activities.

MEMBERSHIP

The Committee shall comprise:

- The Chairman of the Trust*.
- The Chairman of the Investment Committee*
- The Chairman of the Audit Committee*
- An Executive Director*

(* subject to them also not being a director or senior post holder of any Subsidiary).

The Chairman of the Committee shall be appointed by the Board from amongst the Committee's membership.

The Committee may require:

- Directors or senior post holders of Subsidiaries;
- Internal or external auditors;
- Any other relevant third parties

to attend its meetings, as it considers appropriate, for maintaining an oversight of Subsidiary business planning, performance and activities.

The Trust Secretary, or a member of his/her staff, shall be the Secretary to the Committee.

QUORUM

A quorum shall be not less than two members of the Committee of which one shall be a Non-Executive Director and one shall be an Executive Director.

FREQUENCY OF MEETINGS

The Committee shall meet at least once each quarter.

MINUTES AND REPORTING PROCEDURES

1 Reports on the material issues considered by the Committee shall be submitted, together with formal minutes of its meetings, to the Board.

2 Any issues or risks to the Trust's reputation and/or sustainability arising from the performance of Subsidiaries shall be escalated to the Board for its attention in accordance with the Trust's integrated governance arrangements.

3 Any reports provided to the Board on matters which have been subject to consideration by the Committee shall disclose this fact together with details of any views expressed or recommendations made by the Committee.

REVIEW

The terms of reference of the Commercial Oversight Committee shall be reviewed at least annually.

Annex 3

INVESTMENT COMMITTEE (INCLUDING CHARITABLE FUNDS)

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Investment Committee is established under Standing Order 6 of the Board of Directors.

1.2 The Standing Orders of the Board of Directors, as far as they are applicable and with any appropriate alterations, shall apply to meetings of the Committee.

2 FUNCTIONS

2.1 To establish the overall methodology, processes and controls which govern investments.

2.2 To keep the Trust's investment strategy and policy under review and to ensure they are aligned to the ~~Business Development Strategy~~Strategic Direction and Business Plan.

2.3 To consider and provide assurance to the Board on the appropriateness and robustness of:
(a) The medium-term financial strategy, in relation to both revenue and capital.
(b) The Estates and Facilities Management Framework.
(c) The Information Strategy.

2.4 To review the Capital Plan prior to its incorporation in the Business Plan.

2.5 To undertake in-year monitoring of capital expenditure.

2.6 To monitor the implementation of the ~~Business Development Strategy.~~ Strategic Direction and Business Plan.

2.7 To review proposals (including evaluating risks) for major business cases and their respective funding sources and provide assurance to the Board~~.~~

2.8 To review the management and administration of Charitable Funds held by the Trust.

2.9 ~~To review progress towards the achievement of the "upside" scenarios included in the Business Plan.~~ To review progress and to provide assurance to the Board on the achievement of commissioner investment in the service priorities included in the business plan

DELEGATED AUTHORITY

3.1 The investigation of any activity within its terms of reference.

(Note: All employees are directed to cooperate with any request made by the Committee)

2.4 3.2 Approval of outline business cases for projects included in the Business Plan to progress to full business case stage subject to their financial consequences (both capital and revenue) remaining within estimate.

2.5 3.3Approval of full business cases for:

- High risk investments valued under £250,000.
- Low risk investments valued between £250,000 and £1 million.

3.4 Approval of the submission of reference cost information to the Department of Health.

3.5 Approval of applications for financial assistance from the Trust's Charitable Trust Funds.

3.6 The commissioning of any outside legal or other independent professional advice and expertise if it considers this necessary.

4 MEMBERSHIP

4.1 The Committee shall comprise:

- A Non-Executive Director as the Chairman of the Committee
- ~~Two~~ Three other Non-Executive Directors / Associate Non-Executive Directors
- The Chairman of the Trust
- The Chief Executive
- The Director of Finance ~~and Deputy Chief Executive~~
- The Chief Operating Officer and Deputy Chief Executive
- The Director of Planning, Performance and Communications

4.2 The Chairman of the Committee shall be appointed by the Board of Directors.

4.3 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman.

4.4 Any Non-Executive Director of the Trust may attend meetings should they wish and participate in discussions on all matters before the Committee. All Non-Executive Directors will receive agendas and papers.

4.5 The Committee may invite other directors and other Trust staff to attend its meetings as appropriate. It will also invite the attendance of independent external advisors as required subject to the size and complexity of the investment.

4.6 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary of the Committee.

5 QUORUM

5.1 A quorum shall be not less than two Non-Executive Directors, one of which will chair the meeting and one Executive Director.

6 DECISION MAKING

6.1 Normal practice will be to reach decisions through consensus; however, where this is not possible the chairman of the Committee will refer the matter to the Board for decision together with briefing papers.

7 FREQUENCY OF MEETINGS

7.1 The Committee shall meet at least once each quarter.

8 MINUTES AND REPORTING PROCEDURES

8.1 Reports on the material issues considered by the Committee shall be submitted, together with formal minutes of its meetings, to the Board of Directors.

8.2 Any risks to the Trust's sustainability shall be escalated to the Board for its attention in accordance with the Trust's integrated governance arrangements.

8.3 Any reports provided to the Board on matters which have been subject to consideration by the Committee shall disclose this fact together with details of any views expressed or recommendations made by the Committee.

9 REVIEW

9.1 The terms of reference of the Investment Committee shall be reviewed at least annually.

Annex 4

MENTAL HEALTH LEGISLATION COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Mental Health Legislation Committee is established under Standing Order 6 of the Board of Directors

1.2 The Standing Orders of the Board of Directors, as far as they are applicable and with appropriate alterations, shall apply to meetings of the Committee.

1.3 All meetings of the Committee will be held in public.

2 FUNCTIONS

2.1 To provide assurance to the Board on the Trust's compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005, including any statutory Codes of Practice relating thereto, by:

(a) reviewing activity and performance with appropriate comparisons and trends; and

(b) identifying common themes arising from the findings of the Care Quality Commission following visits to the Trust's services

and to escalate risk and propose mitigating actions to the Board where assurance is lacking.

(NOTE: Oversight and monitoring of actions in response to recommendations received from the Care Quality Commission falls within the remit of the Quality Assurance Committee).

2.2 To consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to make recommendations, as required, for changes to the Trust's policies, procedures and practice.

2.3 To ensure appropriate arrangements are in place for the appointment and appraisal of associate managers and oversee managers' hearings.

2.4 To consider other matters at the request of the Board of Directors.

3 MEMBERSHIP

3.1 The Committee will comprise:

- A Non-Executive Director as the Chairman of the Committee
- Two ~~One~~ other Non-Executive Directors/ Associate Non-Executive Directors
- The Chairman of the Trust

- The Director of Nursing and Governance
- The Medical Director
- The Chief Operating Officer and Deputy Chief Executive
- Two Public Governors (as representatives of service user/carers)

3.2 The Chairman of the Committee shall be appointed by the Board.

3.3 The Executive Director Members of the Committee may nominate deputies (with voting rights) to attend meetings on their behalf.

3.4 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman.

3.5 Any Non-Executive Director of the Trust may attend meetings should they wish and all Non-Executive Directors will receive agendas and papers.

3.6 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary to the Committee.

3.7 Other officers of the Trust may attend meetings on the invitation of the Committee.

4 QUORUM

4.1 A quorum shall be three members of whom at least one must be a Non-Executive Director and one must be an Executive Director (or nominated Deputy).

5 FREQUENCY OF MEETINGS

5.1 Meetings will be held at least every quarter.

6 RELATIONSHIP WITH THE BOARD AND OTHER COMMITTEES

6.1 In the course of fulfilling its functions and duties if the Committee becomes aware of any risk which could impact on the Trust's ability to deliver its Strategic Goals it shall seek assurances from the appropriate Director that the risk is being managed effectively. On considering the Director's report it shall:

- When necessary (in conjunction with the Quality Assurance Committee) assure itself that appropriate controls are in place to manage the risk or specify the controls it considers should be established to mitigate the risk.
- Report to the Audit Committee if the risk raises concerns regarding the effectiveness of the Trust's governance arrangements; risk management and assurance arrangements or system of internal control.
- Make a recommendation to the Board that the risk be included in the Board's Chapter of the Integrated Assurance Framework and Risk Register if it believes the risk could have a significant impact on the sustainability/viability of the Trust or on its ability to deliver the Strategic Direction.

7 DELEGATED AUTHORITY

7.1 The Committee is authorised to seek any information it requires through the Executive Directors and Chief Executive.

7.2 All executive action arising from the work of the Committee shall be taken forward either by way of a recommendation to the Board of Directors or by agreement of the relevant Executive Director under their delegated powers.

8 REPORTING ARRANGEMENTS

8.1 Following every meeting the Chairman of the Committee shall report to the next ordinary meeting of the Board of Directors:

- To provide assurance to the Board on the matters considered and to highlight any risks and mitigating actions identified by the Committee at its meeting.
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

9 REVIEW

9.1 The terms of reference of the Committee will be reviewed, at least, annually.

Annex 5

NOMINATION AND REMUNERATION COMMITTEE OF THE BOARD OF DIRECTORS

TERMS OF REFERENCE

CONSTITUTION

The Nomination and Remuneration Committee is established under Standing Order 6 of the Board of Directors.

The Standing Orders of the Board of Directors, as far as they are applicable and with any appropriate alterations, shall apply to meetings of the Committee.

FUNCTIONS

Nominations

1 To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and to make recommendations to the Board with regard to any changes.

2 To be assured that arrangements are in place to support succession planning for Executive Director roles.

3 To be responsible for appointing Executive Directors and other Directors reporting directly to the Chief Executive.

4 To be responsible for appointing the Chief Executive subject to the approval of the Council of Governors.

5 To confirm any matter relating to the continuation in office of any Executive Director (including the Chief Executive) or other Director reporting directly to the Chief Executive at any time including suspension or termination of an individual as an employee of the Trust.

Remuneration

1 To be responsible for reviewing and deciding the terms and conditions of office of the Trust's Executive Directors and other Directors (where these are not determined nationally) including:

- Salary including any performance related pay or bonus
- Provisions for other benefits including pensions
- Allowances

2 To be assured, through the consideration of benchmarking information, that the terms and conditions of employment, including levels of remuneration are sufficient to attract, retain and motivate the Executive Directors and other Directors (where these are not determined nationally).

3 To receive reports on the performance of the Chief Executive and individual Directors who report to the Chief Executive (and other Directors if relevant), as required, to support the consideration of any decisions affecting their remuneration.

4 To advise upon and oversee contractual arrangements for Executive Directors and other Directors (where these are not determined nationally) including but not limited to termination payments.

Miscellaneous

1 To be responsible for authorising applications to ~~Monitor~~ NHS Improvement and HM Treasury for permission to make a special severance payment to an employee or former employee.

2 To consider the engagement or involvement or any suitably qualified adviser to assist with any aspect of its responsibilities.

DELEGATED AUTHORITY

1 The agreement of all matters relating to the appointment of Executive Directors and other Directors (who report directly to the Chief Executive) including the role description and person specification for the position subject to:

- All appointments being advertised externally to the Trust.
- Suitable controls being established to ensure all candidates are considered on merit against objective criteria.
- Suitable controls being established to ensure candidates meet all statutory and regulatory requirements for appointment as directors of the Trust.
- Due regard being given to equality and diversity.

2 The appointment Executive Directors and other Directors (who report directly to the Chief Executive) subject to the Committee being assured that the appointee is a “fit and proper person” as defined in the Licence and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

(Note: the appointment of the Chief Executive requires the approval of the Council of Governors)

3 The approval of the remuneration and terms and conditions of service of the Executive Directors and other Directors (where these are not determined nationally).

4 The approval of any annual uplifts in Trust determined pay structures.

5 The approval of any termination payments to the Executive Directors and other Directors (where these are not determined nationally), ensuring they are properly calculated and are reasonable with regard to their probity and value for money.

6 The approval of applications to ~~Monitor~~ NHS Improvement and HM Treasury for permission to make a special severance payment to an employee or former employee.

MEMBERSHIP

The Committee shall comprise the Chairman of the Trust and all Non-Executive Directors.

The Chief Executive shall be an ex officio member of the Committee for all matters pertaining to the appointment of Executive Directors (excluding to the office of Chief Executive) and other Directors who report directly to the Chief Executive.

The Chairman of the Trust shall be the Chairman of the Committee.

A quorum shall be at least three Members of the Committee.

The number of Non-Executive Directors and their individual attendance at meetings held for the purpose of conducting interviews and appointing Executive Directors or other Directors reporting to the Chief Executive shall be determined by the Chairman in consultation with the Chief Executive.

ATTENDANCE AT MEETINGS

With the agreement of the Chairman meetings of the Nomination and Remuneration Committee may be attended by:

- *The Chief Executive*
- *The Director of Human Resources and Organisational Development*
- *any other person on the invitation of the Committee so as to assist in its deliberations*

The Trust Secretary shall be the secretary of the Committee.

FREQUENCY OF MEETINGS

Meetings shall be held as and when required on dates and at times agreed by the Chairman.

MINUTES AND REPORTING PROCEDURES

1 The minutes of all meetings of the Nomination and Remuneration Committee shall be formerly recorded. These will be retained by the Secretary and not shared with any person who is not a member of the Committee without the permission of the Chairman.

2 The Nomination and Remuneration Committee will report to the Board of Directors after each meeting.

3 Matters pertaining to the work of the Nomination and Remuneration shall be reported, as required by ~~Monitor~~ NHS Improvement, in the Annual Report.

REVIEW

The terms of reference of the Nomination and Remuneration Committee shall be reviewed by the Board of Directors as an when it is considered necessary and expedient to do so.

Annex 6

QUALITY ASSURANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Quality Assurance Committee is established under Standing Order 6 of the Board of Directors.

The Standing Orders of the Board of Directors, as far as they are applicable and with any appropriate alterations, shall apply to meetings of the Committee,

The Committee exists to provide assurance to the Board to enable it ("the Board") to fulfil its responsibilities.

2 FUNCTIONS

2.1 To provide assurance to the Board that the Trust is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008 ("the Act").

2.2 To gain and provide assurance to the Board on:

a. The Trust's compliance with regulation requirements enabling it to maintain registration with the Care Quality Commission to undertake regulated activities at each location;

b. The Trust is compliant with the Regulator's standards of quality and safety as set out in the Health and Social Care Act 2008 (Registration requirements) Regulations 2009 and the fundamental standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014;

c. The delivery of the strategic quality objectives in the Trust's Quality Strategy and its supporting Frameworks;

d. The delivery of the Quality Account priorities and escalate risks of achievement to the Board;

e. That effective processes are in place in the Trust to ensure that lessons are learned and that good practice is shared and implemented across the Trust.

And to escalate risk to the Board where assurance is lacking.

2.3 To make recommendations about priorities in the Trust's Annual Quality Account for the following year.

2.4 To commission and monitor projects/programmes of work to assist the Trust to maintain CQC registration and/or discharge its duty of quality and safety.

2.5 To co-operate fully with all Board Committees and to support those Committees achieving their objectives.

2.6 To develop an annual programme of work to ensure the functions of the Committee are achieved.

2.7 To agree in consultation with the Audit Committee, an annual Clinical Audit programme (aligned to the key clinical risks of the Trust); and to monitor that programme and liaise with the Audit Committee as appropriate.

2.8 To monitor that the risks relevant to the Committee within the Risk Register are regularly reviewed to reflect the dynamic nature of risk.

2.9 To agree the information requirements of the Committee which will assist it to fulfil its functions, identify any risk to the Trust and allow improvement to be monitored. The information will be provided to the Committee through regular reports which meet the requirements of Monitor's Quality Governance Framework.

2.10 To obtain assurance from service users and carers on the quality and safety of service provision through an Essential Standards Group.

2.11 To undertake an annual review of each working group that reports to the Committee.

2.12 To provide the Board of Directors with a monthly report on the quality, assurance and governance activities of the Committee and to escalate any risk to quality to the Board for its attention in accordance with the Trust's integrated governance arrangements.

3 MEMBERSHIP

Voting Members
Chairman of the Committee (a Non-Executive Director)
Trust Chairman
Three ~~Four~~ Non-Executive Directors / Associate Non-Executive Directors
Director of Nursing and Governance
Medical Director
Chief Operating Officer
Chief Executive
Director of Quality Governance

IN ATTENDANCE (Whole meeting)

- ~~The 2 Deputy Medical Directors and Directors of Operations whose LMGB reports are being considered~~. The Deputy Medical Directors and Directors of Operations whose LMGB reports are being considered.
- Deputy Director of Nursing
- Associate Directors of Nursing

The Trust Secretary, on an officer appointed by him/her ~~shall be the secretary of the Committee.~~

NB other staff will attend for the relevant specific agenda item only

4 QUORUM

4.1 A quorum should be not less than two Non-Executive Directors, one of which will chair the meeting and two Executive Directors.

5 FREQUENCY OF MEETINGS

~~The Committee will meet monthly, usually from 14:00 – 17.00 on the 1st Thursday of the month.~~

The Committee will meet 10 times a year usually from 14:00 – 17.00 on the 1st Thursday of the month (except in January and August).

6 RELATIONSHIP WITH THE BOARD AND OTHER COMMITTEES

In the course of fulfilling its duties if the Committee becomes aware of any risk which could impact on the Trust's ability to deliver its Strategic Goals it shall seek assurances from the appropriate Director whether the risk is being managed effectively.

On considering the Director's report it shall:

- Assure itself that appropriate controls are in place to manage that risk or specify the controls it considers should be established to mitigate the risk.
- Report to the Audit Committee if the risk raises concerns regarding the effectiveness of the Trust's governance arrangements; risk management and assurance arrangements; or system of internal control.
- Make a recommendation to the Board that the risk be included in the Board's Chapter of the Integrated Assurance framework and Risk Register if it believes the risk could have significant impact on the sustainability/viability of the Trust or its ability to deliver the Strategic Direction.

7 DELEGATED AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee has delegated authority, subject to consultation with the Audit Committee, to approve an annual programme of clinical audit.

8 REVIEW

The Committee will be reviewed at least annually – within 12 months following approval by the Board of Directors or earlier if required by national guidance or legislation.

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th September 2016**
TITLE:	**Appointment of the Non-Executive Chairmen and Members of Committees of the Board of Directors**
REPORT OF:	**Lesley Bessant, Chairman of the Trust**
REPORT FOR:	**Decision**

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

Executive Summary:

The Board is asked to appoint:

(1) The Non-Executive Director chairmen and members of its committees in accordance with their terms of reference.

(2) The panel of Non-Executive Directors to participate in reviews of serious incidents.

Recommendations:

The Board is asked to approve the appointments set out in Annex 1 to this report with effect from 1st October 2016.

MEETING OF:	**The Board of Directors**
DATE:	**27th September 2016**
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.

2.3 Under minute 14/372 (25/11/14) the Board supported the establishment of a panel of Non-Executive Directors to participate in serious incident reviews in order to improve continuity between meetings and to enable trends to be more easily identified.

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 2016.

3.2 In doing so the Board is also asked to note that the appointments to the Investment and Mental Health Legislation Committees are dependent on the approval of changes to their terms of reference under agenda item 14.

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 2016.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution (October 2015)

Annex 1

Non-Executive Director Committee and SUI Panel Membership from 1st October 2016

	Audit Committee	Investment Committee	Mental Health Legislation Committee	Quality Assurance Committee	Commercial Oversight Committee	SI 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 Chair**	✓
Dr. Hugh Griffiths	✓			**Chair**		✓ **(18 Month Appointment)**
Marcus Hawthorn	**Chair**	✓			**Ex Officio Member**	
David Jennings	✓	✓				
Richard Simpson			**Chair**	✓		✓ **(12 Month Appointment)**
Jim Tucker		**Chair**		✓	**Ex Officio Member**	
Paul Murphy	✓ **(18 Month Appointment)**	✓	✓			
Shirley Richardson			✓	✓ **(18 Month Appointment)**		

(Note: All Non-Executive Directors are members of the Board Nomination and Remuneration Committee)

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th September 2016**
TITLE:	**Board Business Cycle**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Decision**

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

Executive Summary:

The business cycle sets out the matters to be considered by the Board at its formal meetings and seminars taking into account key corporate processes.

The proposed business cycle follows the approach taken in previous years; however, the Board is asked to note that amendments might be required, in year, to reflect potential changes to the submission dates for the NHS Improvement Plan.

Recommendations:

The Board is asked to approve the business cycle for the period 1st October 2016 to 31st December 2017 noting that amendments might be required in year to reflect potential changes to the submission dates for the NHS Improvement Plan.

MEETING OF:	**The Board of Directors**
DATE:	**27th September 2016**
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 2016 to December 2017.

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 recommendations of "The Intelligent Board".
- The recommendations arising from the governance reviews undertaken by Deloitte LLP in 2014/15.
- 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 meetings being held, generally, on the last Tuesday of each month (except in July, August and December).
- 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.
- The Board meeting in December being held on the third Tuesday of the month in view of the Christmas period.
- A special meeting being held in August, if required, to consider urgent business only.
- 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:

3.1 The proposed schedules of matters to be considered at formal Board meetings and Board seminars are set out in Annexes 1 and 2 attached to this report.

3.2 Business Planning

The arrangements for the development and approval of the NHS Improvement (NHSI) Plan and the Business Plan, as set out in attached schedules, are based on previous years.

Board Members are asked to note that there are indications that the timetable for the NHSI Plan will be brought forward with the draft and final plans requiring submission in mid-November and mid-December, respectively.

If these changes are introduced the business planning cycle will need to be amended and might require:

- Changes to the dates of the Board meetings or special Board meetings in November and December 2016.
- Changes to the dates of Board meetings and the Board Business Planning Events in 2017.

Further information on this matter will be provided to the Board once it becomes available.

Formal Board Meetings:

3.3 The Board is asked to note the following proposed changes to the Board's usual business arrangements during 2017:

- At the request of the Chairman, the June meeting will be held on 4th July 2017.
- Due to difficulties in securing a suitable room at Roseberry Park, the meeting in Middlesbrough will be held on 4th July and not 20th July.
- The meeting in May has been scheduled for 23rd of the month to reflect the expected submission date for the Annual Report and Accounts; however, this will be confirmed following the publication of the Annual Reporting Manual by NHS Improvement.
- Some changes have been made to reporting arrangements including:
  - An annual strategic report on nurse staffing (in accordance with revised NQB guidance).
  - Quarterly reports from the Guardian on Safe Working (as required by the new Junior Doctors' contract).
  - Half yearly reports from the Freedom to Speak Up Guardian.

- Half yearly reports on NHS England Independent Investigations (following the introduction of reporting on these matters in July 2016).
- Information on mortality data, and progress on the work of the Mortality Review Group, being reported by way of the Quality and Assurance Committee reports on a six monthly basis.

Board Seminars

3.4 Annex 2 to this report sets out the proposed dates for Board seminars and includes the usual items considered by the Board on an annual basis.

3.5 Board Members are asked to note that

(a) The date of the Board seminar on human rights (as agreed under minute 16/123 – 24/5/16) will be set once the availability of a representative of the British Institute of Human Rights has been confirmed.

(b) Under minute 16/78 (2/6/16) the Quality Assurance Committee suggested that a seminar should be held to consider an independent investigation commissioned by NHS England. The Board is asked to consider, in view of the introduction of regular reporting to formal meetings, whether a separate Board seminar on this topic should be arranged.

3.6 The Board is asked to note that the final annual programme for Board seminars will be agreed by the Chairman and Chief Executive.

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 The report supports compliance with the Integrated Governance Framework.

7. RECOMMENDATIONS:

7.1 The Board is asked to approve its business cycle for the period October 2016 to December 2017 (as set out in Annexes 1 and 2 to this report) subject to:

(a) Consideration of the suggestion received from the Quality Assurance Committee (see paragraph 3.5(b) above).

(b) Amendments required in response to changes to NHS Improvement's planning timetable.

Phil Bellas, Trust Secretary

Background Papers:
Integrated Governance Framework (December 2015)

Tees, Esk and Wear Valleys NHS Foundation Trust

Schedule of Board Business (Oct 2016 - December 2017)

			2016			2017											
	Meeting Date	**Lead**	**25-Oct**	**29-Nov**	**20-Dec Special**	**31-Jan**	**28-Feb**	**28-Mar**	**25-Apr**	**23-May**	**04-Jul**	**20-Jul**	**22-Aug Special - urgent business only**	**26-Sep**	**31-Oct**	**28-Nov**	**19-Dec Special**
	Venue		**York**	**WP**	**WP**	**Durham**	**WP**	**WP**	**Scarborough**	**WP**	**Middlesbrough**	**WP**	**WP**	**WP**	**York**	**WP**	**WP**
1	**Standard Items**																
	Apologies for Absence		√	√	√	√	√	√	√	√	√	√		√	√	√	√
	Minutes		√	√		√	√	√	√	√	√	√		√	√	√	
	Board Action Logs (Public and Confidential)	PB	√	√		√	√	√	√	√	√	√		√	√	√	
	Declarations of Interest		√	√	√	√	√	√	√	√	√	√		√	√	√	√
	Chairman's Report	Chair	√	√	√	√	√	√	√	√	√	√		√	√	√	√
	Chief Executive's Report	CM	√	√	√	√	√	√	√	√	√	√		√	√	√	√
	Governor Issues	Board	√	√	√	√	√	√	√	√	√	√		√	√	√	√
	Reportable Issues Log	CM	√	√	√	√	√	√	√	√	√	√		√	√	√	√
2	**Quality**																
	Locality Briefings	DoOps		**NY**		**CD&D**		**Forensic**	**NY**		**Tees**				**Y&S**		
	Quality Assurance Committee Report	HG/EM	√	√	√		√	√	√	√	√	√		√	√	√	√
	"Hard Truths" Nurse Staffing Report	EM	√	√	*	6 monthly	√	√	√	√	Annual	√	*	√	√	√	*
	MHLC Report	RS/EM		√			√			√				√		√	
	Quality Strategy (to be determined)	EM															
	Progress reports on service support plans	SP						√						√			
	Progress report on the Composite Staff Action Plan	DL		√													
	Nurse recruitment, development and retention	DL		√													
	Report on implementation of phase 3 of the County Durham Rehabilitation Strategy	BK	√														
	Guardian for safe working report	NL							√			√			√		
	Summary report on NHS England Independent Investigations (Investigation Reports will also be reported as and when recevied from NHS England)	EM			√							√					√
	Staff Survey	DL					Results			Action Plan							
	Freedom to Speak Up Guardian Report	DL						√						√			
3	**Strategic**																
	Budget/Capital Programme	DK						√									
	Business/NHSI Plan	SP	√				√	√							√		
	IiP Re-accreditation	DL		√													
4	**Services Developments/Investments**																
	Tender submission approvals (as and when required)	SP/DK															
	Business Cases (as and when required)	DK															
5	**Performance**																
	Performance Dashboard (Reports poss. to be tabled in August and December)	SP	√	√	*	√	√	√	√	√	√	√	*	√	√	√	*
	Workforce Reports (inc six monthly updates from the E&D Steering Group & culture metrics)	DL	√			√			√			√			√		
	Finance Report	DK	√ (x2)	√	*	√ (x2)	√	√	√ (x2)	√	√	√ (x2)	*	√	√ (x2)	√	*
	Strategic Direction Performance Report	SP		√			√			√				√		√	
	Directors' Visits Annual Report	BK										√					
6	**Governance**																
	Register of Directors' Interests	PB												√			
	Board Business Cycle	PB												√			
	Annual Review of Board Committee's terms of reference	PB												√			
	NED Committee Membership Review	Chair												√			
	NHSI Governance Certificates	PB								√							
	Annual Accounts	DK								√							
	Annual Governance Statement	DK								√							
	Annual Report	PB								√							

Tees, Esk and Wear Valleys NHS Foundation Trust

Schedule of Board Business (Oct 2016 - December 2017)

			2016			2017											
	Meeting Date	**Lead**	**25-Oct**	**29-Nov**	**20-Dec Special**	**31-Jan**	**28-Feb**	**28-Mar**	**25-Apr**	**23-May**	**04-Jul**	**20-Jul**	**22-Aug Special - urgent business only**	**26-Sep**	**31-Oct**	**28-Nov**	**19-Dec Special**
	Quality Account/Report	SP								√							
	External Auditors' Report to those charged with Governance (ISA 260)	DK								√							
	External Auditors' Report on the Quality Report	DK								√							
	Charitable Funds Annual Report and Accounts	DK								√							
	Integrated Assurance Framework and Risk Register	PB	Summary	Summary	Full	Summary	Summary	Summary	Summary	Summary	Review	Full		Summary	Summary	Summary	Full
	Risk Assessment/Single Oversight Framework Report	PB	√			√			√			√			√		
	Information & IG Strategy Update Report	DK		√						√						√	
	Approval of IG Toolkit Submission	DK						√									
	Annual Report on Research and Development	NL		√												√	
	Annual Report of the Responsible Officer for Medical Revalidation	NL												√			
	Medical Education Annual Report	NL	√												√		
	Annual Claims Report	EM									√						
	Audit Committee Report	MH	√			√			√	Verbal					√		
	Investment Committee Report (additional reports dependent on provisional meetings)	JT/DK				√			√		√			√			
	Commercial Oversight Committee	Chair	√					√			√			√			
	Board Nomination and Remuneration Committee Report (as and when required)	Chair															
	Equality Act Data Publication	DL				√											
	Core standards on emergency preparedness, resilience and response	BK												√			
	Commissioning the "well led" Governance Review	CM		√													
	Integrated Governance Framework	PB			√												√
7	**For Information**																
	Register of Seals (as and when required)	CM	√	√		√	√	√	√	√	√	√		√	√	√	
	Policies agreed by EMT	CM	√	√		√	√	√	√	√	√	√		√	√	√	

(Note:* indicates report to be circulated under separate cover outside the meeting)

Draft Board Seminar Programme

Annex 2

October 2016 - December 2017

Month	Topic	Lead
4 & 5/10/2016	*Business Planning Event*	*CM/SP*
08/11/2016	Assurance	Chairman/CM
20/12/16 with BoD meeting	SDG Briefing Forensic	Dr. Khouja
	Recovery Phase 2 (inc. attendance by Experts by Experience)	Dr. Brabban
10/01/2017	*Business Planning Event*	*CM/SP*
14/03/2017	Implications of new Mental Health Payment Mechanisms (to be provided pending contract discussions & national consultation)	DK
	Quality Strategy	EM
11/04/2017	SDG Briefing - CAMHS	TBC
	Pathway Development	BK
09/05/2017	SDG Briefing - LD	Dr. Passmore
	Update on actions arising from the Mazars' report on Southern Health NHSFT	EM
11/07/2017	SDG Briefing - MHSOP	Dr. Tolusoga
	TBD	-
12/09/2017	SDG Briefing - AMH	TBC
	TBD	-
3 & 4/10/2017	*Business Planning Event*	*CM/SP*
14/11/2017	SDG Briefing - Forensic	Dr. Khouja
	TBD	-
19/12/2017	TBD	-
	TBD	-

Additional Topics to be scheduled:
Human Rights Act
Staff engagement

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th September 2016**
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:	**27th September 2016**
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 In accordance with the Constitution, Members of the Board of Directors are required to declare details of all directorships and other relevant and material interests relating to business interests, positions of authority in a charity or voluntary body in the field of health and social care and bodies contracting for NHS services.

2.3 The Register is formally reviewed, at least, on an annual basis.

3. KEY ISSUES:

3.1 The updated Register of Interests of Members of the Board of Directors of Tees, Esk and Wear Valleys NHS Foundation Trust is attached as Annex 1 to this report.

3.2 The Register is a public document which is published on the Trust's website and publicised in the Annual Report.

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with the NHS Act 2006 and the Constitution.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note the revised Register of Interests of the Board of Directors.

Phil Bellas, Trust Secretary

Background Papers:
The National Health Service Act2006 (as amended)
The Trust's Constitution (October 2015)

Tees, Esk and Wear Valleys NHS Foundation Trust

Register of Interests of Members of the Board of Directors

Date of last revision: September 2016

Note: 1 - The full description of each interest type is given in the Declaration of Personal Interests form
Note: 2 - (B) denotes that the Director is a voting member of the Board of Directors
Note: 3 - Details of interests must be entered as submitted on the Declaration form including 'NIL RETURNS'
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	Directorships or Position of Authority	Employment and Consultancy	Commercial Interests	Membership of public body, charity or pressure group whose work is related to the business of the Trust	Donations and Sponsorship	Other Interests
Lesley Bessant	Chairman **(B)**	No	**Yes** Husband undertakes consultancy work for Teesside University	No	No	No	No
Dr Hugh Griffiths	Non-Executive Director **(B)**	**Yes** Non-Executive Director North of England Mental Health Development Unit Wife is Director of Planning and Strategy at Mid-Yorkshire Hospitals NHS Trust	**Yes** Director of Hugh Griffiths Associate Ltd Associate contract with GE Finnamore Healthcare	No	**Yes** Fellow of the Royal College of Psychiatrists Member of the British Medical Association	No	No
Marcus Hawthorn	Senior Independent Director **(B)**	No	**Yes** Area Manager, Northern for the Royal British Legion	No	**Yes** Volunteer with the Great North Air Ambulance Service	No	No
David Jennings	Non-Executive Director **(B)**	**Yes** Financial Services Manager and Deputy Section 151 Officer (Chief Finance Officer) at Redcar and Cleveland Borough Council	**Yes** Financial Services Manager and Deputy Section 151 Officer (Chief Finance Officer) at Redcar and Cleveland Borough Council	No	No	No	**Yes** Pensioner Audit Commission Membership of Local Government Pension Scheme Independent Appointed Member: Northumbria University Audit Committee
Paul Murphy	Non-Executive Director **(B)**	**No**	**Yes** Ad hoc consultancy work for City of York Council, North Yorkshire County Council and East Riding Council	No	**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	**No**	**Yes** Daughter is Head of Office for the Office of the National Director, Operations and Information, NHS England
Shirley Richardson	Non-Executive Director **(B)**	**No**	**No**	**No**	**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	**No**	**No**
Richard Simpson	Non-Executive Director **(B)**	**Yes** Gateshead Health NHS Foundation Trust - Non-Executive Director (2006-2013)	**Yes** Northumbria University - Associate	No	No	No	No
Jim Tucker	Deputy Chairman **(B)**	No	No	No	No	No	No

Name	Position	Directorships or Position of Authority	Employment and Consultancy	Commercial Interests	Membership of public body, charity or pressure group whose work is related to the business of the Trust	Donations and Sponsorship	Other Interests
Colin Martin	Chief Executive **(B)**	**Yes** Director of North East Transformation System (NETS) Ltd	No	No	No	No	No
Brent Kilmurray	Chief Operating Officer **(B)**	**Yes** Vice-Chairman of Achieving Real Change in Communities (ARCC) CIC Ltd	**Yes** Wife employed as a Clinical Psychologist by Northumberland, Tyne and Wear NHS Foundation Trust.	No	No	No	No
Drew Kendall	Interim Director of Finance and Information **(B)**	No	No	No	**Yes** Member of HFMA mental health finance group	No	No
Nick Land	Medical Director **(B)**	**Yes** Member of the General Synod of the Church of England Director of Board of Finance for Diocese of York	No	No	**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	No	**Yes** Non-Executive for Areté multi-school academy
Elizabeth Moody	Director of Nursing and Governance **(B)**	No	No	No	No	No	No
David Levy	Director of Human Resources and Organisational Development	No	No	No	No	No	No
Sharon Pickering	Director of Planning, Performance and Communications	**Yes** Husband, Mark Pickering employed by Durham Dales Easington and Sedgefield CCG as Chief Finance Officer	No	No	No	No	No

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th September 2016**
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:	**27th September 2016**
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
266	13.7.16	Counterpart lease relating to parts of Stirling House, Tedder Avenue, Stockton.	Mr. D. Kendall, Interim Director of Finance & Information Mr. P. Bellas, Trust Secretary
267	4.8.16	Agreement relating to PFI negotiations at Roseberry Park.	Mr. C. Martin, Chief Executive Mr. D. Kendall, Interim Director of Finance & Information
268	17.8.16	Contract documents relating to minor internal alterations to the Chester-le-Street Health Centre, Newcastle Road, Chester-le-Street.	Mr. C. Martin, Chief Executive Mrs. E. Moody, Director of Nursing and Governance

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 (October 2015)

ITEM NO.19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27 September 2016**
TITLE:	**Policies and Procedures 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:

-

Recommendations:

The Board are asked to ratify the decisions made by EMT on 07 September 2016

DATE:	**27 September 2016**
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 Authorisation was requested to develop two new documents:

Allocation of Responsible Clinicians

A scoping document was presented requesting authority to develop a procedure for the allocation of responsible clinicians. It is a requirement of paragraph 36.3 of the MHA Code of Practice that hospital managers to have local protocols in place for allocating responsible clinicians to patients. The new procedure would therefore be compliant with requirements of MHA Code of Practice to address allocation, recording, cover and review arrangements as described in paragraph 36.3.

Communication with Service Users and Family/Carer

The Information Governance team has seen a significant increase in the number of queries from staff about best practice in communicating with service users and their families/carer. This includes email, letters and text messages. Authorisation was requested to develop this new procedure which would sit under the Confidentiality and Sharing Information Policy and specify safe practice in communication, covering topics including recording consent and risk mitigation. The new procedure will support the service user by communicating in ways that meet their needs and preference. It would have the added benefit of removing any misconception of information governance being a barrier to communication.

3.2 The following new document was presented for ratification:

CLIN-0087-v1 Transporting of Patients Procedure
Review date 07 September 2019

This procedure has been developed to establish safe working practices to assist with the management of urgent and routine patient transport.

3.3 The following underwent full review and required ratification:

CLIN-0014-v7 Rapid Tranquilisation Policy
Review date: 07 September 2019

Changes are summarised as follows:

- Rationalisation of three policy/procedure documents into a single document – this document incorporates and supersedes the following existing policies/procedures:
    - Rapid tranquilisation policy – CLIN-0014
    - Rapid tranquilisation prescribing procedures – CLIN-0014-01
    - Rapid tranquilisation remedial measures and post-administration monitoring – CLIN-0014-02
- In doing so, all of the above have been reviewed and updated in response to NICE Guideline 10 Violence and aggression: short-term management in mental health, health and community settings (May 2015) – the most significant changes being:
    - Changes to the prescribing algorithms to reflect the drugs (single or combination) recommended by NICE for this indication
    - Routine prescribing of drugs for RT on admission is no longer recommended, except on secure wards where a thorough pre-assessment has identified a likely need
    - Stronger links to other Trust guidance – “Positive approaches to supporting people whose behaviour is described as challenging” and “Procedure for using the early warning score for the early detection and management of the deteriorating patient

3.4 The following underwent minor amendment:

MHA-0012-001 v1.1 Deprivation of Liberty Safeguards (DoLS) Procedure
Review date: 10 September 2017

The above had minor amendment to contact names and telephone numbers.

MHA-0003-001-v1.1 Leave of absence under s17 MHA 1983 and time away from the hospital
Review date: 01 June 2019

This policy had a minor change to the document title to improve accessibility.

3.5 The following required an extension to the review date while they are currently under review:

PHARM/0034 Clozapine Community Initiation Guidance
Review date: 01 March 2017

PHARM/0050 Buccolam Carer Information Sheet
Review date: 05 December 2016

The Responsible Director for the following documents has requested that they are all extended to 31 October 2016 while they are under review:

CLIN-0033 Procedure for inpatient service users who require care in the local acute hospital trust
CLIN-0029 Management of substance misuse on Trust premises protocol
PHARM-0046 Dementia care pathway AChEI decision aid
PHARM-0065 Guidance on the use of atypical antipsychotics as an adjust to the treatment of anorexia nervosa in adults and young people
PHARM-0052 Anxiety disorders pathway medication algorithm
PHARM-0051 Summary of pharmacological treatments for BPSD
PHARM-0038 Guidelines for prescribing and administration of Olanzapine Depot Injection (Zypadhera®)
CLIN-0056 Visiting Policy (General)
CLIN-0008 Non-compliance with treatment policy
CLIN-0051 Care and management of dual diagnosis policy
CLIN-0007 Did not attend (DNA) policy
CLIN-0024 Joint Working Protocol People with Learning Disabilities and Mental Health Problems

3.6 The following are to be removed from the policy portfolio:

CLIN-0014-01 Rapid tranquilisation prescribing procedures

CLIN-0014-02 Rapid tranquilisation remedial measures and post-administration monitoring

These two procedures have been incorporated into the Rapid Tranquilisation Policy and are to be removed from the policy portfolio.

CLIN-0060 Continence Management Procedure

As a result of the introduction of the Royal Marsden Manual, some of the policies and procedures previously developed by the Trust IPC and Physical Healthcare Team have now been replaced with the Royal Marsden, hence the request to remove this procedure from the Trust policy portfolio.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meetings on 03 August 2016 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