AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 24TH NOVEMBER 2015 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 **27th October 2015.**		**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 receive and note the Annual Report on Research and Development.	**NL (Prof Joe Reilly to attend)**	**Attached**
Item 7	To consider the report of the Quality Assurance Committee.	**HG/JI**	**Attached**
Item 8	To consider the monthly Nurse Staffing Report.	**JI**	**Attached**
Item 9	To consider the report of the Mental Health Legislation Committee.	**RS/JI**	**Attached**
Item 10	To receive and note a progress report on the Francis 2 Action Plan.	**MB**	**Attached**
Item 11	To receive and note a progress report on the implementation of the Waiting Times Action Plan.	**BK**	**Attached**
Item 12	To receive and note a progress report on the Trust's composite Staff Action Plan.	**DL**	**Attached**

Strategic Items (10.55 am)

Item 13	To approve the Trust's submission to NHS England with regard to the Core Standards for Emergency Preparedness, Resilience and Response.	**BK**	**Attached**

Performance (11.00 am)

Item 14	To consider the Finance Report as at 31st October 2015.	**CM**	**Attached**
Item 15	To consider the Trust Performance Dashboard as at 31st October 2015.	**SP**	**Attached**
Item 16	To approve the Performance Dashboard indicators for 2016/17.	**SP**	**Attached**
Item 17	To consider the Strategic Direction Performance report as at Quarter 2, 2015/16.	**SP**	**Attached**

Refreshment Break

Locality Briefing (11.35 am)

Item 18	To receive a briefing on key issues in the North Yorkshire Locality.	**Adele Coulthard to attend**	**Presentation**

Items for Information (11.55 am)

Item 19	Policies and Procedures ratified by the Executive Management Team.	**MB**	**Attached**

Item 20 To note that a special meeting of the Board of Directors will be held in public on **Tuesday 15th December 2015** in the Board Room, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (12.00 noon)

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).

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."

Mrs. Lesley Bessant
Chairman
18th November 2015

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 27TH OCTOBER 2015 IN LAKE HOUSE, 20 MANOR COURT, SCARBOROUGH BUSINESS PARK, EASTFIELD, SCARBOROUGH AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. J. Tucker, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mrs. B. Matthews, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. B. Kilmurray, Chief Operating Officer
Dr. N. Land, Medical Director
Mr. C. Martin, Director of Finance and Deputy Chief Executive
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:
Mrs. J. Webster, Public Governor for Scarborough and Ryedale
Mr. N. Ayre, York Mind
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications

15/278 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. M. Barkley, Chief Executive.

15/279 MINUTES

Agreed *– that the public minutes of the meetings held on 14th and 29th September 2015 be approved as correct records and signed by the Chairman.*

15/280 PUBLIC BOARD ACTION LOG

Consideration was given to the Public Board Action Log noting the relevant reports provided to the meeting.

Arising from the report:

(1) Mr. Levy advised that, further to minute 15/131 (26/5/15) and as reported to the meeting of the Quality Assurance Committee held on 1st October 2015, it was not considered appropriate to introduce recruitment and retention premium payments at Springwood as the staffing position at the unit had improved and there were risks that incentives could be counterproductive e.g. problems might arise elsewhere due to staff moving to the unit.

It was noted that alternative approaches to staff recruitment and retention had been discussed at the Board Business Planning Event in October 2015 and these would be further considered.

(2) Mrs. Moody provided an update on the findings of the MHSOP falls audit and the actions being taken in response to the compliance issues identified (minute 15/251 - 29/9/15 refers).

The Board noted that:

(a) The audit had been based on a sample of five patient records in each MHSOP inpatient ward.
(b) Overall there were variations in the results of the audit between the Localities.
(c) In 60% of the sampled cases there had been no record of a falls assessment being completed; however, the County Durham and Darlington Locality had been rated “green”, and Tees and North Yorkshire Localities rated “red”, in this category.
(d) All the Localities had been “red” rated on the provision of information on falls prevention and on the full implementation of the falls pathway when incidents occurred.
(e) A Trustwide clinical audit action plan had been developed and was being taken forward to support full compliance with the falls pathway and a share and spread event had been held.

(3) Mrs. Moody advised that the report on the SUI on Cedar Ward (minute 15/252 - 29/9/15 refers) had not yet been presented to a Directors’ Panel; however, the investigator and the clinical team did not consider that staffing issues had contributed to the incident.

It was noted that, although there had been high use of temporary staffing (due to recruitment difficulties), there had also been environmental issues and changes to the patient mix on the ward, which had limited the time staff were able to spend with patients, at the time of the incident.

The Chairman noted that issues arising from the investigation would be further considered when the SUI report was presented to the Directors’ Panel.

Mr. Bellas undertook to make the required changes to the Action Log.

Action: Mr. Bellas

15/281 DECLARATIONS OF INTEREST

There were no declarations of interest.

15/282 CHAIRMAN’S REPORT

The Chairman reported on her activities since the last meeting as follows:

(1) Spent two days meeting staff and visiting inpatient facilities and community teams in York.

Mrs. Bessant advised that:

(a) The staff were very positive about the Trust and felt well supported.
(b) The estate in the Locality was very disappointing and this would be a key issue going forward. In particular:

- There were significant concerns about the ward environment and facilities for non-clinical staff at Bootham Park Hospital.
- Other units were not being used for the purpose for which they had been designed.

(2) Attended the Bands 1 to 4 Conference at the Riverside Stadium, Middlesbrough on 20th October 2015.

It was noted that the event was the first of its type to be held and it had been well attended.

Mr. Levy reported that general feedback from attendees, which had included a good mix of staff, was that they considered the event had been worthwhile and the presentations had been well received.

The Chairman asked for future conferences to be given a more appropriate title.

(3) Attended the Learning Disability Quality Conference "Colour my day" at the Xcel Centre, Newton Aycliffe on 20th October 2015.

Mrs. Bessant reported that the Conference had been well attended and enjoyable.

(4) Met with the housekeeping, portering and catering staff at West Park Hospital.

It was noted that the staff had been very positive about their roles and the meeting had been very interesting.

(5) Attended the meeting of Trust Chairmen for the Yorkshire and Humber Region on 23rd October 2015 at James Cook Hospital, Middlesbrough.

Mrs. Bessant advised that, at the meeting, South Tees Hospitals NHS Foundation Trust had provided interesting presentations on its:

(a) Transformation Programme.
(b) Therapeutic Volunteers Programme which aimed to provide reassurance to patients and help make their hospital stays more comfortable.

The Board noted that:

- The volunteers provided 24 hour coverage, 7 days a week.
- The programme had been very successful with approximately 370 volunteers recruited to date, including a number of students undertaking health related degrees at Teesside University, against an initial target of 100.
- It was intended that a number of the volunteers would be appointed to full time roles.
- The Trust hoped that, in future, up to 600 volunteers would be available.

The Chairman also highlighted that, with regard to national awards:

(1) Talking Changes and the County Durham and Darlington CAMHS Crisis and Liaison Team had won the Partnership Working and Innovation in Child, Adolescent and Young People's Mental Health categories, respectively, in the Breakthrough Positive Practice in Mental Health Awards 2015.

It was noted that there had been significant interest, nationally, in the work of the latter team.

(2) The Trust had been shortlisted in:
   (a) The Board Leadership and Staff Engagement categories of the Health Service Journal Awards.
   (b) Five categories of the Royal College of Psychiatrists Annual Awards.

15/283 GOVERNOR ISSUES

No issues were raised.

15/284 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 3rd September 2015 (Appendix 1 to the report).
(2) The key issues discussed by the Committee at its meeting held on 1st October 2015.

Mr. Simpson, who chaired the meeting on 1st October 2015, advised that, in addition to the matters included in the report, there had been an interesting debate on the nature of assurance and further discussions on this matter would be taken forward within various groups in the Trust.

Arising from the report:

(1) Mr. Levy reported that the collective grievance by staff at Roseberry Park concerning rest breaks had been resolved.
(2) In response to a question on whether there had been an increase in demand for the Trust's services following the closure of the SSI steelworks in Redcar it was noted that:
   (a) Dr. Lenny Cornwall (Deputy Medical Director for Teesside) had advised that there had been an increase in demand when the plant had been previously mothballed and this had not subsequently subsided.
   (b) It was understood that the impact of the closure was likely to result in an increase in demand in the longer term.
   (c) The Trust had become a member of a taskforce which had been established to help people affected by the closure.
   (d) The Trust had also participated in a job fair in Teesside and would continue to support these events.

15/285 NURSE STAFFING REPORT

The Board received and noted the report on nurse staffing for September 2015 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 reported that:

(1) There had been an improvement on all indicators and a reduction in the number of "red" rated wards on the previous month.

(2) Oak Ward had the lowest fill rate (48.6% of registered nurses for daytime shifts) during September 2015. This was due to four members of staff being absent as a result of long-term sickness and maternity leave.

(3) The highest fill rate was on Westerdale South Ward.

It was noted that the fill rate for this ward was above the budgeted establishment; however, an overspend had been agreed by the Executive Management Team (EMT) due to the complexity of the present patient group.

(4) Agency use had increased during September 2015; however, this accounted for only 0.5% of total hours worked.

(5) The information on the triangulation of staffing data against a range of quality metrics was provided in Appendix 6 to the report.

Mrs. Moody drew attention to the positions of Cedar Ward, Westerdale South Ward and the Westwood Centre.

(6) A joint letter, dated 13th October 2015, had been received from the Chief Nursing Officer, NHS Improvement and NHS England which:

(a) Detailed progress on the development of a template for a model hospital led by Lord Carter.

It was noted that this included:

- The development of a way to use data on nursing and care hours per patient so that staffing arrangements remained safe across a range of different times and situations.
- Lord Carter's team working closely with front-line staff to put in place a more sophisticated approach to the measurement of nursing time and its connections with outcomes, costs and other critical measures.

In response to questions it was noted that Mrs. Moody was considering how data on contact times could be included in the six monthly Board reports and the use of the tools would be explored as part of the safer staffing review.

(b) Confirmed that the development of further safe staffing guidance would be provided in due course.

(c) Re-affirmed that safe staffing guidance should support, but not replace, the application of professional judgement.

Mrs. Moody also drew attention to the mandatory use of approved frameworks for procuring nursing agency staff that came into effect on 19th October 2015 and the plans to introduce a rate cap for all agency staff, including medical and other agency staff, later in the year.

Mrs. Moody advised that, overall, it was difficult to draw meaningful trends from the data provided in the report; however, no risks to patient safety or patient experience had been identified.

The Board's discussions focussed on the potential impact of the rate cap for agency staff.

In response to questions on this matter the Board noted that:

(1) The effect of the rate cap on recruitment would depend on the level at which it was set.

(2) The key concern was that, at present, there were insufficient medical and nursing staff.

(3) There were significant concerns about the impact of the rate cap on the availability of medical staff.

Dr. Land advised that doctors were a very mobile group and junior doctors, in particular, valued their work/life balance. This had led to emigration (details of which he provided to the meeting) which was likely to increase if the rate cap was set too low.

However, he considered that the Trust had been successful in recruiting and retaining medial staff by, in the case of consultants, developing employment packages to attract long-term locums into substantive positions, and in attracting junior doctors even though vacancies remained. This suggested that the Trust might be able to mitigate some of the risks arising from the rate cap.

(4) Risks to the availability of nursing staff were not as significant as they tended to be less interested in joining agencies even though they offered higher pay rates. The key issue for this staff group was the availability of flexible working.

(5) The Migration Advisory Committee was due to publish its recommendations with regard to the appropriateness of responding to any shortage of nurses or specific nursing job titles through changes to the criteria for non-EEA migration.

Mr. Levy observed that it would be interesting to see if the Committee heeded the representations made by the NHS on this matter.

The Board also:

(1) Noted, in response to a question, that the challenging group of patients at the Westwood Centre had contributed to its position against the quality metrics.

Mrs. Moody undertook to provide an update on this matter to the next Board meeting to be held on 24th November 2015.

Action: Mrs. Moody

(2) Discussed the extent that staffing levels could provide assurance on patient care.

The Non-Executive Directors raised concerns that seeking to establish a correlation between the two issues might become overly bureaucratic and complex.

In response to questions on this matter Mrs. Moody advised that:

(a) Staffing numbers, reported in the absence of evidence based guidance on staffing levels, skill mix and competencies, could only provide limited assurance.
(b) Nationally a couple of evidence based tools had been developed; however, as stated in the letter dated 13th October 2015 (see above), safe staffing levels would ultimately remain a matter of professional judgement.
(c) Face to face contact and direct care time was more meaningful to patients and likely to provide greater assurance.
(d) At a service level, safe staffing information was useful in supporting local decision making.
(e) From an external assurance perspective, no issues had been raised about staffing levels during MHA visits.
(f) The Lord Carter review recognised the importance of multi-disciplinary teams and skill mix in the provision of care and it was anticipated that safe staffing reporting would change in the light of this.

15/286 PROGRESS REPORTS ON CLINICAL SUPERVISION AND CLINICAL RISK AND HARM MINIMISATION

The Board received and noted progress reports on the following matters which, in accordance with minute 15/202 (27/7/15), were being taken forward as Trustwide workstreams following the closure of the fifth Malcolm Rae Action Plan:

(1) **The implementation of Clinical Supervision**.

The Board noted that:

(a) The Trust's present policy had been approved in 2012; however, its intention to ensure all employees had managerial supervision and then, in addition, clinical supervision delivered by a clinical expert of their choice, was not being consistently achieved.
(b) There was also evidence from audits and incident and complaint reviews that ensuring clinical staff were delivering effective and best practice compliant casework was not always a core element of the line management function, particularly where the practitioner might have a separate clinical supervisor.
(c) In response to these issues the Trust's policy position had been amended to include, amongst other matters, requirements for clinical management supervision with minimum competencies for supervisors and standard recording requirements.
(d) A Trustwide implementation plan had been developed, which would be led by the Heads of Nursing in each Locality and supported by a programme of audits, for delivery during 2016/17.

In response to questions Mrs. Moody provided clarity that:

(a) The 8 hours of clinical supervision per year was the minimum proposed; however, it was hoped that more time would be made available for this.

(b) Management supervision related to issues such as record keeping, time management and individual performance whilst clinical supervision focused on the management of specific clinical issues and reflection on patient care.

(c) The policy position reflected variations in line management arrangements. Overall, it was intended that all employees delivering clinical practice should receive 12 hours of supervision per year. Where an employee's line manager was a practising clinician, sessions for management and clinical supervision would be combined. In other cases the employee would receive 8 hours clinical supervision from a senior clinician and 4 hours management supervision from their line manager.

(d) Any senior clinician providing clinical supervision would need to be a competent practitioner approved by the employee's line manager.

In addition:

(a) Mr. Levy advised that discussions would need to be held, and clarity provided, on the implications of the revised appraisal scheme for the delivery of management supervision.

(b) Dr. Land highlighted that, although the report stated that the revised supervision arrangements related to all employees, the position for medical staff was slightly different.

He assured the Board that all medical staff received at least 12 hours supervision per year and many, particularly junior doctors, received more. However, it was not practicable for consultants to receive all their supervision from their clinical director and peer arrangements had been developed for the provision of their clinical supervision.

(2) **The Clinical Risk and Harm Minimisation Project**.

In introducing the report Mrs. Moody:

(a) Advised that the PM1 (scoping) document for the project had been approved by the EMT on 18th August 2015.

(b) Drew attention to the aims of the project listed in section 3 of the report.

(c) Reported that an expert by experience had been identified to support the project and they were due to attend the next meeting of the steering group.

(d) Advised that the PM3 (business case) was due to be considered by the EMT in November 2015.

In response to a question on when changes arising from the project would be evident:

(a) It was noted that the project was due to be delivered by the end of 2016/17; however, some changes were already being seen as services were reviewing their local approaches to risk assessment.

(b) Mrs. Moody advised that the cultural changes required to embed the principles of positive risk management, one of the aims of the project, would take time.
(c) Mrs. Pickering highlighted that, as a priority in the Quality Account for 2015/16, work was being undertaken on the implementation of age appropriate risk assessments and care plans in C&YPS.

Agreed – *that ongoing work with regard to the policy and implementation plan for clinical supervision and the development of the clinical risk and harm minimisation project be supported.*

15/287 OUT OF LOCALITY ADMISSIONS ACTION PLAN

Further to minute 15/168 (23/6/15) the Board received and noted a progress report on the Out of Locality Admissions Action Plan.

In introducing the report Mr. Kilmurray advised that:
(1) A training programme for crisis teams had been developed and this would be rolled out, following evaluation, in January 2016.
(2) Work was being undertaken by services and with GPs in response to the findings of an audit of admissions in Richmondshire. Dual diagnosis had been identified as an issue and the Trust would be seeking to re-establish links with the provider of substance misuse services in the Locality.
(3) As a complex issue, the extent the action plan had addressed out of locality admissions was uncertain; however, it was considered that the work undertaken had contributed to the improvement in performance.

He considered that, as all actions had been completed, the action plan should be closed; however, he assured the Board that levels of out of locality admissions would continue to be monitored through the Trust's performance management arrangements.

Mrs. Pickering added that the EMT regularly monitored out of locality admissions and actions were put in place in response to any "hot spots" identified.

The focus of discussions was on the impact of out of locality admissions from York and Selby following the closure of Bootham Park Hospital by the Care Quality Commission.

On this matter it was noted that:
(1) There had been admissions from York and Selby into inpatient services in the Trust's other Localities with the largest cohort of these patients being admitted to Roseberry Park; however, the Trust was seeking to maintain trigger levels so that beds remained available to local people.
(2) In general, patients from York and Selby had been transferred into AMH inpatient services. MHSOP in the Locality had been able to manage within the existing bed base.
(3) Information on patients transferred into the Trust's services was available from the PARIS system.
(4) Patients transferred to inpatient services in the Trust's other Localities had been predominately from York and Selby. Patients previously accommodated at Bootham Park Hospital from Leeds had been returned to Leeds and York Partnership NHS Foundation Trust.

(5) Information on out of locality admissions by CCG area, including from the Vale of York, was provided in data tables circulated separately to the report.

In addition it was noted that:

(1) The reasons for the spike in the number of out of locality admissions in August 2015 (17.5%) was unknown.

(2) The statistical modelling on the impact of variables influencing the probability of inpatient admissions, being undertaken by Dr. Paul Tiffin at Durham University, (minute 14/316 – 28/10/14 refers) was coming to a conclusion and the Board would be updated on its findings in due course.

(3) The RAG ratings in the data tables for September 2015 had been applied incorrectly.

Agreed – *that the Out of Locality Admissions Action Plan be closed.*

Action: Mr. Kilmurray

15/288 CONSULTATION ON THE DEPRIVATION OF LIBERTY SAFEGUARDS

Consideration was given to the Trust's response to the consultation being undertaken by the Law Commission in relation to the Deprivation of Liberty Safeguards (DoLS).

Mrs. Moody reported that:

(1) The DoLS had been subject to considerable criticism since their introduction. In particular:
   (a) In 2014 the House of Lords post-legislative scrutiny committee on the Mental Capacity Act had published a report which, amongst other matters, concluded that the Act was "not fit for purpose".
   (b) The Supreme Court judgment (Cheshire West) had widened the definition of deprivation of liberty with significant practical implications for the Trust.

(2) The Law Commission had published a consultation document which set out broad proposals for the review of the DoLS; however, details of how these proposals would work in practice had not been provided.

(3) It was proposed to replace the DoLS with a "Protective Care Scheme" (PCS), as described in a flowchart attached as Appendix 1 to the above report, which had three main elements as follows:
   (a) Supportive Care which would apply to people who lacked capacity to consent to their accommodation and who were living in care homes, supported living and shared lives accommodation but not hospitals.
   (b) Restrictive Care and Treatment which would apply to people who lacked capacity to consent to their care and treatment, which might or might not amount to deprivation of liberty, and who were living in care homes, supported living and shared lives accommodation but not hospitals.
   (c) A Hospital Scheme to authorise deprivations of liberty in NHS, independent and private hospitals, for the provision of care and treatment for physical disorders, and in hospices.

(4) The PCS would not apply to mental health hospitals and, instead, it was proposed to amend the Mental Health Act (MHA) to introduce a Mental Health Scheme which would allow for the admission of incapacitated compliant patients; however, it would not provide powers for treatment. The Scheme included safeguards, similar to those available under the MHA, but there would be no automatic eligibility to Section 117 aftercare.

(5) The proposed response to the consultation document was set out in Appendix 2 to the report. This reflected comments received to the proposals, as requested by the Law Commission, rather than a single coherent response on behalf of the Trust.

(6) The proposed response had been considered at the meeting of the Mental Health Legislation Committee held on 26th October 2015. Discussions had focussed on the views expressed on Chapter 10 of the consultation document ("The Mental Health Act Interface") as summarised below:
   (a) The Mental Health Scheme would have limited application in large mental health and learning disability providers.
   (b) Safeguards for the people admitted under the MHA were already provided in the Act.
   (c) From the Trust's perspective the removal of Section 117 aftercare would remove issues with regard to agreeing placements and associated funding which could lead to significant delays in discharge from hospital.
   (d) It would be preferable, instead of the Mental Health Scheme, that any person requiring admission to hospital for a mental disorder, in the absence of their capable consent, should be admitted subject to the MHA (in its current form). This approach would remove ambiguity on which scheme should be applied and ensure the application of all safeguards available under the Act.
   (e) Alternatively the restrictive care and treatment regime (the replacement for DoLS) should be used for non-objecting non-capacitous admissions to mental health hospitals as this would provide a clearer legal framework for these patients and would not have the stigma associated with the MHA.

(7) The Committee had supported the proposed response subject to minor amendments.

Dr. Land advised that:

(1) The proposals included in the consultation document were very complicated and the Trust's response reflected strongly held views from across the organisation.
(2) The proposed Mental Health Scheme would have very limited application within the Trust as it was unlikely that patients would meet its criteria.
(3) There would be benefits if the Hospital Scheme (for acute providers) was made available to the Trust, for example for certain MHSOP patients, as this would provide lighter regulation and only require the application of the MHA if they objected to treatment.
(4) The proposal not to apply Section 117 to the Mental Health Scheme would have benefits for the Trust but would have a negative impact on both families and local authorities due to funding implications.

Board Members:

(1) Raised concerns about the consultation process, due to the lack of detail.
(2) Sought clarity on:
   (a) The arrangements for any changes to the MHA as a result of the consultation.
   (b) The potential impacts of the proposals on local authorities.

In response it was noted that:

(1) It was estimated that changes to legislation could not be made until 2020 at the earliest.

(2) Further consultation was likely to be required on formal recommendations arising from the present consultation.
(3) The proposals would place significant financial burdens on local authorities and it was expected that they would raise the issue in their responses to the consultation document.

Agreed – *that the Trust's response to the consultation on the Deprivation of Liberty Safeguards (as set out in Appendix 2 to the above report), as amended to take into account the views of the Mental Health Legislation Committee, be approved and be submitted to the Law Commission by 2nd December 2015.*

Action: Mrs. Moody

15/289 SUMMARY FINANCE REPORT AS AT 30TH SEPTEMBER 2015

Consideration was given to the summary Finance Report as at 30th September 2015 including the declarations on the Financial Sustainability Risk Rating and Capital Expenditure for Quarter 2, 2015/16 as required under Monitor's Risk Assessment Framework.

Mr. Martin drew attention to:
(1) An error in section 3.66 of the report in that a decrease of £3,956k in the operating surplus would be required to reduce the I&E margin component of the Financial Sustainability Risk Rating to 3. A decrease in the sum of £5,386k, as stated in the report, would reduce the I&E margin component to 2.
(2) The Trust's overall financial performance which was ahead of plan.
(3) The adjustments to the Trust's CRES plans which had resulted in a number of schemes being deferred until 2016/17.

In response to questions on this matter:
(a) Mr. Martin advised that he was confident that most of the schemes would be delivered; however, certain ones, which related to rationalising the bed base, might take longer either as a result of a need to undertake consultation or due to pressure in the system.
(b) Dr. Land considered that, in addition, the need to address the dichotomy between localism and specialism, as previously discussed by the Board, might impact on the delivery of certain CRES schemes.

Agreed –
(1) that the report be received and noted; and
(2) that the following declarations for Quarter 2, 2015/16, be signed off and submitted to Monitor:
(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. Martin

(See also minute 15/292 below).

15/290 PERFORMANCE DASHBOARD AS AT 30TH SEPTEMBER 2015

The Board received and noted the Performance Dashboard Report as at 30th September 2015.

Mrs. Pickering reported that KPI 17 (number of unexpected deaths) was showing as a reported value of 0 as the IIC had been unable to action late changes in the data within the required timescale. However, actual performance on this indicator was a rate of 0.74 per 10,000 caseload (which equated to 4 unexpected deaths). This was below target and an improving position.

The Non-Executive Directors highlighted the overall position provided by the report, including the downward trends on the majority of the indicators, and sought clarity on the reasons for this.

In response Mrs. Pickering advised that:

(1) There were a variety of reasons for the downward trends, for example those for three of the four indicators for IAPT services (metrics 4 to 7) were influenced by the present transitional arrangements for the service in Teesside.
(2) The positions on readmissions, indicators 13 and 14, had been reviewed. No "hot spots" had been identified and services had not raised concerns.
(3) A number of the indicators were volatile and could be affected by a small number of cases.
(4) As shown in the detailed graphs, there had only been a slight change in the trends for a number of indicators (e.g. KPI 13) over the last 3 years.

The Chairman considered that the position shown in the report could be related to pressure in the system and, although significant work had been undertaken to address performance on a number of indicators (for example waiting times) there were risks that this was unsustainable.

Board Members also raised concerns that the resources expended on improving performance on waiting times could impact elsewhere (e.g. on access to treatment), and considered that capacity modelling across pathways should be considered.

With regard to this matter, in response to a question from the Chairman on whether the work of the KPO team was being focussed in the right areas, it was noted that the key priority of the team was to support the productivity agenda.

15/291 QUARTERLY WORKFORCE REPORT

The Board received and noted the Workforce Report including:

(1) Key workforce information for the period July to September 2015 (Appendix 1 to the report).
(2) Information about medical staffing issues (Appendix 2 to the report).
(3) A copy of the Staff Friends and Family Test (FFT) results for Quarter 2, 2015/16 (Appendix 3 to the report).

Mr. Levy highlighted that:

(1) The data presented a mixed picture.

(2) Work was being undertaken (as referenced in the report) to address long standing issues, for example the centralised recruitment team had now been established; however, in certain cases more radical approaches might be required if significant improvements in performance were to be made.

The Non-Executive Directors raised the following issues:

(1) How the 100 teams which did not receive team FFT results, due to their small size, could be supported in making improvements.

In response it was noted that:

(a) The FFT was a confidential survey and staff were not obliged to respond to it.
(b) The survey organisers, the Picker Institute, required at least 5 responses to report at team level.
(c) No process had yet been developed for providing feedback to those services where less than 5 responses were received to the survey and this was recognised as a barrier to responding to the issues raised.
(d) The focus, to date, had been on teams with over 200 staff as these comprised the majority of the Trust's workforce.
(e) In overall terms there were approximately 700 staff who were dissatisfied with the Trust.

The Chairman considered that this was a sizable number and presented a concern for the Trust.

(2) Whether the staff FFT results were triangulated with clinical data.

Mr. Levy advised that there was now sufficient data from the staff FFT surveys to consider how it should be used in conjunction with clinical data.

(3) Whilst recognising that the number of grievances was relatively low, about a quarter of them related to bullying and harassment but no information was provided on the number of these which were upheld.

Mr. Levy advised that:

(a) Data on the outcome of grievance cases involving allegations of bullying and harassment had been previously reported to the Board.
(b) Only a minority of these cases were upheld.

(4) The timescale for the incorporation of information on services in York and Selby in the Workforce reports.

It was noted that:

(a) Information on staff in the York and Selby Locality was due to be uploaded onto the ESR system on 1st November 2015.
(b) It was intended to:
- Include data on York and Selby in workforce reporting as soon as practicable.
- Provide initial information in the Board Workforce Reports from Quarter 3, 2015/16 and build on this over time.

- Keep the information on York and Selby separate from the data on the other Localities until the end of 2015/16 and provide a single report thereafter.

(c) The Trust had received basic information on staff in the York and Selby Locality from Leeds and York Partnership NHS Foundation Trust but the quality of the data needed to be confirmed.

(5) The effectiveness of the Trust's talent management processes as all appointments to posts graded band 6 and above during the Quarter had been filled by external candidates.

Mr. Levy responded that:

(a) The position reflected the amount of recruitment undertaken over the last 2-3 years which had exhausted the supply of internal candidates.

(b) The key issue was the time it would take for staff presently on band 5 to have the experience, confidence and ambition to seek promotion.

15/292 MONITOR RISK ASSESSMENT FRAMEWORK REPORT

Further to minutes 15/289 and 15/290 above, consideration was given to the Monitor Risk Assessment Framework Report for Quarter 2, 2015/16.

Agreed *–*

(1) that the Quarter 2, 2015/16 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 Monitor (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 exception report set out in Annex 2 to the above report; and

(2) that the Quarter 2, 2015/16 Risk Assessment Framework return be submitted to Monitor by 31st October 2015.

Action: Mr. Martin and Mr. Bellas

15/293 GOVERNANCE ACTION PLANS

Further to minute 15/209 (27/7/15) the Board received and noted the progress report on the Governance action plans (Annex 1 to the covering report).

In response to a question it was noted that, in accordance with the Risk Assessment Framework, the Trust was due to undertake a further external governance review by the end of Quarter 4, 2016/17.

Taking this into account, the Chairman questioned whether there was any further value to be derived from the action plan and considered that its closure should be discussed when the next progress report was presented to the Board.

Action: Mr. Barkley

Agreed *– that a copy of the above report and action plans be provided to Monitor.*

Action: Mr. Barkley

15/294 INFORMATION STRATEGY AND GOVERNANCE ASSURANCE REPORT

The Board received and noted the Information Strategy and Governance Assurance Report for Quarter 2, 2015/16.

Mr. Martin:
(1) Apologised that Appendix D (the domain roadmaps) had been omitted from the report.
(2) Drew attention to the changes made to the report in response to previous discussions.

In response to questions from Non-Executive Directors he advised that:
(1) Some, but not all, of the information disclosed in error represented personal sensitive information and that the Trust usually became aware of these incidents through complaints.
(2) The Trust was only at the stage of beginning to understand what real time clinical decision support systems could deliver.
(3) The Trust was able to respond to requests for laptops from services (an issue raised during a recent Directors' Visit); however, some of its stock was being held back for use, if required, in York and Selby.
(4) A few Microsoft "Surface" tablets were in use in the Trust; however, these devices were relatively expensive.

15/295 USE OF THE TRUST SEAL

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

15/296 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting of the Board of Directors would be held, in public, at 9.30 am on Tuesday 24th November 2015 in the Board Room, West Park Hospital, Darlington.

15/297 CONFIDENTIAL MOTION

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 1.00 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: 24th November 2015

Title: Board Action Log

Lead: Phil Bellas, Trust Secretary

Report for: Information/Assurance

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of our communities	
To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services		Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					✓

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes		**No** (Details must be provided in Section 4 "risks")		**Not relevant**	✓

Board of Directors Action Log

RAG Ratings:

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

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/07/2014	14/233	Further Board discussions to be held on the key factors influencing trends on unexpected deaths	MB	Mar-16	See also minute 15/C/267 - 29/9/15
30/09/2014	14/284	A briefing to be provided to a Board Seminar on Equality and Diversity	MB/DL	Dec-15	
24/03/2015	15/68	Provision of a report on the updated culture metrics	DL	~~24/11/2015~~ 15/12/2015	
26/05/2015	15/132	A progress report on the implementation of the waiting times action plans (including data on performance by team over time) to be presented to the Board	BK	Nov-15	See agenda item 11
26/05/2015	15/133	Future reporting of data on additional hours worked by staff to differentiate between full and part-time staff	DL	Nov-15	See agenda item 12
26/05/2015	15/133	Consideration to be given to providing greater flexibility within the Trust's 12 hour shift system as part of the Working Longer Review	DL	Mar-16	
26/05/2015	15/133	Progress report on the implementation of the Trust Composite Staff Action Plan to be presented to the Board	DL	Nov-15	See agenda item 12
23/06/2015	15/170	Information on the three wishes raised by teams to be included in future reports on Directors' visits	BK	Jun-16	
29/09/2015	15/251	The potential use of premia as a recruitment incentive, as suggested by HMP Northumberland, to be discussed with Mr. Buckley (Director of Operations)	DL	Nov-15	

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/09/2015	15/252	An analysis of the number of incidents of control and restraint compared to temporary staff usage to be provided in the next six monthly nurse staffing report	EM	26/01/2016	
27/10/2015	15/284	An update on the staffing/quality metric position at the Westwood Centre to be provided in the Nurse Staffing Report	EM	24/11/2015	Verbal update to be provided under agenda item 8
27/10/2015	15/287	Approval of the closure of the Out of Locality Admissions Action Plan	BK	-	Approved
27/10/2015	15/288	The Trust's response to the consultation on the Deprivation of Liberty Safeguards to be submitted to the Law Commission	EM	02/12/2015	Completed
27/10/2015	15/292	The Trust's Quarter 2, 2015/16 Risk Assessment Framework return to be submitted to Monitor	CM/PB	30/10/2015	Completed
27/10/2015	15/293	The Board to discuss the closure of the Governance Action Plans	MB	26/01/2016	
27/10/2015	15/293	The report on the Governance Action Plans to be provided to Monitor	MB	-	Completed

ITEM 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **24 November 15**

Title: **Research and Development Annual Report and Strategy**

Lead Director: **Joe Reilly**

Report for: **Information**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users	✓	Consent to care and treatment	✓		
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **24 November 2015**

Title: **Research and Development Annual Report and Strategy**

1. INTRODUCTION & PURPOSE

- To report on Research and Development activity for the period Apr 2014 to Mar 2015 (Appendix 1a)
- To put forward the Trust's R&D Strategy 2015-2020 for approval (Appendix 2)
- To give an update on key progress areas during the course of 2015/16

2. BACKGROUND INFORMATION

The Trust is committed to active involvement in research and development across all its localities and services. The NHS research environment is rapidly changing and an active approach is needed to ensure we maintain and further expand our research activity to the benefit of service users and carers.

3. KEY ISSUES:

3.1. Annual Report 2015

The Report details The Trust's activity and progress in this field, including the wide range of NIHR portfolio studies conducted and the increased external funding obtained to support this.

It is noted that NIHR portfolio recruitment was substantially reduced in the 2014/15, with a shift in our activity away from larger multicentre studies to smaller more intensive clinical trials.

The Durham University Mental Health Research Group Annual Report for 2014 is appended (Appendix 1b), provided by Dr Helen Stain, Clinical Senior Lecturer and Head of Group. The Report outlines the Group's continuing achievements in publication, user involvement and the delivery of clinical trials in primary mental health in particular.

3.2 R&D Strategy 2015-2020

The R&D Strategy (Appendix 2) was approved by the Executive Management Team on 26 August 2015. The opportunities and challenges for the Trust moving forward to the next stage of its development is outlined in the document. Critical points are planning for the impact of reduced NIHR portfolio study recruitment numbers on the Trust's income from the NIHR Clinical Research Network, and hence a strong focus on achieving a more balanced profile of external funding from externally funded grants led by our own Trust Chief Investigators, including both substantive clinicians and honorary clinical academics within university partnerships. The strategic goals are as follows:

- Maintain excellent performance in the governance, management and delivery of research
- Move from collaboration to leadership in research
- Ensure that our research drives improvement in care
- Embed research access and participation
- Substantial growth in research-related income

An implementation plan has been prepared for consideration by the Executive Management Team on 18 November 2015, addressing the three priorities of public and patient involvement, the development of the Trust's R&D workforce, and academic leadership of externally funded research programmes.

The further sustainability and development of the Trust's academic collaborations is crucial to success in the large scale research grants from NIHR and other funders which we aim to achieve. The Trust has agreed the 2016-17 Business Plan Priority 4.5 as to 'Evaluate and agree future collaboration with Durham and York Universities on research' by Q2 16/17. This process has begun with discussions with both universities, including the future development of clinical academic posts within the Trust.

3.3 Developments in York and Selby

In October 2015 the Trust began its provision of services to the York and Selby locality. This has three implications for research. Firstly, this is an opportunity to promote and embed research activity in a new locality with benefits for service users, carers and staff. Secondly, a number of University of York clinical academics provide clinical services within the locality, so their honorary clinical status passes over to the Trust. Hence the transfer of services in itself leads to academic collaboration with the University of York in addition to Durham University. Thirdly, there are important opportunities for the further development of this collaboration; The University's School of Health Sciences has a large Mental Health and Addiction Group focused on clinical and health services research led by Professor Simon Gilbody. The Group has a strong portfolio of primary care mental health research in collaboration with Dr David Ekers, Clinical Senior Lecturer with our Durham University Mental Health Research Group. The Trust is already collaborating with Professor Gilbody on a major clinical trial of enhanced smoking cessation intervention in severe mental illness (the SCIMITAR PLUS Trial).

3.4 NIHR Clinical Research Network

Recruitment to NIHR portfolio studies has continued to be lower than in the past over the course of 2015/16 with a likely projected total of 300 participants for the full year. We continue to recruit to important clinical trials with implications for practice. The shift from national specialty based networks to regional networks in April 2014 was a major transition, and one consequence appears to be that fewer large scale national studies with large numbers of participants are being run outside their lead networks. The implication for the Trust is a lower level of funding from the Clinical Research Network than in previous years,

as this is calculated on recruitment numbers. Implementation of the R&D Strategy will address how our R&D workforce needs to develop to sustain our research delivery on reduced network funding, whilst supporting and developing the clinical academic staff who can win large scale research grants which we lead ourselves.

3.5 Governance

A revised Research Governance Policy was reviewed and approved by the Executive Management Team in August 2015 (Appendix 2). The NHS research environment is changing, with gradual implementation of more centralised arrangements via the Health Research Authority which aim to streamline approval processes to improve the efficiency of research delivery. Hence we anticipate that our governance processes will need further update in 2016 to reflect these changes.

4. IMPLICATIONS / RISKS:

4.1 Quality:

Research conducted in the Trust remains compliant with the NHS Research Governance Framework and meets required quality and governance standards.

4.2 Financial:

The Annual Report details the wide range of external funding sources for the Trust's R&D activity. The outlook going forward as described above is of reduced funding from research networks, but with strong focus on achieving external research grants which offset this:

4.3 Legal and Constitutional:

The Trust's responsibility for the monitoring and standards of research activity involving its service users, carers and staff are laid down in the Research Governance Framework. The R&D office processes are designed to ensure compliance by all involved via the Trust's Standard Operating Procedures for research.

4.4 Equality and Diversity:

The Trust's R&D Strategy explicitly seeks to ensure that wherever possible there is equity of access to research for service users and carers across the Trust's specialties and geographies.

4.5 Other Risks:

None.

5. CONCLUSIONS

The Trust has embedded research in its core business, with widespread engagement across its services and localities. Implementation of the R&D Strategy will ensure that research activity is sustained into a more challenging funding context for NHS research, with the opportunity for growth via university partnerships based on common interests and priorities.

6. RECOMMENDATIONS

The Board is asked to receive the 2014 Annual Report (Appendix 1a and 1b) and approve the Trust R&D Strategy 2015-2020 (Appendix 2)

Prof Joe Reilly
Clinical Director of Research and Development

Background Papers:
Research and Development Annual Report 2014 (Appendix 1a)
Durham University Mental Health Research Group 2014 (Appendix 1b)
Research and Development Strategy 2015-2020 (Appendix 2)

Item 6 Appendix 1a

BOARD OF DIRECTORS

Date of Meeting: **24/11/15**

Title: **Research and Development annual report 14/15**

Lead Director: **Joe Reilly**

Report for: **Information**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users	✓	Consent to care and treatment	✓		
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **24/11/15**

Title: **Research and Development annual report**

1. INTRODUCTION & PURPOSE

To report on Research and Development activity for the period Apr 2014 to Mar 2015

2. BACKGROUND INFORMATION

We are committed to supporting and promoting research across all our services and localities. The more research-active we are as a Trust, the better care we will provide. Our involvement in large-scale clinical trials gives service users and carers access to treatments at the forefront of knowledge. In our work with the National Institute of Health Research (NIHR) and our collaboration with national and international academic partners, we contribute to the worldwide evidence base for mental health care. We seek to create a culture of enquiry within our services which welcomes innovation and challenge.

2. KEY ISSUES:

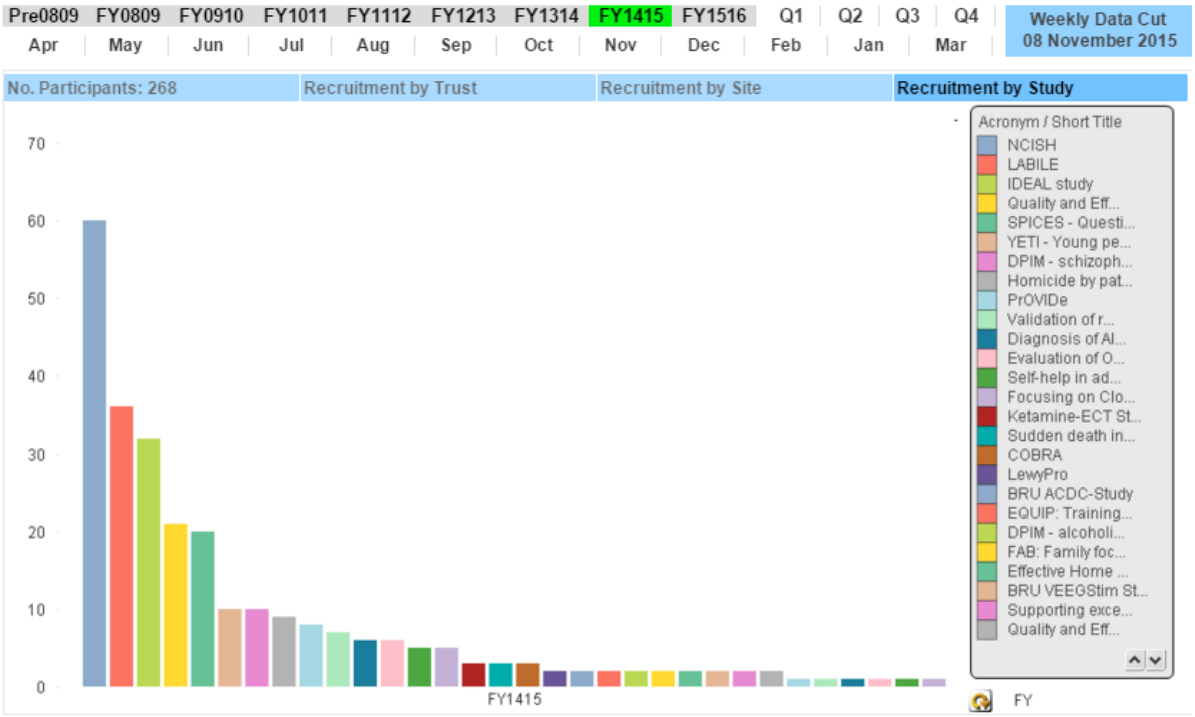
3.1. Research governance

Research conducted in the Trust is compliant with the NHS Research Governance Framework and meets required quality and governance standards, including progress on the Trust's R&D strategic goal of access to and promotion of research across geographies and specialities, and the meeting of key external performance indicators. The Trust's Standard Operating Procedures for research are published on its intranet, and Principal Investigators agree compliance to these procedures on taking responsibility for a study. Researchers conducting clinical studies within the Trust are required to undergo the internationally recognised Good Clinical Practice research training to ensure their knowledge and expertise in research conduct.
In 2014/15 a total of 50 research studies were approved for conduct in the Trust. Of these 15 studies were on the NIHR portfolio, the national list of externally funded studies of high quality. 35 non-portfolio studies (most frequently undertaken as part of a postgraduate masters or doctoral qualification) were approved. The time from receipt of a valid application to study approval for conduct in the Trust is externally monitored by the NIHR Clinical Research Network; in 2014/15 the national target was 30 days, the Trust achieved a median approval time of 6 days.

3.2 Research study activity

Recruitment to NIHR (National Institute of Health Research) studies in TEWV in 14/15 totalled 268 participants. The reduced recruitment was anticipated due to fewer number of

high recruiting portfolio studies available to us in 14/15, such as the Shire dental mental health study which recruited 684 participants in 13/14. The charts below detail recruitment activity for the 14/15 period.



Acronym / Short Title	Main Specialty	Opening Date	Closure Date	Participants
IDEAL study	Dementias and neurodegeneration	01/08/2014	30/06/2016	32
PrOVIDe	Dementias and neurodegeneration	27/11/2012	11/07/2014	8
Diagnosis of Alzheimer's disease by measuring blood proteins	Dementias and neurodegeneration	08/04/2014	10/06/2016	6
LewyPro	Dementias and neurodegeneration	21/02/2013	21/02/2016	2
BRU VEEGStim Study	Dementias and neurodegeneration	09/01/2014	30/11/2016	2
BRU ACDC-Study	Dementias and neurodegeneration	18/12/2013	01/09/2016	2
Supporting excellence in end of life care (SEED)	Dementias and neurodegeneration	02/02/2015	30/09/2018	2
Effective Home Support Dementia Care:Patterns of Current Provision v1	Dementias and neurodegeneration	31/03/2015	31/12/2015	2
DEMO-POD study	Dementias and neurodegeneration	10/01/2013	30/06/2014	1
YETI - Young people's Experiences of Transltion	Health services and delivery research	01/02/2013	31/01/2017	10
NCISH	Mental Health	01/04/1997	31/03/2018	60
LABILE	Mental Health	13/06/2013	31/10/2015	36
Quality and Effectiveness of Supported Tenancies (QEST) WP2	Mental Health	15/10/2013	28/02/2017	21
SPICES - Questionnaires	Mental Health	22/07/2013	31/12/2014	20
DPIM - schizophrenia	Mental Health	01/10/2010	31/12/2017	10
Homicide by patients with schizophrenia: a case-control study	Mental Health	11/10/2012	31/03/2016	9
Validation of risk assessments for patients from MSS (VoRAMSS)	Mental Health	01/09/2010	30/09/2016	7
Evaluation of Offender Liaison and Diversion Trial Schemes	Mental Health	28/08/2014	31/08/2015	6
Focusing on Clozapine Unresponsive Symptoms	Mental Health	01/01/2013	15/06/2015	5
Self-help in adjunct to Pharmacotherapy	Mental Health	04/12/2012	30/06/2014	5
Sudden death in psychiatric in-patients and the relationship with psychotropic drugs	Mental Health	19/03/1999	19/03/2019	3
COBRA	Mental Health	10/09/2012	03/04/2014	3
Ketamine-ECT Study	Mental Health	01/11/2012	30/06/2015	3
DPIM - alcoholism	Mental Health	01/11/2009	31/12/2017	2
FAB: Family focused treatment for Adolescents with Bipolar Disorder	Mental Health	15/01/2014	15/07/2015	2
Quality and Effectiveness of Supported Tenancies (QEST) WP3	Mental Health	07/11/2013	30/06/2014	2
EQUIP: Training to promote user involvement in care planning 3	Mental Health	05/02/2014	19/11/2014	2
Molecular Genetic Investigation	Mental Health	01/04/2006	31/12/2016	1
AMICUS	Mental Health	10/10/2011	31/12/2014	1
PPiP	Mental Health	01/03/2013	31/12/2014	1
SPICES - Interviews	Mental Health	22/07/2013	31/12/2014	1
ASPIRE Phase 1	Mental Health	04/12/2013	31/08/2014	1
TOTAL				**268**

The TEWV R&D team also continued to be funded for and demonstrate support in recruiting to studies in other NHS Trusts in the region, recruiting 45 participants to Parkinson's disease and dementia studies at South Tees NHS Trust and contributing to 316 participants for the Developing and evaluating interventions for adolescent alcohol use

disorders presenting through emergency departments study from County Durham and Darlington FT and North Tees and Hartlepool FT.

3.3 Clinical Trials

During 14/15 the R&D team continued to express interest in commercial industry clinical trials; however success to date has been limited due to the lack of clinical trials pharmacy facilities. In October 2014, EMT approved a business case to setup an R&D clinical trials pharmacy department within TEWV which will provide more opportunities for us being successful in attracting industry studies in future years.
By the end of 14/15 period, job descriptions for the Senior Clinical Pharmacist for R&D and Senior pharmacy technician for R&D have been approved for advertising early in 15/16 period. The pharmacy trials room had also been scoped and ordering commenced for the refit of a room at West Park Hospital to convert to a Clinical Trials Pharmacy Room.

3.4 Clinician engagement

The NIHR Clinical Networks transitioned from the topic specific and comprehensive research networks to the Clinical Research: North East and North Cumbria on 1st April 2014 and TEWV is an active and committed partner member with Joe Reilly taking a leading role as division 4 Clinical Lead for the region. A number of Programmed Allocations continued to be funded by the CRN for TEWV clinicians leading on research in a number of different clinical areas.
Joe Reilly has continued to meet quarterly with a group of research leaders to provide support and guidance to grow new research in the Trust.
Sarah Dexter-Smith has also provided leadership for the MHSOP research studies and now has a ‘research champion’ in each of the memory services across the Trust. An advanced nurse practitioner continued her leadership as Principal Investigator for the PROVIDE dementia study and enable TEWV to become the highest national recruiting site for the study and was shortlisted as a finalist for the Nursing Times Awards event which took place in London in October 2014.

3.5 User and carer involvement in research

- Emergence
- Results group
- Labile management group
- Links with CRN PPI group
- MHSOP engagement event led by Sarah Dexter-Smith and Dave Ekers

3.6 Academic Partnership with Durham University

Appendix 1b details the Mental Health Research Group at Durham University annual report

3.7 Publications

As detailed in Appendix 1b

4. IMPLICATIONS / RISKS:

4.1 Quality:

Research conducted in the Trust remains compliant with the NHS Research Governance Framework and meets required quality and governance standards.

4.2 Financial:

The Trusts external research income for 14/15 was £849,000, an increase of £150,000 from last year's 13/14 income of £708,085.
R&D income continues to be from two main categories of funding, these being 1) External research grant funding from NIHR, received via the lead organisation for a specific research project which often includes costs for Principal investigator and TEWV research staff time for conducting research specific activities. 2) NIHR Clinical Research Network funding which meets the costs the NHS incurs in hosting NIHR portfolio research. From 1st April 2014, the previous NIHR networks of the Comprehensive Local Research Network (CLRN), Mental Health Research Network (MHRN), and Dementias and Neurodegeneration (DeNDRoN) were superseded by the Clinical Research Network: North East and North Cumbria. Some income from the previous networks was due for the 14/15 period following the submission of final reports.
Detailed 14/15 R&D income is listed in the table below:

2014/15 External Research Income

Funding Type	Organisation	Nature/Description	Amount
NIHR Research Networks			
Mental Health Research Network	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	Allocation via network business planning process on annual basis based on study recruitment.	£10,345
CRN: North East and North Cumbria	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	As above	£464,407
DeNDRoN Research Networ	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	As above	£6,424
County Durham and Tees Valley Comprehensive Clinical Research Network	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	As above	£48,960
External Research Grants			
CASPER PLUS (NIHR HTA)	UNIVERSITY OF YORK	Fixed grant to Sept 2015	£773
COBRA (NIHR HTA)	UNIVERSITY OF EXETER	Fixed grant to April 2016	£84,008
COBRA (NIHR HTA)	UNIVERSITY OF DURHAM	Fixed funding for admin support for COBRA for 8 weeks	£1,064
Ketamine ECT (NIHR EME)	UNIVERSITY OF MANCHESTER	Fixed grant to Sept 2015	£35,050
LABILE (NIHR HTA)	IMPERIAL COLLEGE LONDON	Fixed grant to July 2017	£43,279
PEPS (NIHR HTA)	NOTTINGHAMSHIRE HEALTHCARE NHS TRUST	Fixed grant to July 2014	£24,957
TRANSITIONS (NIHR programme grant)	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	Fixed grant to June 2016	£15,260
Academic Health Science Network			
Improving Lithium Safety Grant	THE ACADEMIC HEALTH SCIENCE NETWORK FOR THE NORTH	Fixed funding	£70,000
Salary recharge for TEWV staff on MSc Research studies	UNIVERSITY OF NEWCASTLE	Fixed funding until Sept 2015	£40,259
Other Income			£1,740
TOTAL			**£849,000**

4.3 Legal and Constitutional:

The Trust's responsibility for the monitoring and standards of research activity involving its service users, carers and staff are laid down in the Research Governance Framework. The R&D office processes are designed to ensure compliance by all involved via the Trust's Standard Operating Procedures for research. The Trust R&D Strategy and its implementation seek to fulfil the NHS constitution commitment to make research participation accessible to as many service users as possible.

4.4 Equality and Diversity:

The Trust's R&D Strategy explicitly seeks to ensure that wherever possible there is equity of access to research for service users and carers across the Trust's specialties and geographies. In 2014/2015 this included a continuing increase in engagement of service users into the local management groups of individual studies. During this year there was an increase in R&D staffing for MHSOP and dementia research reflecting the changing government priorities and access to dementia research.

4.5 Other Risks:

5. CONCLUSIONS

The Trust's Research and development department activity continues to enable service users and carers across all Trust localities to access new research opportunities for research involvement. The Trust's partnership with Durham university reports continued achievements in publication, user involvement and the delivery of clinical trials in primary mental health in particular.

6. RECOMMENDATIONS

The board is asked to receive and approve the 2014/2015 R&D annual report

Prof Joe Reilly
Clinical Director of Research and Development

Background Papers:
Appendix 1b – Mental Health Research Group, Annual Report 2014, Dr Helen Stain

MENTAL HEALTH RESEARCH GROUP

ANNUAL REPORT
2014

Dr Helen J Stain

Contents

1.0 Executive Report

The Mental Health Research Group (MHRG) had a very successful year in 2014. Our inaugural Mental Health Research conference was held in April at Durham University in conjunction with the TEWV R&D and showcased the Group's research achievements. The conference was well attended by academic researchers, clinicians, service users, carers and members of the community. There were other major network meetings throughout the year as the Group's national and international collaborators came to Durham University to develop research grant applications. These network events are a wonderful opportunity for researchers, clinicians and members of the community to be informed about research evidence and to engage in skill development through workshops. In September, Professor Joe Reilly stepped down from his role as Head of Group due to increasing clinical commitments. He continues as an active member of the Group in his Honorary academic role. I would like to thank Joe for his vision in establishing the MHRG, wish him the best in his future professional roles and the MHRG looks forward to further research collaboration with him.

The Youth Mental Health research programme of the MHRG led a five country European consortium in a 6 million euro Horizon2020 EU grant application in August 2014. The proposal was for 'Young people at risk for severe mental health disorder: targeting mechanisms and resilience for early intervention and healthy ageing despite adversity'. The proposed study addressed critical questions about what leads to both adverse outcomes and recovery from early adversity, and aimed to establish a robust platform for international clinical trials. The Consortium was successful at Stage 1 of the application (25% success rate) but missed out at Stage 2 (8% success rate). The Consortium has identified another EU funding call in 2016 and is currently preparing the application. Smaller studies and research publications are being completed within the Consortium.

In 2014 we have taken major steps towards the fullest engagement of mental health service users and carers in our research. This was exemplified by the contribution many service users made to our inaugural Conference in March, in speaking from the platform and leading a workshop. Youth Speak has become a very effective enhanced Public and Patient Involvement group; its members, all aged between 14 and 24 years, have developed a strong voice which is substantially influencing the choices we make in large scale grant applications, such as the recent Horizon2020 application. Their role in the conference received special praise from our keynote speaker, the Chief Executive of the NIHR Clinical Research Network, Jonathan Sheffield. Our May 2015 conference will have wider community engagement as its theme and will be facilitated by Youth Speak.

We continue to bring global research leaders and their teams to the North East, encouraging them to share both their research and their experience of implementing the results. In May 2014 Dr Helen Stain hosted a visit from the TIPS Regional Centre for Clinical Research in Psychosis, from Stavanger, Norway. In addition to consolidating our existing research collaboration, the TIPS team participated in a symposium on early intervention approaches, a service visit and shared discussions with TEWV staff, with mutual learning on the diverse approaches taken to achieving a shared goal of preventing or reducing the impact of psychosis in young people. In 2014 Dr David Ekers and Dr Paul Tiffin hosted a visit from Professor Jonathan Kanter of the University of Wisconsin, a world leader in the application of behavioural activation interventions, who delivered a masterclass for TEWV clinicians.

Milestones have been reached in a number of clinical trials in which Research Group senior academics are Co-Investigators. The PEPS (Psychoeducation and Problem-Solving in Personality Disorder) Trial (Reilly) has completed follow up assessments and will report results within the next six months. The COBRA (Costs and Outcomes of Behavioural Activation) Trial (Ekers) has fully recruited its 150 participants at the Durham site, with results expected in 2016 which will influence future NICE guidelines in primary care depression. It is of note that the winning of clinical trial grants brings concrete benefits to

patients in terms of increased access to treatment. External excess treatment funding of c. £200k has supported our primary care depression trials over the past 2 years, from both the Durham CCG and the Department of Health.

The Group's academic staff are making the essential contribution to the delivery and improvement of Trust services which we envisaged at the outset of the MeHRY Collaboration. As an established clinical senior lecturer, Paul Tiffin takes both a critical clinical role in the Trust's forensic adolescent services, and a leadership role as Associate Clinical Director of R&D. In 2014 he has successfully piloted a new approach to increasing patient access to research via the Trust's PARIS electronic records system (OptiC). Helen Stain works as a Clinical Psychologist in a Trust early intervention in psychosis team, and in 2014 she has contributed to the current Model Lines quality improvement process for community mental health teams, advising on how young people at risk of psychosis should be assessed. David Ekers has been working with the University Counselling Service and the TEWV Affective Disorder Team in Durham City to improve services for students, providing direct clinical interventions and developing a new Mental Health Advisor pilot partnership between the University and Trust. Applying his research expertise in the area, he has advised on the design of a Trust-commissioned Teesside University training module in behavioural activation, and is working with Trust clinicians to increase behavioural activation access and treatment effectiveness.

Dr Helen J Stain

2.0 Mental Health Research Group

The Mental Health Research Group (MHRG) is a joint initiative of the Tees Esk and Wear Valleys (TEWV) NHS Foundation Trust and Durham University. It was established in 2008 through core funding from TEWV under the MeHRY contract. The focus of the Group's two research programmes of Youth Mental Health and Primary Care Mental Health is on clinical trials to provide evidence based interventions for translation into practice. The MHRG is led by Dr Helen Stain and in 2014 finalised its business strategy in alignment with the next five year plan for the Group.

Mission Statement
To enhance mental health and wellbeing for all, through high quality research and education that generates knowledge to inform health services and health policy.

Vision
Better mental health and wellbeing for all.

Objectives
- Internationally recognised as leading researchers in:
    - Youth mental health
    - Primary care mental health
    - Service user engagement
- Dissemination - Making research knowledge accessible across the community including sharing of clinical research knowledge with the TEWV NHS Trust
- Support the Trust in building research culture and skills
- Leaders of large scale research projects that improve quality and value for money of health services
- Inform and influence policy through our research
- Recognised for investing in our Group as evidenced by a vibrant PhD community

The MHRG employs an enhanced paradigm for youth involvement by developing youth ambassadors and placing young people at the heart of all activities driving the research. Youth Speak, a group of young people aged 14-25 years, was established in 2013 for this purpose. By increasing our knowledge base of critical determinants, psychological mechanisms and pathways characteristic of mental health and wellbeing, our research will underpin future strategies for the promotion of healthy ageing, targeted disease prevention and clinical interventions.

The MHRG brings together partners with research expertise and infrastructure of world renowned research institutes and centres of excellence for mental health and wellbeing of young people. For example, the Wolfson Research Institute for Health and Wellbeing (Durham. UK), the Centre for Excellence for Adolescent Psychopathology (FORIPSI, Italy), the Institute of Psychology Health and Society (Liverpool, UK), TIPS Early Intervention in Psychosis Centre (Stavanger, Norway), and Innovations in Mental Health Care (Maastricht, Netherlands).

3.0 MeHRY Contract Objectives

1. **Research-led education and training,** via both Trust CPD programmes and University masters programmes.

2. **Research-led service improvement**, with high quality methodological and analytic input to raise the Trust's standards in evaluating safety and effectiveness, taking into account the NHS Quality, Innovation, Productivity and prevention (QIPP) agenda.

3. **International quality research publications,** ensuring the highest possible rating in the higher education sector's Research Excellence Framework.

4. **Research grant funding,** from the National Institute for Health Research and other funders including industry to ensure sustainable capacity and further growth.

5. **Recruitment of participants,** to NIHR Portfolio studies will be substantially increased by this expansion in our capacity to attract funding and lead world-class research.

3.1 Staffing

Professor Joe Reilly	-	Head of Group (until Sept 2014) and Honorary Professor from Sept 2014
Dr Helen Stain	-	Clinical Senior Lecturer (Psychological Interventions) and Head of Group from Sept 2014
Dr David Ekers	-	Clinical Senior Lecturer (Psychological Interventions)
Dr Paul Tiffin	-	Clinical Senior Lecturer
Dr Patrick Welsh	-	Post Doctoral Research Associate
Dr Lisa Webster	-	Post Doctoral Research Associate
Dr Lauren Mawn	-	Post Doctoral Research Associate
Mrs Susan Williams	-	Business Manager
Dr Alison Brabban	-	Honorary
Dr Jose Mediavilla	-	Honorary
Dr Soraya Mayet	-	Honorary
Dr Mona-Lisa Kwentoh	-	Honorary

3.2 Management

3.2.1 Team Meetings

The Mental Health Research Group members meet formally on the first Monday of each month to discuss operational issues, review progress of current research projects, discuss public and patient involvement (PPI) opportunities and challenges, consider future developments and to report on publications and research grant status. All members of the Group are expected to attend. Minutes are taken by the Business Manager and are available on request.

3.2.2 MeHRY Programme Operational Management Group

A Programme Operational Management Group composed of at least 3 senior members of each party meets on a quarterly basis. The issues raised at these quarterly review meetings include the following:

- Preparation and review of the Services Specification;
- Performance of the Service Specification, including activity plans;
- Identification of any operational problems;
- A report on the resolution of matters raised since the previous meeting;
- Any in-year changes in activity;
- Financial review of the Services against the contract value;
- Review of progress versus milestones.

Minutes are taken by the Business Manager and are available on request.

3.2.3 MeHRY Programme Steering Group

A Programme Steering Group composed of at least 5 senior members of each party and including a Trust non-Executive Director and Trust CEO or deputy, meets annually. The purpose of the Programme Steering Group is to (i) provide a strategy guidance and overview to the MHRG; (ii) advise on the Services Specification for the upcoming year; and (iii) review and attempt to resolve any disputes (referred to in accordance with Clause 19.2 of the TEWV/University Contract) that may have arisen. The University presents the following to the Programme Steering Group:

- Headline progress report in relation to agreed deliverables;
- Audited annual accounts of the Unit;

- A detailed annual financial report showing the total contract value, funds utilised to date and total funds still available; and
- An annual value for money review report;

Minutes are taken by the Business Manager and are available on request.

4.0 Public Relations

4.1 Public Relations Team

The MHRG Public Relations Team works closely with the TEWV R&D office to promote the Group's research programmes and to inform the community and stakeholders of research opportunities. The Public Relations Team is supported by the Marketing and Communications Department of Durham University as well as the TEWV Communications office. Public Relations activities are reported and minuted at the MHRG monthly team meetings.

4.2 Noticeboards

There are two noticeboards on display at Queens Campus of Durham University and are situated in the Wolfson Building. The Recent publications and events noticeboard is displayed in the F corridor near the main seminar room. The second noticeboard also displays information about active research grants and future events but also has leaflet handouts for visitors and is situated next to reception.

4.3 Newsletters

A MHRG newsletter is produced twice yearly to disseminate the activities and research findings for the Group. The newsletters are available on our website at: www.durham.ac.uk/school.health/mhrg/newsbulletins/

4.4 Website

The Mental Health Research Group has dedicated web pages on the Durham University website, within the School of Medicine, Pharmacy and Health. See: http://www.durham.ac.uk/school.health/mhrc/

The website provides information on staff, research projects, publications and awarded research grants. The website also provides links to partners such as TEWV, North East Mental Health Research Network and the National Institute of Health Research. We also ensure that there are links to the Durham University Mental Health Research Group from the TEWV web pages.

5.0 Research Activities

5.1 Research Themes

The Group conducts its research under two main themes, namely, Youth Mental Health and Primary Care Mental Health.

5.1.1 Youth Mental Health (Lead: Dr Helen J Stain)

Mental health conditions are prevalent among young people and nearly one fifth of the global population is comprised of youth aged 14-24 years. Mental and behavioural conditions are the leading causes of health problems in young people in both high- and
low- resource countries, accounting for one third of all years of lost productivity due to disability. On a global level, it is estimated that approximately 20 per cent of youth experience a mental health condition each year and young people are at greater risk of developing mental ill-health as they transition from childhood to adulthood. It is well established that 70% of mental health disorders commence in adolescence or young adulthood and persist across the lifespan. The emergence of psychiatric disorders in adolescence disrupts the attainment of educational goals and relationship skills, thus reducing social inclusion in adulthood and resulting in high societal economic and social burden. Our youth mental health research programme focuses on both risk and resilience for mental health problems.

Young people at risk of developing serious mental health problems

Research has focused on the at risk (AR) for psychosis classification, however we argue that young people identified as AR are at risk for a range of negative mental health outcomes in adulthood. Therefore, identification of key pathways and psychological mechanisms to be targeted by interventions is critical for many mental health disorders, and not solely psychosis. Gene by environment interactions are being researched and it is becoming clearer how these play a role in the development of serious mental illness. Our research focuses on a second important set of determinants, namely how childhood adversity and other adversities influence mental health and wellbeing. We also examine the role of moderators and mediators such as attachment, resilience, stress sensitivity, and cognitive style. Whilst these psychological mediators and moderators play an important role, it is not known how pathways to healthy ageing and wellbeing are affected.

Our research integrates current knowledge of wellbeing, psychopathology, adversity and risk, and hypothesised psychological mechanisms, to extend this understanding by testing trajectories that result in mental ill-health or wellbeing despite adversity. In relation to exposure to an adversity, an individual may vary in i) the level of mental wellbeing before the exposure; ii) the speed and severity of mental health disturbance in response to the exposure; iii) the speed and timing of mental health recovery; and, iv) the level of mental health and wellbeing after the exposure-related disturbance and recovery. Our research aims to elucidate psychological mechanisms that feed these trajectories and identify psychological variables that are more likely to result in a wellbeing trajectory as opposed to a psychopathological trajectory.

Y*oung people at risk of disengaging from education, employment or training*

Adolescence is a period of rapid physical, emotional and social growth. Young people are faced with significant developmental challenges including the establishment of a stable identity, mastery of personal relationships and the achievement of major educational and vocational goals. Many young people lack the socio-emotional skills necessary to successfully negotiate the transition through adolescence, and are at increased risk of disengaging from education, family and community. While the majority of young people succeed in education and make a positive transition to adult life and the world of work, a challenge exists in terms of opportunities for young people, with 1.16 million young people in England aged 16-24 not in education, employment or training (NEET). Of these 150,000 are 16-17 year olds who may need additional opportunities or support to re-engage in education or training; 523,000 are 18-24 year olds who are unemployed, not in education, and looking for work. 249,000 have been unemployed for over six months and may need significant help to find work; and 490,000 are 18-24 year olds who are economically inactive (HM Gov 2011).

Once disengaged, youth are at risk of a range of adverse outcomes such as reduced social and community participation in young adulthood and beyond. Much of this social disadvantage could be avoided if disengaged youth had access to effective prevention and early intervention programs. Further to decreased economic activity, young people who are not in education, employment and training are at higher risk of experiencing adverse wellbeing conditions.

For example, NEETs have greater risk of psychiatric disorders, substance use and suicidal behaviour. The association of poor mental health with NEET status above and beyond social disadvantage suggests that mental health may be an important factor in the successful transition from school to work. Disengagement from education and employment may be a reflection of prior mental disturbance or may increase the risk of psychopathology either by failing to provide structure and the necessary developmental experiences, or by increasing exposure to other disenfranchised or non-normative peers. Our research programme aims to develop and then evaluate the effectiveness of interventions designed to re-engage young people.

5.1.2 Primary Care Mental Health (Lead: Dr David Ekers)

The majority of anxiety and depression is treated within primary care. Psychological approaches to the management of common mental health disorders remain challenging to deliver to the high numbers of people found in this setting. Recent surveys indicate less than 15% of people with such problems access a talking treatment. We feel this is disappointing as a successful psychological intervention can reduce relapse by half compared a comparably effective medication which is discontinued following recovery (Hollon, *et al.*, 2005). The cost of these conditions is substantial, with 38% of those claiming incapacity benefit reporting to have a mental health condition as their main disability and a further 10% as an additional disability (Layard, 2004).

Symptoms of anxiety and depression are the primary cause of such complaints and have been estimated to cause one fifth of all sick days in Britain (Das-Munshi, *et al.*, 2008). The financial impact of lost productivity and employment has been estimated at 23 times that of direct treatment costs (Thomas and Morris, 2003).

Our research focusses on the development and testing of simple psychological interventions that can be delivered by non-specialists in primary care settings and beyond. The aim is to increase accessibility by embedding these approaches into general healthcare as a key component of treatment meeting both physical and psychological needs. Treatments are parsimonious, using the least complex approach to meet a need. Commonly based upon a behavioural framework interventions are patient centred and based upon a shared rationale and delivered by a variety of means. Using both primary and secondary research methods we examine the clinical and cost effectiveness of these approaches and work with key stakeholders to translate into clinical settings.

5.2 Active Research Projects

5.2.1 Youth Mental Health

Behavioural activation for Obese and Depressed Youth (BODY) and Mind

Dr Paul Tiffin is conducting research into childhood-onset non-affective psychosis in the UK and ROI through the Child and Adolescent Psychiatric Surveillance System (CAPSS). Schizophrenia and related psychoses are uncommon before the age of 14. When they do occur in young people, they are often associated with poor outcomes and persistent disability. With reporting from consultant child and adolescent psychiatrists, the survey is intended to estimate incidence, describe features, presentation, co-morbidities and family psychiatric history of the effected population and assist in finding more ways to meet their needs. Current management and short-term outcomes will also be investigated. This project is funded by the Wolfson Research Institute for Health and Wellbeing.

CAPSS Early-Onset Non-Affective Psychosis Study

Dr Paul Tiffin is conducting research into childhood-onset non-affective psychosis in the UK and ROI through the Child and Adolescent Psychiatric Surveillance System (CAPSS). Schizophrenia and related psychoses are uncommon before the age of 14. When they do occur in young people, they are often associated with poor outcomes and persistent disability. With reporting from consultant child and adolescent psychiatrists, the survey is intended to estimate incidence, describe features, presentation, co-morbidities and family psychiatric history of the effected population and assist in finding more ways to meet their needs. Current management and short-term outcomes will also be investigated. This project is funded by the Wolfson Research Institute for Health and Wellbeing.

Risk Assessment Suite for Child and Adolescent Mental Health Services

Dr Paul Tiffin has developed a novel electronic risk assessment tool which is currently being piloted in Child and Adolescent Mental Health Services by research assistant Charlotte Kitchen. This research is funded through a Knowledge Transfer Partnership Grant (which includes contributions from Technology Strategy Board, ESRC, FACE co. and Tees, Esk and Wear Valleys NHS Foundation Trust).

Minds in Transition (MinT)
Dr Helen Stain is co-investigator on the five year Minds in Transition (MinT) study that is examining the neurocognitive correlates of risk for transition to psychosis for young people. Primary Healthcare Professionals (GPs, Psychologists, School Counsellors, Social Worker, Nurses, etc) can refer their clients to us with their (and parental/carer) consent. The research is funded by the Australian Government through the National Health & Medical Research Council of Australia.

TIPs – Regional Centre for Clinical Research in Psychosis
Dr Helen Stain is an invited Research Fellow with the internationally acclaimed TIPs programme at Stavanger University Hospital, Norway. She is working with Professor Mark van der Gaag to develop a program of research for the early identification and intervention for young people at ultra-high risk for psychosis who have also experienced childhood trauma. This will be both a cohort study and a randomised controlled trial with collaborating sites across Europe. This research is funded by the TIPs programme.

Social Wellbeing and Engaged Living (SWEL)
Dr Helen Stain is a Chief Investigator on The Social Wellbeing and Engaged Living (SWEL) study. This study is a randomised clinical trial being conducted across three states (Western Australia, New South Wales and Queensland. In order to reduce the impact of mental illness in youth and increase access to psychological interventions, Helen has broadened her research target beyond young people identified as being at 'ultra high risk' of developing a psychotic disorder and is currently conducting a psychological intervention trial aimed at improving the social engagement of youth who are disengaging from education and family. This is the first clinical trial to investigate the efficacy of a telephone delivered intervention for increasing the social engagement and emotional well-being of disengaged youth namely youth who have dropped out of school and are not engaged in other forms of education or training (NEET). It is proposed that the intervention will facilitate (i) resumption of education or employment; and/or (ii) ability to engage with, and therefore benefit from, linkage (NEET focused) services. This unique intervention aims to foster positive social and emotional skills in adolescents, to decrease the risk of adverse outcomes and promote health enhancing lifestyles. The key outcomes for the study are improved social inclusion (engagement with school), peer and family relationships, and life satisfaction. The SWEL intervention is designed to increase youth access to psychological interventions and to be a cost effective intervention that can be delivered with minimal training and therefore sustainable within a health or youth service beyond the life of a research trial. Helen is currently working with regional organisations here in order to run a similar trial in the UK. This research is funded by the National Health & Medical Research Council.

Youth informed mental health research group – 'Youth Speak'
Dr Helen Stain, Dr Lauren Mawn and Dr Patrick Welsh have established a youth informed mental health research group - Youth Speak. The United Nations Convention on the Rights of the Child require that children should be informed, involved and consulted about all decisions that affect their lives. However this right does not always equate to meaningful involvement in research (Kellett, 2010) despite evidence indicating that research involving patients and members of the public is more robust, is likely to increase participation and recruitment as well as facilitating translation of research findings into practice (Staley, 2009, Ennis et al., 2013).

Youth Speak is an enhanced Patient and Public Involvement (PPI) group model focusing on youth mental health research. The group comprises young people (aged 14-24 years) who have experienced mental health problems themselves OR been a carer/sibling of someone with mental health problems OR have had no personal experience of mental health issues. The inclusion of young people with and without mental health experience has been a strategic approach (i) for the reduction of mental health stigma for youth and (ii) to ensure that youth mental health research focusses on resilience and wellbeing rather than solely on illness. Youth Speak has three primary objectives:

- Giving young people a voice and skills in mental health research
- Reducing mental health stigma for young people through research and action
- Shaping research to influence mental health services for young people.

Members of Youth Speak meet on a monthly basis to discuss research priorities, feedback information from local and national conferences, and support academics from Durham University with their youth mental health research.

Youth Speak is a unique concept at both a local and national level and is a valuable resource for academics and clinicians across the north of England. If you are a young person interested in joining Youth Speak or a researcher seeking youth involvement in your research please contact Dr Helen Stain. This project is funded by a Wolfson Research Institute for Health and Wellbeing.

5.2.2 Primary Care Mental Health

Nurse-delivered collaborative care for depression and long-term physical conditions
Dr Dave Ekers is principal-investigator on a small grant to examine the outcomes of practice nurse delivered collaborative care in depression in the Durham dales. This work follows on from that published by Ekers and Wilson in 2008. It aims to scope the current evidence base, identify key components of collaborative care for co-morbid depression and physical health problems. Dr Dave Ekers, Dr Rebecca Murphy and Deborah Kemp with colleagues from Manchester University, Sheffield University and the University of York produced a systematic review and meta-analysis of Nurse led Collaborative Care for Depression in people with Long Term Health Problems. From this and NICE guidance a project is underway in Bradford and Airedale CCG areas where 6 practices are piloting this care delivery model. Dr Ekers is leading the quantitative and qualitative evaluation of this service development project in partnership with the local NHS. This research is funded by Bradford and Airedale Primary Care Trust and Research Capability Funding.

Behavioural Activation in Youth Feasability (BAY-F) Study
Dr Paul Tiffin is exploring the feasibility of using Behavioural Activation (BA) as a brief intervention in depressed adolescents, delivered by primary care nurses. Depressed mood is prevalent in adolescents seen in primary care settings and is relatively chronic and predictive of mood disorder in adulthood. BA is a time-limited psychotherapy informed by behaviour theory. With qualitative and quantitative methods, this study intends to assess the acceptability and experience of receiving and delivering the intervention in the patients and health professionals respectively and to estimate the effect of BA on depressive symptoms compared to existing data for intervention of depression in under 18s. This research is funded by The Wolfson Research Institute and Tees, Esk and Wear Valleys NHS Foundation Trust.

General Practice Research Database Study
Dr Jose Mediavilla, Dr Paul Tiffin and Dr Patrick Welsh are currently involved in a study looking at the influence of national guidance on the prescription of antidepressant medication to young people using the GPRD (General Practice Research Database).

Collaborative Care for Screen Positive Elders/depressed elders (CASPER/CASPER plus)
Dr Dave Ekers is local principal investigator for the CASPER and CASPER plus studies These are NIHR multi-centre randomised controlled trials over 4 years, examining the cost and outcome of Collaborative Care for sub threshold and depressed older adults compared to treatment as usual. Clinical and cost outcomes will be examined at an 18 month follow up in a sample of 990 depressed adults randomised between intervention arms across the 2 studies. This research is funded by the NIHR HTA.

Cost and Outcome of Behavioural Activation (COBRA)

Dr Dave Ekers, local principal investigator (supported by Rose McNulty, Deborah Kemp and Claire Farrow) is working on COBRA - examining the cost and outcome of Behavioural Activation delivered by non specialists compared to Cognitive Behavioural Therapy. Clinical and cost outcomes will be examined at an 18 month follow up in a sample of 440 depressed adults randomised between intervention arms. This is an NIHR multi-centre randomised controlled trial over 4 years. This research is funded by the NIHR HTA. This study was led by Professor Dave Richards at Exeter University

5.2.3 Mental Health

Cognitive Behavioural Therapy for People Not Taking Antipsychotics (ACTION Trial)

Dr Alison Brabban is working as a local collaborator in a randomised controlled trial evaluating the effectiveness of Cognitive Behavioural Therapy in people with psychosis who are not taking antipsychotics. The trial is running across three sites: Manchester, Newcastle and Durham Universities. Professor Tony Morrison, at Manchester University is the Principle Invesigator for the study. The ACTION trial builds on promising results of a pilot study. For more information see the website:
http://www.ncbi.nlm.nih.gov/pubmed/21914252. This research is funded by the National Institute for Health Research (NIHR) (UK) and the Central Commissioning Facility (CCF).

Psycho-Education with Problem-Solving (PEPS) therapy for adults with personality disorders

Professor Joe Reilly (supported by Helen Beckwith) is conducting the HTA-funded PEPS Trial. PEPS is the first multi-site, randomised-controlled trial for a psychotherapy intervention in personality disorder in the world and has been running in the North East, South Wales and Central London since 2010. This trial compares PEPS therapy with the usual treatment that people with personality disorder receive from mental health services in the community. PEPS is running locally within Tees, Esk & Wear Valleys NHS Foundation Trust, in collaboration with the Mental Health Research Group at Durham University. We have recruited participants from all over Teesside and North Yorkshire. PEPS is a pragmatic trial, giving service-users access to an important new therapy whilst contributing to the worldwide evidence base and aims to influence service provision and delivery as a result. For more information see the website www.peps-trial.co.uk. This research is funded by the NIHR HTA.

Lamotrigine and Borderline personality disorder: Investigating Long-term Effectiveness (LABILE)

Prof Joe Reilly is co-investigator on LABILE a 3 year NIHR HTA study. It is a multicentre, two arm, parallel group, double blind, placebo controlled, randomised trial, to be conducted in secondary care mental health services, at five UK centres: East Midlands, North, South East, and West London, and Teeside. The trial will integrate a clinical and economic evaluation and examine the impact of adding lamotrigine to treatment as usual for adults with Borderline Personality Disorder over a 54 week period. All those taking part in the study will continue to receive treatment as usual from primary and secondary care services. In addition, those randomised to active treatment will be prescribed up to 200mg of generic lamotrigine titrated over a six week period while those randomised to the control treatment will receive treatment as usual plus an inert placebo. This research is funded by the NIHR HTA.

Observational Assessment of Safety in Seroquel (OASIS)

Prof Joe Reilly is a co-investigator on OASIS is a cohort study to monitor the safety and use of extended-release quetiapine (Seroquel XL(tm)) compared to the immediate release formulation in the Mental Health Trust Setting; this is a national study covering the whole of England. Seroquel XL is a new formulation and this study aims to evaluate its short term safety when used by patients with schizophrenia and mania associated with bipolar disorder in real−life. This study was requested by the Medicines and Healthcare Regulatory Authority (MHRA) who oversee the safety of all medicines in the UK. The study will be recruiting patients started on Seroquel XL as well as a comparator group started on Seroquel IR (the older formulation) and will also ask their care team to answer some simple questions about them at the time they start

and again in 12 weeks' time. The study lasts for 4 years (with data being collected for 3 years), although each individual patient will only be involved for a 12 week period of observation. The study is to be carried out independently by the Drug Safety Research Unit (DSRU) in Southampton, although is funded by Astra Zeneca.

5.3 Publications in 2014

Professor Joe Reilly

Journal articles

- Crawford MJ, MacLaren T, & **Reilly JG.** (2014). Are mood stabilisers helpful in treatment of borderline personality disorder?. *Practice* 349: g5378.
- Beckwith H, Moran PF, & **Reilly JG.** (2014). Personality disorder prevalence in psychiatric outpatients: A systematic literature review. *Personality and Mental Health* 8(2): 91-101.
- Close H, **Reilly JG**, Mason JM, Mukesh K, Wilson D, Main J, & Hungin APS. (2014). Renal Failure in Lithium-Treated Bipolar Disorder: A Retrospective Cohort Study. *PLOS ONE* 9(3): e90169.

Dr Helen Stain

Journal articles

- Shah S, Mackinnon A, Galletly C, Carr V, McGrath JJ, **Stain HJ**, Castle D, Harvey C, Sweeney S, & Morgan VA. (2014). Prevalence and impact of childhood abuse in people with a psychotic illness: Data from the second Australian national survey of psychosis. *Schizophrenia Research.*
- Morgan VA, McGrath JJ, Jablensky A, Badcock JG, Waterreus A, Bush R, Carr V, Castle D, Cohen M, Galletly C, Harvey C, Hocking B, McGorry P, Neil AL, Saw S, Shah S, **Stain HJ,** & Mackinnon A. (2014). Psychosis prevalence and physical, metabolic and cognitive co-morbidity: data from the second Australian national survey of psychosis. *Psychological Medicine* 44(10): 2163-2176.
- Oliver EJ, Mawn L, **Stain HJ,** Bambra CL, Torgerson C, Oliver A, & Bridle C. (2014). Should we 'hug a hoodie'? Protocol for a systematic review and meta-analysis of interventions with young people not in employment, education or training (so-called NEETs). *Systematic Reviews* **3**: 73.

Dr David Ekers

Journal articles

- Murphy R, **Ekers D.** & Webster LAD. (2014). An update to depression case management by practice nurses in primary care: a service evaluation. *Journal of Psychiatric and Mental Health Nursing* 21(9): 827-833.
- **Ekers D**, Webster LAD, Van Straten Annemieke, Cuijpers P, Richards D. & Gilbody S. (2014). Behavioural Activation for Depression: An Update of Meta-Analysis of Effectiveness and Sub Group Analysis. *Plos One* 9(6): e100100.
- Welsh PR, Kitchen C, Webster LAD, **Ekers D,** & Tiffin PA. (2014). Behavioural activation therapy for adolescents 'at-risk' for psychosis. *Early Intervention in Psychiatry* Early View.
- Overend K, Lewis H, Bailey D, Bosanquet K, Chew-Graham C, **Ekers D**, Gascoyne S, Hems D, Holmes J, Keding A, McMillan D, Meer S, Mitchell N, Nutbrown S, Parrott S, Richards D, Traviss G, Trepel D, Woodhouse R, & Gilbody, S. (2014). CASPER plus (CollAborative care in Screen-Positive ElderRs with major depressive disorder): study protocol for a randomised controlled trial. *Trials* 15: 451.
- Rhodes S, Richards DA, **Ekers D**, McMillan D, Byford S, Farrand PA, Gilbody S, Hollon SD, Kuyken W, Martell C, O'Mahen HA, O'Neill E, Reed N, Taylor RS, Watkins ER, & Wright KA. (2014). Cost and outcome of behavioural activation versus cognitive behaviour therapy for depression (COBRA): study protocol for a randomised controlled trial. *Trials* 15: 29.
- Masterson C, **Ekers D**, Gilbody S, Richards D, Toner-Clewes B, & McMillian D, (2014). Sudden gains in behavioural activation for depression. *Behaviour Research and Therapy* 60: 34-38.

Dr Paul Tiffin

Journal articles

- Steele R. & **Tiffin PA.** (2014). 'Personalised evidence' for personalised healthcare: Integration of a clinical librarian into mental health services – a feasibility study. *The Psychiatric Bulletin* 38(1): 29-35.
- **Tiffin PA**, Illing J, Kasim AS, & McLachlan JC. (2014). Annual Review of Competence Progression (ARCP) performance of doctors who passed Professional and Linguistic Assessments Board (PLAB) tests compared with UK medical graduates: national data linkage study. *BMJ* 348: g2622.
- Welsh P. & **Tiffin PA.** (2014). Assessing adolescent preference in the treatment of First episode psychosis and psychosis risk. *Early Intervention in Psychiatry* 8(3): 281-285.
- Welsh PR, Kitchen C, Webster LAD, Ekers D, & **Tiffin PA.** (2014). Behavioural Activation therapy for adolescents 'at-risk' for psychosis. *Early Intervention in Psychiatry* Early View.
- **Tiffin PA**, McLachlan JC, Webster LAD & Nicholson S. (2014). Comparison of the Sensitivity of the UKCAT and A levels to sociodemographic characteristics: a national study. *BMC Medical Education* 14: 7.
- Welsh P, Cartwright-Hatton S, Wells A, Snow L, & **Tiffin PA.** (2014). Metacognitive beliefs in adolescents with an at-risk mental state for psychosis. *Early Intervention in Psychiatry* 8(1): 82-86.
- Welsh P, & **Tiffin PA.** (2014). The 'At-Risk Mental State' for psychosis in adolescents: Clinical presentation, transition and remission. *Child Psychiatry and Human Development* 45(1): 90-98.

Dr Lauren Mawn

Book Sections

- Woodman T, **Mawn L,** & Martin C. (2014). Models of emotion-performance in Sport. In Encyclopaedia of Sport and Exercise Psychology. Eklund R. & Tenenbaum G. SAGE.

Journal articles

- Loughead TM, **Mawn L**, Hardy JT. & Chandler K. (Accepted). Athlete Leadership. In Fundamental Concepts in Sport and Exercise Psychology. Papaioannou AG. & Hackfort D. Taylor & Francis.
- Oliver EJ, **Mawn L,** Stain HJ, Bambra CL, Torgerson C, Oliver A, & Bridle C. (2014). Should we 'hug a hoodie'? Protocol for a systematic review and meta-analysis of interventions with young people not in employment, education or training (so-called NEETs). Systematic Reviews 3: 73.
- Stain HJ, Brønnick K, Hegelstad WtV, Joa I, Johannessen JO, Langeveld J, **Mawn L,** & Larsen TK. (2014) The impact of interpersonal trauma on the social functioning of adults with first episode psychosis. *Schizophrenia Bulletin*. (6):1491-8. doi: 10.1093/schbul/sbt166. IF 8.60.

Dr Lisa Webster

Journal articles

- Murphy R, Ekers D, & **Webster LAD.** (2014). An update to depression case management by practice nurses in primary care: a service evaluation. *Journal of Psychiatric and Mental Health Nursing* 21(9): 827-833.
- Ekers D, **Webster LAD.**, Van Straten Annemieke, Cuijpers P, Richards D, & Gilbody S. (2014). Behavioural Activation for Depression: An Update of Meta-Analysis of Effectiveness and Sub Group Analysis. *Plos One* 9(6): e100100.
- Welsh PR, Kitchen C, **Webster LAD**, Ekers D, & Tiffin PA**.** (2014). Behavioural activation therapy for adolescents 'at-risk' for psychosis. *Early Intervention in Psychiatry* Early View.

- Tiffin PA, McLachlan, JC, **Webster LAD,** & Nicholson S. (2014). Comparison of the sensitivity of the UKCAT and A levels to sociodemographic characteristics: a national study. *BMC Medical Education* 14: 7.

Official Reports:

- Ekers D, & **Webster LAD**. (2014). Practice nurse delivered case management of depression: Service development proposal. Bradford & Airedale NHS.

Dr Patrick Welsh

Journal articles

- **Welsh P**. & Tiffin PA. (2014). Assessing adolescent preference in the treatment of First episode psychosis and psychosis risk. *Early Intervention in Psychiatry* 8(3): 281-285.
- **Welsh PR**, Kitchen C, Webster LAD, Ekers D, & Tiffin PA**.** (2014). Behavioural Activation therapy for adolescents 'at-risk' for psychosis. *Early Intervention in Psychiatry* Early View.
- **Welsh P**, Cartwright-Hatton S, Wells A, Snow L, & Tiffin PA. (2014). Metacognitive beliefs in adolescents with an at-risk mental state for psychosis. *Early Intervention in Psychiatry* 8(1): 82-86.
- **Welsh P,** & Tiffin PA. (2014). The 'At-Risk Mental State' for psychosis in adolescents: Clinical presentation, transition and remission. *Child Psychiatry and Human Development* 45(1): 90-98.

5.4 Patient and Public Involvement

Youth Speak is an enhanced Patient and Public Involvement (PPI) group focusing on youth mental health research. Membership is open to anyone aged between the ages of 14-24 years old with an interest in mental health. Meetings occur on a monthly basis in Durham City but between meeting we keep in touch using social media: @YouthSpeakMH or visit our website: www.youthspeakmh.com

Our Aims

Youth Speak has three primary objectives:

- Giving young people a voice and skills in mental health research;
- Reducing mental health stigma for young people through research and action;
- Shaping research to influence mental health services for young people.

Some of our achievements to date

Since we began in October 2013, with the support of a Wolfson small grant, we have done some amazing work including:

- Supporting the development of a €6 million European Union grant (GROWING) submitted by Helen Stain and Lauren Mawn;
- Designing and delivering a workshop at the *Mental Health Research Group Annual Conference, 2014* to foster participation and engagement. Members also designed and led exercises challenging prejudices around young people and managed small group discussions highlighting important principles of youth engagement.
- Supporting Charlotte Kitchen, a PhD student at Durham University, in researching treatment for depression in young people. To date Youth Speak members have informed the name and logo of the proposed study as well as supporting information leaflets;
- Attendance and presentation by some of our members at a self-harm conference hosted by Investing in Children.

5.5 Recruitment to Trials (R&D)

The MHRG has continued its work in collaborating with the UK's leading centres in mental health research to conduct interventional clinical trials in the areas of primary mental health and personality disorder. An expanding group of clinical leaders has spread our trials involvement across the large geography of the Trust, improving access to new treatments for service users. The Group's trials work has encouraged the wider involvement of the Trust in NIHR Portfolio

studies supported by the North East and North Cumbria NIHR Clinical Research Network. Group member Joe Reilly leads the Network's NHS support for mental health, dementia and neurological disorders. In October 2014, the Executive Management Team considered and approved a business case to embed clinical trials of investigational medicinal products (CTIMPs) into core Trust business, readying us as a partnership to host and expand work of this kind. Recruitment continued successfully in 2014 for the LABILE trial of lamotrigine in borderline personality disorder, led locally by Joe Reilly in collaboration with Imperial College.

The PEPS (psychoeducation and problem-solving in personality disorder) and CASPER (collaborative care for subthreshold depression in older people) trials were completed in 2014, with results awaiting publication and dissemination. Led by David Ekers as co-applicant and Principal Investigator we have successfully completed recruitment to the COBRA study, a randomised controlled trial to determine both the clinical and cost effectiveness of behavioural activation compared to cognitive behavioural therapy (CBT) for depression in adults within primary care. If the findings show that behavioural activation is as effective as CBT in reducing depression severity, then this could mean a significant saving in direct health care costs for the NHS.

Having successfully collaborated on the CASPER, CASPER PLUS and COBRA studies, we continued to collaborate with the University of York as co-applicants on large scale grant applications for clinical trials. In 2014 York University secured a Health Technology Assessment (HTA) grant to fund SCIMITAR PLUS – a trial of smoking cessation intervention for people with severe mental ill health. Both Joe Reilly and Suzy Ker, a consultant psychiatrist with the Trust are co-applicants and the Trust will be a major site for recruitment.

5.6 Conference Presentations

Dr Helen Stain

Invited presentations

- **Stain HJ**, Joa I, Hegelstad WtV, Mawn L**.** & Johannessen JO. (2014) The relational model of childhood trauma and ultra high risk for psychosis. Symposium at International Conference on Early Psychosis, Tokyo, Japan**;**
- **Stain HJ**, Bucci S, Baker A, Halpin S**,** Emsley R, Schall U, Lewin T, Carr V, Crittenden K, Clarke V. & Startup M. (2014). DEPTh: randomized controlled trial of cognitive behavioral therapy for young people at ultra high risk for psychosis. Symposium at International Conference on Early Psychosis, Tokyo, Japan;
- **Stain HJ.** (2014) Childhood trauma and risk for psychosis. Sant Pere Claver, Barcelona;
- **Stain HJ**. (2014). Addressing youth mental health stigma. ESRC Seminar, University of Nottingham;
- Mawn L**,** Welsh P, **Stain, HJ.** & Youth Speak (2014) Engaging young people in mental health research. Invited workshop presented to the Mental Health Research Group Annual Conference, Durham, UK;
- Mawn L**,** Welsh P, & **Stain HJ.** (2014) Youth Mental Health: Research engagement and focus. School of Medicine Pharmacy and Health, Durham University, UK;
- **Stain HJ.** (2014). Overcoming the legacy of childhood trauma. Mental Health Research Group conference, Durham University, UK;
- **Stain HJ.** (2014). Childhood trauma, relationships and mental health. Psychiatry Society, Durham University, UK.

Poster Presentations

- Short V, **Stain HJ**, Mawn L, Reilly J. (2014) Team formulation: A scoping review, BABCP. Birmingham, UK;
- Short V, **Stain HJ**, Mawn L, Reilly J. (2014) Team formulation: A scoping review. Mental Health Research Group Annual conference. Durham, UK;
- Youth Speak (2014) Youth Speak on Mental Health Research: Who we are! Mental Health Research Group Annual Conference. Durham, UK;

- **Stain HJ**, Hides L, Baker A, Jackson C, Lenroot R, Paulik-White G, McElduff P, Clark S. & Wolfenden L. (2014). Social Wellbeing and Engaged Living (SWEL): Results of a pilot trial and a RCT for re-engaging young Australians in education and work**.** International Conference on Early Psychosis, Tokyo, Japan;
- **Stain HJ**, Brønnick K, Hegelstad WtV, Joa I, Johannessen JO, Langeveld J, Mawn L. & Larsen TK. (2014). Interpersonal trauma and social functioning of adults with first episode of psychosis. Society for International Research on Schizophrenia Conference, Florence, Italy.

Dr David Ekers

Conferences Presentations

- Hosted/Chair 2015 international Primary Care Mental Health Research Conference;
- Spoke at the Wolfson Research Colloquium;
- Mental Health Research Group R&D Annual Conference;
- TEWV Tees Nursing Conf Workshop Presentation;
- AHSN NE workshop lead;
- Researcher Links Presentation funded by British Council Qatar.

Dr Paul Tiffin

- TEWV audit day (12th Feb 2014) presented findings from CAMHS domestic violence audit;
- Mental Health Research Group Annual Conference 2014
- ACAMH 'Hearing voices conference' Darlington

Dr Lauren Mawn

Invited presentations

- **Mawn L,** Whitfield J, Welsh P. (2014) Youth Mental Health: Listening to the voices of young people. Counselling Services Multi-Disciplinary Conference, Urshaw College, Durham UK.
- **Mawn L.** (2014) Inside the minds of the world's top athletes. Durham Sports and Exercise Medicine Society. Stockton, UK.
- Stain HJ, Joa I, ten velden Hegelstad W, **Mawn L,** Johannessen J. (2014) The relational model of childhood trauma and ultra high risk for psychosis. Symposium at International Conference on Early Psychosis, Tokyo, Japan
- **Mawn L,** (2014) Youth Mental Health: Engagement and Focus. Sant Pere Claver Barcelona.
- **Mawn L,** Welsh P, Stain, HJ**.** & Youth Speak (2014) Engaging young people in mental health research. Invited workshop presented to the Inaugural Mental Health Research Group Annual Conference, Durham, UK.
- **Mawn L,** Welsh P, & Stain HJ. (2014) Youth Mental Health: Research engagement and focus. School of Medicine Pharmacy and Health, Durham University, UK.

Oral Presentation

- **Mawn L,** Callow N, Hardy J, Arthur CA. (2014) Developing Transformationa Leadership in Higher Education: A pilot field study. International Congress of Applied Psychology. Paris 2014.

Poster Presentations

- Short V, Stain HJ, **Mawn L**, Reilly J. (2014) Team formulation: A scoping review BABCP. Birmingham, UK.
- Short V, Stain HJ, **Mawn L**, Reilly J. (2014) Team formulation: A scoping review. R&D conference. Durham, UK.
- Youth Speak (2014) Youth Speak on Mental Health Research: Who we are! R&D Conference. Durham, UK.

- Stain HJ, Bronnick K, ten Velden Hegelstad W, Joa I, Johannessenn JO, Langeveld J, **Mawn L,** & Larsen, TK. (2014) Interpersonal trauma and social functioning of adults with first episode psychosis. Presented at Schizophrenia International Research Society Conference. Florence Italy.

Dr Lisa Webster

Poster Presentations

- Murphy R, Ekers D. **& Webster LAD**. (2014). An update to depression case management by practice nurses in primary care: A service evaluation. Wolfson Research Colloquium, Durham University;
- Ekers D, **Webster LAD**. et al. (2014). Behavioural activation for depression: An update of meta-analysis of effectiveness and sub-group analysis. Wolfson Research Colloquium, Durham University.

5.7 Conferences Hosted

Mental Health Research Group Conference

We held our inaugural MHRG conference in conjunction with TEWV R&D, on Friday, 14th March 2014 at Durham University. This was well attended and attracted a wide audience from service users and carers to senior Trust managers. Mr Martin Barkley opened the conference followed by a key-note speech by Dr Jonathan Sheffield, Chief Executive, NIHR Clinical Research Network in which he gave us some excellent examples of what we can learn from the successes of the NIHR networks. The Head of School Designate Dr Simon Forrest spoke inspirationally about his personal commitment to youth mental health, and Dr Dave Ekers, Dr Paul Tiffin and Dr Helen Stain gave very impressive summaries of their work so far and their ambitions for the future. Young people from the Group's Youth Speak programme led a highly valued workshop and two service users spoke about their involvement in clinical trials. Other workshops focused on our success in making partnerships work to deliver NHS research, and on methodological approaches to service evaluation. The conference ended with a summary of the day by Dr Nick Land. The formal feedback was excellent, and focused particularly on the strength of user and carer participation. More than 20 posters were displayed showing the breadth and depth of research activity across our partnership, with the poster prize awarded by Dr Simon Forrest to the Youth Speak group. Photographs and presentations were posted on the Mental Health Research Group website and an article published in the Trust's Insight Magazine.

Network Meetings and seminars

- TIPS Early Intervention Network meeting;
- Prof C Bridle. Dementia and Physical Activity;
- Dr L Valmaggia. From help-seeking to help accepting: Implementing early detection in a prison setting;
- Dr H Fisher. The impact of childhood trauma on outcomes of psychosis.

5.8 Indicators of Esteem

Dr Helen Stain

- **Invited Fellow** of the Royal Society of Medicine, London, UK;
- **Research Fellow**, TIPS-Regional Centre for Clinical Research in Psychosis, Stavanger University Hospital, Norway;
- **Associate Professor Conjoint,** University of Newcastle, School of Medicine & Public Health, Australia;
- **Senior Clinical Lecturer Conjoint,** University of Sydney, School of Medicine, Australia;
- **Invited member** of Professional Advisory Group for **"**The effectiveness, acceptability and cost-effectiveness of psychosocial interventions for maltreated children and adolescents: An evidence synthesis". University of Belfast;
- **Elected member** of Academic Senate, Durham University (2013-present);
- **Elected member** of Senate Governance Review Committee, Durham University (2014-2015);

- **Member** of the NIHR Research for Patient Benefit North East grant review committee (2013-present);
- **Member** of the School of Medicine, Pharmacy and Health's Research Committee (2013-present);
- **Member** of the School of Medicine, Pharmacy and Health's Athena Swan Committee (2014).

Dr David Ekers

- **Psychiatric Nurse Rep** on NICE Depression Guideline Development Group;
- **Member of NHS** NE Research Ethics Committee;
- **Chair** of Durham University School of Medicine, Pharmacy and Health Research Ethics Committee;
- **External Examiner** for Exeter University PG Dip in Low Intensity Interventions (PWP course);
- **Reviewer** for NIHR;
- **Invited delegate** of British Council Researcher Links event Qatar;
- **Member** of TEWV Nurse Advisory Groups Durham and Teesside;
- **AHSN facilitator** for Depression and Long term Health Conditions Workstream.

Dr Paul Tiffin

- **Member** of the NIHR Research for Patient Benefit North East grant review committee;
- **Member** of Executive Steering Committee of the Predictive Modelling for Medicine (POEMS) EPSRC supported network;
- **Elected to Fellowship** of the Royal College of Psychiatrists.

Dr Lauren Mawn

- **Member** of School Research Committee, ECR Representative. School Medicine, Pharmacy and Health, Durham University 2014-Present;
- **Member** of Concordat Implementation Committee, Durham University 2014-Present.

Dr Lisa Webster

- **Member** of Chartered Member and Associate Fellow of the British Psychological;
- **Member** of Chartered Member and Associate Fellow British Psychological Society;
- **Member** of Post-doctoral representative Durham University Research Committee;
- **Member** of Post-doctoral representative Durham University Concordat Implementation Group;
- **Reviewer** for Journal of Psychiatric Mental Health Nursing;
- **Reviewer** for NIHR programme grants for applied research.

5.9 Events Hosted

SPIRE (Support and Partnership for Ideas, Research and Empowerment)

The Mental Health Research Group hosts a monthly seminar series on mental health called SPIRE seminars (Support and Partnership for Ideas, Research and Empowerment). The SPIRE seminar series is aimed at engagement of service users and carers in research. Topics for the seminars include research studies and findings as well as sharing the experiences of service users and carers experience.

Date	Speaker	Title
9th January 2014	Victoria Moran, Clinical Psychologist, TEWV	"How do mental health professionals experience and make sense of managing risk in self-harm and suicide with patients diagnosed with borderline personality disorder? A study using Interpretative Phenomenological Analysis"
27th February 2014	Dr Helen Fisher & Dr Lucia Valmaggia (Kings College London)	"The impact of childhood trauma on outcomes of psychosis" And "From help-seeking to help accepting: Implementing early detection in a prison setting"

31st March 2014	Sophie Hodgetts, Research Postgraduate, Durham University	"Estrogen as a neuroprotective agent in schizophrenia"
10th April 2014	Dr Ian Maidment, Senior Lecturer, Pharmacy, Aston University	"Medication management in dementia – key research priorities"
30th June 2014	Michael Sykes, Head of Patient Safety, TEWV	"Social Learning and Diffusion of Healthcare Innovation"
11th September 2014	Dr Philip Wilkinson, Consultant Old Age Psychiatrist, Oxford Health NHS Foundation Trust and Honorary Senior Clinical Lecturer, University of Oxford and Senior Lecturer, Pharmacy, Aston University	"Electricity rendered useful? Transcranial direct current stimulation for late life depression"

6.0 Postgraduate Research Community

6.1 Aims and Objectives

We have taken forward our objective to develop a mental health PhD programme, focusing on both high quality academic candidates, and nurturing talent within the Trust. Dr Helen Stain is leading on developing this programme and working closely with the Director of Research for the School of Medicine, Pharmacy and Health of Durham University through her roles on both the Postgraduate and the School Research committees. Opportunities for PhD research with the MHRG have been advertised online through FindAPhD.com

6.2 Postgraduate Students

Name	Type	Part/full Time	Title of Research	Supervisors	Start Date	End Date
Charlotte Kitchen	PhD	Full	Behavioural interventions for depression in children and young people	Dr D Ekers (primary) Dr P Tiffin	Oct 2013	Sept 2016
Valentina Short	PhD	Part	Team formulation in mental health services.	Dr H Stain (primary) Prof J Reilly	April 2013	April 2019
Jo Davision	Masters	Full	Young people's experiences of engagement with child and adolescent mental health	Dr H Stain	2015	2015
Lisa Boyd	MSc	Part	Improving access to psychological therapies	Dr D Ekers (primary) Prof J Reilly	Nov 2012	Oct 2012

7.0 Funding in 2014

7.1 Grants Awarded

Applicants	Funding Body	Title	Amount	Date Awarded
Dr Paul Tiffin Dr Jan Illing	Department of Health	Education Outcomes Framework Grant	£550k	April 2014
Professor Joe Reilly T Donaldson S Hunter Dr Andrew Husband Dr Paul Tiffin	Academic Health Science Network	Improving Lithium Safety in the North East	£120k	May 2014
Dr Helen Stain Dr Lauren Mawn	Global Engagement Facilitation Grant, Durham University	EU Grant Funding, Barcelona	£1330.39	May 2014

Dr Lauren Mawn Dr Patrick Welsh Dr Helen Stain Clare Pounder Laura Degnan Lauren Kirkpatrick	Leverhulme Trust	Youth Speaking Stigma	£14,950	November 2014
Dr Lisa Webster Dr Judith Covey	Wolfson Early Careers Research Grant, Durham University	Investigating the pre, peri and post deployment risk factors for mental and physical ill health in a sample of UK reservists	£2136.00	November 2014
Dr David Ekers	Wolfson Small Grant Scheme, Durham University	National Mental Health Primary Care Conference	£2k	December 2014
Dr David Ekers	TEWV	National Mental Health Primary Care Conference	£2k	December 2014
Dr David Ekers	School of Medicine, Pharmacy and Health, Durham University	National Mental Health Primary Care Conference	£2k	December 2014
Dr Paul Tiffin Dr David Ekers	UK MHRN	Clinical Research Group – Youth Mental Health problems and Primary Care – Improving Clinical Outcomes in Young People through Early Effective Engagement (CoYoTE3)	£3700	December 2014

Item 6 Appendix 2

EXECUTIVE MANAGEMENT TEAM

Date of Meeting: **26 August 2015**

Title: **Research and Development Strategy**

Lead Director: **Dr Nick Land**

Report for: **Approval**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users	✓	Consent to care and treatment	✓		
Personalised care, treatment and support					
Care and welfare of people who use services		Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

EXECUTIVE MANAGEMENT TEAM

Date of Meeting: 26 August 2015

Title: Research and Development Strategy

1. INTRODUCTION & PURPOSE

1.1. To present a new Research and Development Strategy for approval, covering the five years until 31 March 2020.

1.2. To request approval of a revised Research Governance Policy.

2. BACKGROUND INFORMATION

2.1. We are committed to supporting and promoting research across all our services and localities. The more research-active we are as a Trust, the better care we will provide. Our involvement in large-scale clinical trials gives service users and carers access to treatments at the forefront of knowledge. In our work with the National Institute of Health Research (NIHR) and our collaboration with national and international academic partners, we contribute to the worldwide evidence base for mental health care. We seek to create a culture of enquiry within our services which welcomes innovation and challenge.

3. KEY ISSUES:

3.1. The Trust's existing R&D Strategy has five goals which have guided its activity since 2011. These are 1) to ensure the highest standards of research governance, 2) to achieve research-led improvement in quality of care, 3) to ensure public and patient involvement in all aspects of research, 4) to embed research across the Trust's geographies and specialities, and 5) to achieve a substantial increase in research income.

3.2. The Trust has made significant achievements on every goal of the strategy, but there are now new challenges to sustainability of research which require a renewed focus on maximising external research grants which are led by Trust clinicians. The new strategy emphasises this as a key consideration in developing both existing and new academic collaborations.

3.3. It is proposed that approval of the Strategy will be followed by the preparation of an Implementation Plan including options for development of existing and new academic collaborations, which will be completed by 31 October 2015.

3.3. The Trust's existing Research Governance Policy, due for review, is fit for purpose with the minor revisions included in the attached document. Further revisions will be required over the next six months to adapt procedures in response to new processes for research permissions led by the Health Research Authority (HRA). These will be incorporated and approved through the Research Governance Group when the requirements and their implications become clear.

4. IMPLICATIONS / RISKS:

4.1 Quality:

Research conducted in the Trust is compliant with the NHS Research Governance Framework and meets required quality and governance standards.

4.2 Financial:

The sustainability of the Trust's research income requires a robust strategy driving forward external research grant applications with university partners.

4.3 Legal and Constitutional:

The Trust's responsibility for the monitoring and standards of research activity involving its service users and staff are laid down in the Research Governance Framework. The R&D Office processes are designed to ensure compliance by all involved, via the Trust's Standard Operating Procedures for research. The Trust R&D Strategy and its implementation will seek to fulfil the NHS Constitution commitment to make research participant accessible to as many service users as possible.

4.4 Equality and Diversity:

The Trust's R&D Strategy explicitly seeks to ensure that wherever possible there is equity of access to research for service users and carers across the Trust's specialities and geographies.

4.5 Other Risks: None.

5. RECOMMENDATIONS

5.1. To approve the Research and Development Strategy and the timescale for preparation of an implementation plan.

5.2. To approve the revised Research Governance Policy.

Prof Joe Reilly
Clinical Director of Research and Development

Background Papers:
Research and Development Strategy 2015-2020
Revised Research Governance Policy

Tees, Esk and Wear Valleys NHS Foundation Trust

Research and Development Strategy 2015-2020

1. Purpose

To continue and expand the Trust's applied health research, delivering outcomes which matter to service users and carers.

2. Strategic context

2.1. The Trust is committed to an active programme of research and development as part of its Strategic Goal 2 *'to continuously improve the quality and value of our work'*. An active and well-embedded research and development programme delivers outcomes across all of the Trust's strategic goals.

2.2. For Strategic Goal 1 *'to provide excellent services'*, access to clinical trials for service users contributes to the effectiveness of their care and improves knowledge and use of clinical evidence by professionals.

2.3. In Strategic Goal *3 'to recruit, develop and retain a skilled, compassionate and motivated workforce'*, involvement in research and the Trust's links with research-led universities create opportunities for individual development and improve our wider education and training.

2.4. Research contributes to Strategic Goal 4 *'to have effective partnerships'* by establishing our place as a strong and effective partner in academic collaborations with universities.

2.5. In delivering Strategic Goal 5 *'to be recognised as an excellent and well-governed foundation trust'*, robust research governance procedures are essential.

3. Achievements and strengths

3.1. The Trust is now a research partner of choice for a number of academic institutions leading large scale clinical research funded by the National Institute of Mental Health, due to our record of delivery in clinical trials. This strategy follows up on the major progress made on the five goals of the Trust's 2010 R&D Strategy.

3.2. The Trust has established the MeHRY (Mental Health Research for the Young) collaboration within Durham University's Mental Health Research Group, with joint programmes of research in youth and primary care mental health, which has expanded academic leadership capacity.

3.3. There is a growing group of experienced clinician collaborators and investigators. The Trust has made a substantial contribution to the goals of the NIHR Clinical Research Network, reaching a peak of 7th of 56 mental health trusts for NIHR participant recruitment in 2014. We have achieved a doubling of annual research income to £700k.

3.4. There is improved research access for service users across all the Trust's current geographies and specialities. Service user and carer involvement in research has grown with the establishment of interest groups and the launch of YouthSpeak, the research involvement group for young people supported by the Durham University Mental Health Research Group.

4. Challenges

4.1. The development of the NIHR Clinical Research Network in 2006 created opportunities for the Trust as an organisation with little research track record to grow its activity quickly with substantial network funding.

4.2. The environment has now changed. Transition to the Local Clinical Research Networks (LCRN's) in 2014 has led to increasing challenge in terms of value for money and sustainability of a research portfolio which is heavily dependent on studies which are designed and led outside our LCRN area.

4.3. Lower participant recruitment has already led to reduced funding from the LCRN in the current year, and this is likely to reduce further even where recruitment is sustained. Moreover, the move of much of the work of NHS R&D permissions from Trust level to the Health Research Authority from 2015 onwards may mean reduced Clinical Research Network funding for the R&D Management and Governance function.

4.4. Beyond the Trust's current level of growth, its business model for Trust R&D is not sustainable in the longer term without the achievement of large scale external research grants which are locally led by Trust Chief Investigators, including University academics with honorary clinical status. Such grants will provide a more balanced and predictable income stream, together with the added benefit of NIHR Research Capability Funding in proportion to income, where grants are NIHR funded and Trust hosted. Over the next five years we can expect an increasing demand to demonstrate value for money and efficiency in our delivery of research.

5. Opportunities

5.1. The Trust has a growing group of service users and carers with both interest and expertise in research, who are highly motivated and able to make a much greater contribution.

5.2. There is continuing and growing potential for the achievement of large scale clinical trial and programme grants in partnership with Durham University and other institutions, including the University of York. Existing and new academic partnerships will focus even more clearly on areas of shared priority and capacity for both Trust and University.

5.3. The Trust has substantial presence and close joint working in a range of regional NHS structures including the Clinical Research Network, Academic Health Science Network and Strategic Clinical Networks, which can variously support research delivery, the application to practice and research-led improvement of care.

5.4. The Trust's Quality Improvement System presents great opportunity for leading initiatives to improve the process and efficiency of research delivery.

5.5. The Trust has established a pharmacy clinical trials function which is fit for purpose to deliver large scale complex drug trials including those in the commercial sector, with consequent access for service users to new treatments and additional capacity-building income.

6. Goals

The five R&D strategic goals below maintain continuity with progress over the last five years, with challenge to deliver at a higher level.

1. **Maintain excellent performance in the governance, management and delivery of research.** To do this we will

- Achieve the NIHR benchmarks for performance in the initiation and delivery of research
- Recruit to time and target for NIHR portfolio studies we lead, and contribute to the timely recruitment of studies we are partners in
- Contribute to the NIHR CRN North East and North Cumbria's achievement of NIHR High Level Objectives, and CRN NENC local strategic objectives
- Improve the efficiency of our research delivery using the Trust's Quality Improvement System, investing savings in expanding research capacity
- Train and support users and carers to participate in the management and delivery of our research
- Seek feedback from service users and carers on their experience as research participants and act to improve in response to this

2. **Move from collaboration to leadership in research.** To do this we will

- Work with academic partners to achieve large-scale applied clinical research grants which are led by Trust Chief Investigators (both

substantively employed clinicians and academics with honorary clinical contracts)
- Review and develop the Trust's existing research partnership with Durham University with a focus on achieving Chief Investigator-led grants.
- Develop new university collaborations in research areas where the Trust and academic partners have a shared priority, capacity and potential for achieving Chief Investigator-led grants.
- Invest in academic posts together with university partners to grow and sustain leadership of large scale research programmes.

3. **Ensure that our research drives improvement in care.** To do this we will

- Support academic collaborations with a commitment to applying research to service improvement and education within the Trust
- Raise the quality of the Trust's evaluation of its service developments, its implementation of evaluation findings, and the skills of the clinical workforce in this regard
- Continue to seek involvement as a partner organisation in large-scale multicentre clinical trials of new interventions, giving service users access to the latest developments in treatment
- Ensure effective dissemination across the organisation of the results of studies the Trust has participated in, to service users, carers and staff.
- Use research evidence to ensure the care we provide is effective and cost-effective

4. **Embed research access and participation** in all geographies and specialties of the Trust's services. To do this we will:

- Establish and achieve Trust targets for research participant recruitment in NIHR portfolio non-commercial and commercial studies
- Support the development of staff involvement in research, including the job planning of senior clinician research activity, and the provision of training opportunities across all clinical disciplines, managerial staff and postgraduate clinical trainees.
- Identify and support the development of talent in research, working with academic partners to develop individual research careers via Masters and PhD routes, including the support of external fellowship applications
- work with the Trust's service users and carers to give full access to research training opportunities open to staff, and to involve service users and carers in the design and delivery of research training in the Trust
- Support systems to enable participant access to research in line with the NHS Constitution, for example continued support of Join Dementia Research
- Effectively communicate about research the Trust is involved in, in ways that are easily accessible to users and carers, and available for the general public and potential partners
- Support the growth and development of user and carer research interest groups, which make a contribution at all stages of the research cycle, including the enhancement of research grant quality and research delivery.

5. **Substantial growth in research-related income for the** Trust, in order to robustly sustain the resources to achieve our goals. Our aim is a doubling of research income to £1.4 million by 2020. To achieve this we will:

- Establish and maintain the infrastructure and corporate systems needed to manage large-scale research grant applications, including joint arrangements where appropriate with NHS and university partners.
- Set annual goals for Trust Chief Investigator-led and Trust-hosted grant applications and income
- Respond rapidly to Expression of Interest opportunities for commercial research
- Work with academic partners on agreed shared goals for multicentre clinical trial and programme-level grants (over £1 million value) which attract direct grant income, associated research network income, excess treatment costs and subsequent research capability funding.
- Ensure service user and carer involvement in every grant application we lead or in which the Trust is a collaborating partner.

7. Scorecard Metrics

The Strategy's implementation plan will be monitored by a range of metrics, both those required by external stakeholders and measures which hold us to account on our progress in achieving the fullest service user and carer involvement in our research. The proposed metrics are:

- Quarterly NIHR performance metrics for the initiation and delivery of NIHR portfolio research, including achieving the first participant recruitment for each study within 70 days and the recruitment of studies to time and target
- Annual NIHR CRN North East and North Cumbria objectives where these have a measured organisational contribution
- Yearly targets for the submission of Chief Investigator led grant applications
- Annual goals for increase of overall Trust external research grant income, including secondary goals for commercial income, and the proportion of external research funding which is Trust-hosted and attracts RCF
- User and carer involvement demonstrable in 100% of studies
- Dissemination of results of studies with Trust involvement demonstrable in 100% of studies within one year of study closure
- User and carer experience of research involvement as measured by a Friends and Family Test or equivalent.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Policy Number:	**CORP/0050/v2**
Issue/Version No.:	**3**

RESEARCH GOVERNANCE POLICY

Current Status:	Revised awaiting approval

Compliance

All members of Tees, Esk and Wear Valleys NHS Foundation Trust staff will adhere to the parameters of trust policies. The consequences of non-compliance may include disciplinary action and/or legal action.

DOCUMENT CONTROL

Application	This policy pertains to all areas, departments and services of Tees, Esk and Wear Valleys NHS Foundation Trust
Associated policy reference and title	Not applicable
Date of Ratification	
Date of Review	
Replacing	CORP/0050/v1
Lead	Sarah Daniel R&D Manager
Members of working party	

This policy has been agreed and accepted by: (Director)

Name	Designation	Signature	Date
Dr Nick Land	Medical Director		

This policy has been ratified by:

Trust Board or Trust Board Sub Committee (specify) Clinical Governance and Clinical Risk Committee	Date
Executive Management Team	
This policy has gone through an equality impact assessment(EqiA)	Date of EqiA

Amendment
July 2011 Policy reviewed
2 August 2014 – Review date extended to 1 January 2015
6 May 2015 Review date extended to 30 June 2015

1. INTRODUCTION

1.1 The Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV NHS FT) recognises the importance of research for the successful promotion and protection of health and wellbeing. However, research can involve an element of risk, both in terms of return on investment and sometimes for the safety and wellbeing of the research participants. Therefore, correct governance of research is essential to ensure that the public can have confidence in, and benefit from, high quality research in health and social care.

1.2 The *Research Governance Framework for Health and Social Care*[1] was developed by the Department of Health to provide a framework for the governance of research. This framework has five core domains including:

- Ethics
- Science
- Information
- Health and Safety
- Finance and Intellectual Property

All those involved in research with human participants, their organs, tissue or data are responsible for adhering to these five legislated domains. Further details on each of these domains are documented in Appendix 1.

1.3 All NHS organisations must comply with the Research Governance Framework. Research governance is one of the core standards for health care requiring NHS organisations to have systems in place to ensure the principles and requirements of the framework are consistently applied. Health care organisations have to take this standard into account in discharging their duty of quality under *Section 45 of the Health and Social Care (Community Health Standards) Act 2003*[2].

1.4 TEWV is a partner organisation of the National Institute for Health Research Clinical Research Network: North East and North Cumbria (CRN NENC). TEWV is committed via the Partnership Agreement with the CRN to streamline research management and governance with a view to increase the amount of NIHR portfolio research carried out locally and in the UK as a whole.

2. PURPOSE

2.1 This policy provides a framework for the conduct and management of research across TEWV which is formulated with reference to the standards and guidelines outlined in the *Research Governance Framework for Health and Social Care* [1].

2.2 This policy facilitates a safe system of high quality research that enables improvements in patient care and greater organisational efficiency and effectiveness by:

- Enhancing ethical and scientific standards and promote good research practice
- Clearly defining accountability and responsibility for research governance
- Informing all staff of the appropriate procedures for conducting research within the NHS

3. SCOPE

3.1 This policy and procedure applies to all staff and external researchers who wish to undertake research within the Trust. Research is defined as the attempt to derive generalisable new knowledge, including studies that aim to generate a hypothesis, as well as studies that aim to test them This policy does not apply to audit or service evaluations. For guidance on the differentiation between research, audit and service evaluations, please see Appendix 2.

4. DEFINITIONS

4.1 A comprehensive list of definitions and links has been provided in Appendix 3.

5. RESPONSIBILITY AND ACCOUNTABILITY

5.1 All organisations conducting, sponsoring, funding or hosting health and social care research must have systems to ensure that they and their staff understand and follow the standards set out in the framework. A summary of the key responsibilities of people and organisations accountable for the conduct of research has been provided in Appendix 4.

5.2 The Chief Executive has overall responsibility for the strategic direction and operational management of TEWV, including ensuring that the Trust policies comply with all legal, statutory and good practice guidance requirements.

5.3 The Trust Board has responsibility for setting the strategic context in which organisational policies and procedures are developed, and for establishing a scheme of governance for the formal review and approval of policies.

5.4 The Clinical Director for R&D supported by the Research Governance Group has the following responsibilities::

- To ensure that the Trust's services fully implement the NHS Research Governance Framework.
- To establish appropriate working relationships with a range of Trust corporate departments and external partners critical to good research governance (including the NIHR Clinical Research Network).
- To ensure increasing user and carer involvement in all stages of the research process.

- To report to the Clinical Governance and Clinical Risk Committee on research governance matters.
- To contribute to the development of the R&D strategy and monitor its implementation

5.5 The R&D Manager is responsible for:

- Ensuring efficient systems are in place within the Trust to support the research process
- Research management and governance
- Streamlining research approvals procedures
- To manage implementation of R&D Strategy
- Day-to-day management of research activity

5.6 Researchers must::

- Ensure compliance with the Research Governance Framework
- Ensure all research has been approved by an appropriate Research Ethics Committee (REC)
- Comply with any current legislation and policy requirements relating to research and implement effectively
- Comply with Trust R&D Standard Operating Procedures
- Ensure patients, users and carers are provided with information on research that may affect their care
- Maintain a record of their research activity being undertaken in the Trust
- Notify the R&D department of any amendments, adverse incidents or complaints arising from the research
- Assist with monitoring and auditing when approached
- Submit progress and final reports to aid research monitoring
- Promote a quality research culture in the Trust

6 EQUALITY AND DIVERSITY STATEMENT

6.1 The Trust is committed to providing equality of opportunity, not only in its employment practices but also in the services for which it is responsible. As such, this document has been screened, and if necessary an Equality Impact Assessment has been carried out on this document, to identify any potential discriminatory impact. If relevant, recommendations from the assessment have been incorporated into the document and have been considered by the approving committee. The Trust also values and respects the diversity of its employees and the communities it serves. In applying this policy, the Trust will have due regard for the need to:

- Eliminate unlawful discrimination
- Promote equality of opportunity
- Provide for good relations between people of diverse groups

7. LEGAL AND PROFESSIONAL OBLIGATIONS

7.1 R&D approval of all research projects is addressed by a number of agreements, good practice guidelines and more recently by legislation. These include:

- Research Governance Framework for Health and Social Care [1]
- Healthcare Commission Core Standards [5] (Section C12)
- Declaration of Helsinki [6]
- International Conference on Harmonisation Good Clinical Practice [7] (ICH GCP)
- Medicines and Healthcare products Regulatory Agency [8] (MHRA)

8. TRUST R&D APPROVAL

8.1 All research projects taking place within the NHS must have Trust R&D approval before the commencement of any research activity. Projects may only commence at TEWV when a letter of approval, signed by the Clinical Director of R&D or an appropriate deputy, has been issued.

8.2 The Trust has an established organisational structure for managing R&D. The Research Governance Group provides assurance to the Quality Assurance Committee that all research projects have adequate consideration of: sponsorship; ethical review; scientific review; evidence of funding; safety of participants, researchers and other staff; Trust resource requirements; data protection and intellectual property.

8.3 The Trust has two research approval processes: 1) for those projects eligible and adopted on the NIHR portfolio (see Appendix 3 definition); and, 2) for projects which are not deemed eligible to be on the NIHR portfolio. The standard procedure for approving portfolio and non-portfolio projects are documented in the Standing Operating Procedures (SOPs): *'Approval of Portfolio Research Projects' and 'Approval of Non-Portfolio Research Projects'*, respectively. The Trust will follow the national standardised Central System for Permissions (CSP) for NIHR portfolio studies.

8.4 The Trust will process projects which have already gained approval from another NHS Trust more efficiently by accepting the initial checks undertaken, where possible.

8.5 The R&D Manager will ensure that the process of research approval is as streamlined as possible, and work with corporate departments to deal with barriers in the system which delay approvals.

8.6 The Research Governance Group will specifically report to the Quality Assurance Committee on any targets for time to research approval which the Trust is required to achieve, for instance within NIHR CRN objectives.

9. RESEARCH SPONSORSHIP

All research that takes place in the context of the NHS must have an identified research sponsor which takes overall responsibility for the proper initiation, financing, management and monitoring of the study. This could be the Chief Investigator's employing organisation, or the lead organisation providing care, or for commercially initiated research, the commercial company will act as research sponsor. Evidence of research sponsorship will be required before R&D approval is granted. The decision for The Trust to sponsor a project will be based on Trust priority, capability and impact on the organisation.

10. ETHICAL REVIEW

10.1 The dignity, rights, safety and wellbeing of participants must be the primary consideration in any research study. The Department of Health requires that research involving patients, service users, care professionals or volunteers, or their organs, tissue or data is reviewed independently to ensure it meets ethical standards. The NHS Research Ethics Committee (REC) is not accountable in any way to NHS Trusts, and in particular is separate from Trust Research Departments in respect of the accountability for their operational processes and decision-making. All studies must have appropriate arrangements for gaining consent. Particular care is needed for obtaining consent for children and vulnerable adults such as those with mental health problems or learning disabilities. Where ethical approval is obtained for research with participants lacking capacity to consent, the requirements of the Mental Capacity Act 2005 must be followed (Appendix 3).

10.2 Research applications for all REC approvals must be made using the Integrated Research Applications Service (IRAS) via http://www.myresearchproject.org.uk/

10.3 Evidence of a full favourable opinion from an NHS REC, including confirmation that the participant information sheet(s) and informed consent form(s) have been reviewed, is required before the Trust will grant R&D approval.

10.4 Significant changes or developments to research proposals, such as change in protocol, must be communicated to the REC approving the original research proposal.

11. SCIENTIFIC REVIEW

All existing sources of evidence must be considered carefully before undertaking research. Research which duplicates other work unnecessarily, or which is not of sufficient quality to contribute something useful to existing knowledge, is unethical.

Every proposal must be subjected to review by experts in the relevant fields able to offer independent advice on its quality. It is the research sponsor's responsibility to ensure adequate peer review is in place which is proportional to the scale of the research. For example:

- Research approved via CSP has been peer reviewed
- Externally funded research (i.e. from a research council or charity) - it is expected that peer review would have been undertaken as part of the application process.
- Commercial sponsored projects - it is the responsibility of the commercial sponsor to arrange peer review.
- Student projects - the peer review processes of the university involved should normally be adequate.
- Self-funded/ own account research where the Trust is to act as the research sponsor - the R&D department will arrange an independent peer review.

Evidence of a favourable peer review must be in place before R&D approval will be granted.

12. RESEARCH FUNDING AND FINANCE

The Trust does not directly fund research and funding for projects must be identified prior to R&D approval application. It is recognised that some non-portfolio studies, particularly conducted as part of postgraduate education, will not be externally funded, but any costs to services as a result of hosting such research should be acknowledged and minimised. All externally funded research projects should contain clear financial arrangements and should be realistically costed with support of the R&D Office in liaison with Trust Finance Department. Definitions of research funding types (service support, research costs and excess treatment costs) are found in Appendix 3 and the Trust R&D Office will advise and facilitate costing including allocation of an appropriate overhead.

Funding for commercially contracted research (funded and sponsored by a commercial company) should cover the full costs incurred including appropriate Trust overheads. For all commercial research at TEWV there will also be a non-refundable R&D fee.

All research income will be managed in separate research accounts within specific Trust departments. Trust budget holders are required to authorise all expenditure from the research accounts and all credits to budget accounts. The Trust Finance Department will monitor and report on accounts for research purposes in accordance with Trust finance policies.

The Trust receives NHS service support funding via the Clinical Research Network North East and North Cumbria (NIHR CRN NENC) in relation to its activity on NIHR portfolio studies. The R&D Manager will work together with the Trust Finance Department to allocate CRN funding appropriately, and will report back to the CRN on use of resources.

The R&D Office must be informed of all external grant funding applications which Trust staff are involved in, either as lead or co-applicants. This should occur before the application is submitted to allow assessment of whether the Trust can host the proposed research. R&D Office support is required for all external grant funding applications by Trust staff. The R&D Office will consult with the Finance Department as part of this process. Where external funding applications include Trust costs, costings should be obtained from the Finance Department.

Where an NIHR portfolio study requires Excess Treatment Costs to be met locally, the R&D Office should be informed as early as possible, so that any requests can be discussed with the Director of Finance and the Director Plannng and Performance, and included in annual commissioning agreements wherever possible.

13. CLINICAL TRIALS OF INVESTIGATIONAL MEDICINAL PRODUCTS

There is a strict legal framework within which clinical trials of Investigational Medicinal Products (ctIMPs) must be conducted. The EU Clinical Trials Directive and GCP Directive (transposed in UK Law through the Medicines for Human Use (Clinical Trials) Regulations 2004 (SI 1031) and Amendment Regulations 2006 (SI 1928), state that clinical trials must be carried out to the principles of Good Clinical Practice (GCP) based on Article 2 to 5 of the GCP Directive.

This legislation states it is against the law to start or conduct, or to recruit participants to a clinical trial involving a medicinal product until there is a favourable opinion from an ethics committee and a Clinical Trials Authorisation from the licensing authority, the Medicines and Healthcare products Regulatory Agency (MHRA).

The Trust will not issue Trust R&D approval for a ctIMP study without evidence of a favourable opinion for the study from the main REC and evidence that a Clinical Trials Authorisation has been obtained from MHRA. During risk assessment for ctIMP studies the Trust will also consider issues regarding the long-term management of patients at the end of the trial in terms of appropriate exit strategies relevant to each study. The Trust will also require confirmation.

that monitoring arrangements are in place for ctIMP studies (see section below on Audit and Monitoring) and confirmation of arrangements for safety reporting before Trust R&D approval will be granted.

14. USE OF PATIENT DATA

Data and information collected in the course of research must be recorded, handled and stored in a way that allows its accurate reporting, interpretation and verification to ensure data integrity. Furthermore, the appropriate use and protection of patient data should be paramount and particular attention must be given to systems for ensuring confidentiality of personal information.

The handling of personal information in research must be compliant with Trust information governance policies in relation to the Data Protection Act 1998 and any dataor confidentiality breaches must be reported using relevant Trust policy.

To ensure the security of systems used in research for data collection, storage and transfer of data, all uses of patient-identifiable data for research purposes must be reviewed by the Trust Caldicott Guardian.

All use of patient data for research purposes requires the consent of the patient. There are some exceptions where patient data can be used without consent under Section 60 of the Health and Social Care Act 2001. Requests for this use are now through the National Information Governance Board for Health and Social Care (NIGB) at http://www.nigb.nhs.uk/

Evidence of Caldicott approval must be provided for studies where patient identifiable information is required to be used in the research before Trust R&D approval is granted. If data is to be used for research without consent then evidence of approval from NIGB must also be provided to Trust R&D before approval will be granted.

15. PATIENT AND PUBLIC INVOLVEMENT

Service users and carers should be involved in the design, conduct, analysis and reporting of research. National organisations, such as INVOLVE (see http:www.invo.org.uk/), are working to support and promote active public involvement in the NHS and this includes involvement in research. Chief and principal investigators will be encouraged to consider PPI, as appropriate, in their research. Trust policies and procedures regarding PPI should be followed, including the provision of appropriate expenses.

The R&D Office will encourage investigators to include service user and carer representation on any steering groups in relation to research studies.

Appropriate training will be provided for service users and carers who become significantly involved in Trust R&D.

16. STUDY AGREEMENTS AND CONTRACTS

Before a piece of research can start, sponsors and host institutions need to have appropriate agreement in place which set out the responsibilities of the parties involved in research. The UK Clinical Research collaboration (UKCRC) and stakeholders have developed a suite of model agreements as follows:

- Commercial ctIMP studies: Commercial companies are expected to use the national model Clinical Trial Agreement (mCTA or CRO mCTA) for pharmaceutical companies working in the NHS.
- Commercial studies involving medical devices: Commercial companies are expected to use the national model Devices Clinical Trials Agreements (Devices mCTA).
- Non-commercial studies: non-commercial partners are expected to use the national non-commercial Clinical Trial Agreement (mNCA)

The model agreements can be found at:
http://www.nihr.ac.uk/policy-and-standards/standard-research-agreements.htm

Appropriate employment arrangements must also be in place for research staff. For NHS staff, evidence of their employment status will be required. Researchers not employed by any NHS organisation and requiring access to the Trust will be reviewed in accordance with the Research Passport Policy.

It is the responsibility of the Chief Investigator or Principal Investigator to ensure staff have the necessary contracts or letters of access in place before staff begin research work within the Trust.

All externally funded research will have contractual arrangements in place. All contracts must be signed by the Chief Executive unless delegated to Directors, or the Clinical Director for R&D.

17. RISK ASSESSMENT AND MANAGEMENT

Research can involve increased risks arising from the research activity as opposed to the baseline level of risk arising from normal clinical practice.

Risk should be assessed during protocol development to manage risk with patient autonomy and safety as paramount concerns. Risk will be controlled by systems in place to ensure that:

- Projects have a sponsor
- Projects are peer-reviewed
- Projects are approved by the Trust and by a REC
- Research proposals are taken through a staged approach of approval before the research can commence

- Sponsors and Researchers act within the Research Governance Framework
- Staff have appropriate training
- Research is appropriately audited and monitored

All proposals will be assessed for risk by the R&D Office. Where serious risks are identified which are anticipated to persist despite the above controls, a proposal will be formally discussed at the Research Governance Group and the Quality Assurance Committee as appropriate. R&D approval may in some circumstances not be granted until such discussions have taken place and agreement achieved.

Researchers should immediately notify the R&D Manager, the study sponsor and the main REC that originally approved the study of any unanticipated problems involving risks to subjects or others. In addition, all adverse incidents should be reported as documented in the appropriate Trust policies and procedures.

For ctIMP studies, the Research Sponsor is required to report unexpected serious adverse reactions to the Medicines and Healthcare Products Regulatory Agency (MHRA) within its deadlines, and, Researchers should follow the conditions of ethical approval (see Monitoring and Audit section for reporting ctIMPs).

The responsibility for project management of research lies with the chief or principal investigator, with appropriate delegation to other members of the research team (research assistants, clinical studies officers and other clinical colleagues). The R&D Office will offer support and advice on project management matters, and coordinate local steering groups for large-scale NIHR portfolio studies as appropriate.

18. MONITORING AND AUDIT

Organisations and individuals involved in research are expected to be able to demonstrate compliance with the Research Governance Framework and the requirements in legislation and regulations described within the Framework. Systems are required that should include a risk-based programme of routine and random monitoring and audit.

It is a statutory requirement that ctIMP studies are conducted in accordance with the principles of Good Clinical Practice (GCP). GCP is a set of internationally recognised ethical and scientific quality requirements which must be observed for designing, conducting, recording and reporting ctIMPs that involve the participation of human subjects. Compliance with GCP provides assurance that the rights, safety and well-being of trial subjects are protected and that the results of clinical trial are credible and accurate. Working to GCP standards involves meeting stringent criteria in respect of study documentation, safety monitoring and reporting, data capture and management, study monitoring, training of study personnel and study conduct

in general. Meeting these standards has significant resource implications in terms of time, personnel, equipment, software etc. It is imperative that investigators plan and budget for meeting these obligations of regular monitoring.

To ensure that all studies are carried out in accordance with the principles of GCP, all staff must receive GCP training on a regular basis. The Trust requires that GCP training is updated at least every three years. GCP courses are available through the NIHR CRN.

Safety reporting to MHRA is also a legal requirement which allows the authority to identify when trial participants are at increased risk and where to assess when a trial should be modified or stopped. Chief Investigators, Principal Investigators and Research Sponsors have responsibilities for the recording and reporting of adverse events or reactions within a ctIMP study. Certain types of events, (Suspected, Unexpected, Serious Adverse Reactions – SUSARs) have particularly strict requirements with expedited reporting of 7 days (fatal and life-threatening) and 15 days (non fatal or non -life threatening). All ctIMP studies must have appropriate arrangements for safety reporting clearly outlined in the study protocol.

A percentage of randomly selected research projects taking place across theTrust will be monitored and audited each year for compliance with the agreed research proposal and the standards in accordance with the Research Governance Framework. The Trust will ensure that all data, records and other materials are kept confidential. All Principal Investigators should maintain a Trial Site File with all relevant research documents and approvals. This must, on reasonable notice, be available for inspection.

19. INDEMNITY

TEWV provides standard NHS indemnity to compensate anyone harmed by negligence by its employees. The Trust does not provide compensation for non-negligent harm. NHS Indemnity may be extended to research partners, e.g., academic researchers, who are not directly employed by the NHS through honorary research contracts where appropriate (i.e., where the researcher has a direct bearing on the care on the Trust's patients). For non-commercial university-sponsored studies, the university may provide additional indemnity for non-negligent harm via its own insurance arrangements.

For commercial ctIMP studies, commercial companies will be expected to provide cover for negligent and non-negligent harm under the standard Clinical Trial Compensation Guidelines recommended by the Association of the British Pharmaceutical Industry. This should be clearly outlined in the Clinical Trial Agreement.

20. RESEARCH MISCONDUCT

Research misconduct includes, but is not limited to, the following, whether deliberate, reckless or negligent.

Misconduct in relation to grant applications and fund utilisation:

- Failure to obtain appropriate permission to conduct research
- Deception in relation to research proposals
- Fraud or other misuse of research funds or research equipment

Misconduct in relation to treatment of/ dealing with experimental subjects:

- Unethical behaviour in the conduct of research, e.g. in relation to research subjects
- Unauthorised use of information which was acquired confidentially
- Deviation from good research practice, where this results in unreasonable risk of harm to humans, animals or the environment

Misconduct in relation to analysis and reporting of findings:

- Fabrication, falsification or corruption of research data
- Distortion of research outcomes by distortion or omission of data
- Dishonest misinterpretation of results
- Publication of data known or believed to be false or misleading
- Plagiarism, or dishonest use of unacknowledged sources
- Misquotation or misrepresentation of other authors
- Inappropriate attribution of authorship

Misconduct in relation to misconduct of others:

- Attempting, planning or conspiring to be involved in research misconduct
- Inciting others to be involved in research misconduct
- Collusion in or concealment of research misconduct by others

The Trust's system for monitoring and auditing provides a mechanism for detecting any evidence of mismanagement, fraud or other scientific or professional conduct. Suspected fraud or misconduct will be investigated using the Trust's policies and disciplinary procedures.

21. RESEARCH DISSEMINATION

Established findings (positive or negative) should be published in a way that allows critical review and dissemination through the accepted scientific and professional channels. Information on research being conducted in the Trust

must be accessible to staff, the public and to all those who could benefit from the findings.

Information about what research is being conducted and what research has been completed will be made available to all staff through the Trusts intranet site. In addition, internal communications such as the Trust's internal magazine will be used to inform staff of research developments.

Research findings will be published in peer-review journals or other relevant publications where possible. The format will be subject to the specific journal requirements. Researchers are required to share their publication plans with the R&D Office and to submit a copy of any accepted papers to the R&D Office and Trust Library service, so that evidence of dissemination is held by the organisation.

22. INTELLECTUAL PROPERTY

NHS Trusts are required by the Department of Health to protect and manage intellectual property arising from R&D funded by the NHS. The Trust recognises the need for the wider recognition, improved understanding and increased protection of intellectual property facilities. Intellectual property within the North East NHS is exploited via Innovations North (The North East NHS IP Hub). The potential for generation of intellectual property will be considered by the R&D Office as part of the research approval process, and all intellectual property outputs from the Researcher's research activity in the Trust, should be declared to the R&D department for our records, e.g. peer-reviewed papers. Advice should be sought from the R&D Manager before publicly disclosing any work where there may be likelihood of intellectual property. Staff procedures to be followed in the event of the creation of commercially exploitable new knowledge should be consulted within the Trust Intellectual Property Policy.

23. STAFF TRAINING AND DEVELOPMENT

Appropriate staff training and development will be provided to improve knowledge of the research process, systems, guidance and support available so as to develop capacity, expertise and skills required to undertake research.

All staff undertaking research in the Trust should hold a certificate of Good Clinical Practice (GCP), within the past three years. Researchers are required to update their GCP training regularly to provide assurances to the Trust that they have the necessary skills to implement best research practices.

25. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed at least annually or when appropriate after changes in legislation or guidance. The R&D Manager is responsible for this review.

26. REFERENCES

1 Department of Health (April 2005) *NHS Research Governance Framework for Health and Social Care: Second Edition*. Accessed from: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

2 Office of Public Sector Information. (2003) Health and Social Care (Community Health Standards) Act 2003. Accessed from: http://www.opsi.gov.uk/acts/acts2003/ukpga_20030043_en_1

3 Department of Health (2008) The Operating Framework for 2009/10 for the NHS in England. London: Department of Health.

4 Department of Health (2006) Standards for Better Health. Accessed from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665

5 Department of Health (2008) World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. Accessed from: http://www.wma.net/e/policy/pdf/17c.pdf

6 International Conference on Harmonisation Good Clinical Practice (1996) Guidelines for Good Practice. Accessed from: http://www3.imperial.ac.uk/portal/pls/portallive/docs/1/49860.PDF

7 Medicines for Human Use (Clinical Trials) and Blood Safety and Quality (Amendment) Regulations (2008) Medicines and Healthcare products Regulatory Agency (MHRA) http://www.opsi.gov.uk/si/si2008/pdf/uksi_20080941_en.pdf

8 National Patient Safety Agency (2008) *National Research Ethics Service: Defining Research.* Accessed from: www.nres.npsa.nhs.uk

APPENDIX 1

Requirements of the Research Governance Framework

1. Ethics

The dignity, rights, safety and well being of participants must be the primary consideration of any research study.

- All research involving patients, service users, care professionals or volunteers, or their organs, tissue or data, is reviewed independently to ensure it meets ethical standards.
- All studies must have informed appropriate arrangements for obtaining consent and the ethics review process must pay particular attention to those arrangements.
- Protection of patient data is paramount, all those involved in research must be aware of their legal and ethical duties in this respect. Attention must be given to the systems developed for ensuring the confidentiality of personal information and to the security of these systems.
- Participants should be involved wherever possible in the design, conduct, analysis and reporting of research.
- Research should respect the diversity of human culture and conditions and take account of ethnicity, gender, disability, age and sexual orientation in its design, undertaking and reporting.
- Research may involve an element of risk. Risk must be kept to a minimum and explained clearly to the relevant ethics committee and to participants. Arrangements for compensation in the event of non-negligent harm must be explained.

2. Science

- It is essential that existing sources of evidence, especially systematic reviews, are considered carefully prior to undertaking research. Research which duplicates other work unnecessarily or which is not of sufficient quality to contribute something useful to existing knowledge is in itself unethical.
- All proposals must be subject to review by experts in the relevant fields able to offer independent advice on its quality. For many student research projects the university supervisor may provide adequate review.
- Research involving medicines is regulated under the Medicines Act. All trials of new medicinal products on people must be notified to the Medicines Control Agency. Research involving new medical devices is regulated by the Medical Devices Agency.
- Data collected in the course of research must be retained for an appropriate period to allow further analysis by the original or other research teams subject to consent and support monitoring of good research practice by regulatory and other authorities.

3. Information

- There should be free access to information on research being conducted and on the findings of the research, once these have been subjected to appropriate scientific review, this information must be presented in a format understandable to the public.
- Some advances in health and social care need to be developed commercially if they are to be made widely available, successful commercial development often depends on the protection of intellectual property or commercial confidentiality at critical points. The timing of the publication of research findings needs to take account of this.
- All those pursuing research must open their work to critical review through the accepted scientific and professional channels. Once established findings must be made available to those participating in the research and to all those who could benefit from them through publication and/or other appropriate means.

4. Health and Safety

- Research may involve the use of potentially dangerous or harmful equipment, substances or organisms. The safety of participants, research and other staff must be given priority at all times and health and safety regulations must be strictly observed.

5. Finance

- Financial probity and compliance with the law and rules laid down by HM Treasury for the use of public funds are as important in research as in any other area.
- Organisations employing researchers must be in a position to compensate anyone harmed as a result of negligence. Any organisation offering participant's compensation in the event of non-negligent harm must be in a position to do so.
- Careful consideration must be given to the appropriate exploitation of intellectual property (IP).

Adapted from: Research Governance Framework (2002)

APPENDIX 2

Research, clinical audit or service evaluation

Research	Clinical Audit	Service Evaluation
The attempt to derive generalisable **new** knowledge, including studies that aim to generate a hypothesis, as well as studies that aim to test them	Designed and conducted to produce information to inform delivery of best care	Designed and conducted solely to define or judge current care
Quantitative research – designed to test a hypothesis Qualitative research – identifies/explores themes following established methodologies	Designed to answer the question 'does this service reach a predetermined standard?	Designed to answer the question 'what standard does this service achieve?
Addresses clearly defined questions, aims and objectives	Measures against a standard	Measures current service without reference to a standard
Quantitative research – may involve evaluating or comparing interventions, particularly new ones Qualitative research – usually involves studying how interventions and relationships are experienced	Involves an intervention in use ONLY (the choice of treatment is that of the choice of the clinician and patient according to guidance, professional standards and/or patient preference)	Involves an intervention is use ONLY (the choice of treatment is that of the choice of the clinician and patient according to guidance, professional standards and/or patient preference)
Usually involves collecting data that are additional to those for routine care but may include data collected routinely. May involve treatments, samples or investigations additional to routine care.	Usually involves analysis of existing data but may include administration of simple interview or questionnaire.	Usually involves analysis of existing data but may include administration of simple interview or questionnaire.
Quantitative research – study design may involve allocating patients to intervention groups Qualitative research uses a clearly defied sampling framework underpinned by conceptual or theoretical justifications	No allocation to intervention groups: the healthcare professional and patient have chosen intervention before clinical audit.	No allocation to intervention groups: the healthcare professional and patient have chosen intervention before service evaluation
May involve randomization	No randomisation	No randomisation
ALTHOUGH ANY OF THESE THREE MAY RAISE ETHICAL ISSUES, UNDER CURRENT GUIDANCE:		
RESEARCH REQUIRES REC REVIEW	**AUDIT DOES NOT REQUIRE REC REVIEW**	**SERVICE EVALUATION DOES NOT REQUIRE REC REVIEW**

Adapted from: National Patient Safety Agency [9]

APPENDIX 3

Definition of Terms

Adverse Event: any untoward medical occurrence in a patient or clinical investigation subject administered a pharmaceutical product and that does not necessarily have a causal relationship with this treatment.

Caldicott Guardian: responsible for agreeing and reviewing internal protocols governing the protection and use of patient-identifiable information by the staff of their organisations.

Chief Investigator: the authorised health professional who takes primary responsibility for the design, conduct and reporting of a study.

Clinical Audit: 'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change' (Standards for Better Health, DH, 2004). Accessed from: http://www.dh.gov.uk/assetRoot/04/08/66/66/04086666.pdf

Costs: costs relating to research in the NHS are defined in the guidance note 'Attributing revenue costs of non-commercially funded research in the NHS' (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4125280). Three costs are distinguished:
Research costs- attributable directly to the research activity and met by research grant funding
NHS support costs- the costs to the NHS of hosting the research, now met by Trusts via research network funding
Excess treatment costs- treatment costs as a result of the research project which exceed those attributable to standard care, and are met through the normal commissioning arrangements for NHS care.

Indemnity: provides protection against any action by an individual, a group or an organisation that believe they received bad or negligent services, and incurred a loss as a result. Most professional bodies have professional indemnity cover; in some cases it is compulsory. The limit of an indemnity policy relates to the maximum amount of money that an individual or organisation will pay out in the event of a claim being made.

Integrated Research Application System (IRAS): a single system for applying for the permission and approvals for health and social care research in the UK. See http://www.myresearchproject.org.uk

International Conference on Harmonization Good Clinical Practice (ICH GCP): an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. Compliance with this standard provides public assurance that the rights, safety and well-being of trial subjects are protected; consistent with the principles that have their origin in the Declaration of Helsinki, and that clinical trial data are credible. See http://www.emea.eu.int/pdfs/human/ich/013595en.pdf

Medicines and Healthcare products Regulatory Agency (MHRA): the Executive Agency of the Department of Health protecting and promoting public health and patient safety by ensuring that medicines, healthcare products and medical equipment meet appropriate standards of safety, quality, performance and effectiveness, and are used safely. See http://www.mhra.gov.uk/

Mental Capacity Act 2005: Places clear responsibilities on researchers seeking participants lacking in capacity (see Trust MCA guidance)

National Institute for Health Research Coordinated System for gaining NHS Permissions (NIHR CSP): a system for gaining permissions from all NHS organisations to undertake research. The system provides assurances to NHS hosts that the necessary preparations and checks have been completed, and that there is appropriate evidence of all the regulatory approvals, so that the NHS body can move quickly to confirm its permission and sign other agreements enabling a study to begin. It also ensures that a minimum set of information and documentation is available electronically to the research networks and NHS organisations that need it.

NIHR Portfolio: a national database of high quality studies which have been deemed eligible to receive NHS support.

National Research Ethics Service (NRES): a directorate within the Health Research Authority which provides help and leadership for Research Ethics Committees by

coordinating the development of operational and infrastructure arrangements in support of their work. See http://www.nres.npsa.nhs.uk/

Research: 'an attempt to devise generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods' (Research Governance Framework, DH, 2005).

Researchers: those conducting the study and bear day-to-day responsibility for the conduct of the research at the trial site.

Service Evaluation: 'a set of procedures to judge a pilot's merit by providing a systematic assessment of its aims and objectives, activities, outputs, outcomes and costs' (Newton, J., et al., *Journal of Management in Medicine* 2000; 14:37-47)

Suspected Unexpected Serious Adverse Reaction (SUSAR): All adverse events that are suspected to be related to an investigational medicinal product and that are both unexpected and serious are considered to be SUSARs.

United Kingdom Clinical Research Collaboration (UKCRC): is a partnership of organisations working to establish the UK as a world leader in clinical research, by harnessing the power of the NHS. Its aim is to re-engineer the environment in which clinical research is conducted in the UK, to benefit the public and patients by improving national health and increasing national wealth.

APPENDIX 4

Responsibilities for conducting research

Chief Investigator, Investigators and Researchers	• Adhering to TEWV Standing operating procedures (SOPs) for research • Developing proposals that are scientifically sound and ethical • Submitting the design for independent peer review • Obtaining Trust R&D approval from each NHS organisation involved in the study before any research activity begins and for submitting any amendments to the trust R&D approval for review at the same time as submitting these to the ethics committee. • Obtaining a favourable opinion from an ethics committee before any research activity begins and for obtaining approval for any amendments of the study. • For ctIMP studies, obtaining a Clinical Trials Authorisation from MHRA before any research activity begins and for obtaining approval for any amendments to the study. • Conducting the study to the agreed protocol (or proposal) in accordance with legal requirements, guidance and accepted standards of good practice. The investigator is also responsible for submitting any amendments to the protocol to the ethics committee, to Trust R&D and MHRA (if applicable) and for having a robust system for ensuring the latest version of the protocol is always used. • Ensuring that all participants in the study are appropriately consented before any research activity begins using a patient information sheet and consent form approved by the ethics committee. • Preparing and providing patient information sheets for participants that have been reviewed and approved by the ethics committee and for ensuring that any changes are submitted to the ethics committee for review. • Ensuring participants' welfare while in the study. • Controlling the research budget and ensuring financial probity during the course of the research project. • Ensuring all staff are appropriately trained and qualified for the tasks delegated. • Ensuring that all staff have appropriate contracts with this NHS (substantive contracts, honorary research contracts or letters of access) before beginning work on the research project. • Arranging to make findings and data accessible following expert review • Feeding back results of research to participants
Main Funder	• Assessing the scientific quality of the research as proposed • Establishing the value for money of the research as proposed • Considering the suitability of the research environment in which the research will be undertaken, particularly the experience and expertise of the chief investigator, principle investigator and other key researchers involved • Requiring that a sponsor takes on responsibility before the research begins.

Sponsor	Is responsible for confirming that everything is ready for the research to begin including: • taking the responsibility for putting and keeping in place arrangements to initiate, manage and fund the study • satisfying itself the research protocol, research team and research environment have passed appropriate scientific quality assurance • satisfying itself the study has ethical approval before it begins • for ctIMP studies, ensuring that a Clinical Trial Authorisation is in place and that there are arrangements for the appropriate handling of investigational medicinal products • satisfying itself that arrangements are kept in place for good practice in conducting the study and for monitoring and reporting, including prompt reporting of suspected unexpected serious adverse events (SUSARs) or reactions in accordance with the legal requirements for safety reporting.
Employing organisation	• Ensuring researchers understand and discharge their responsibilities • Ensuring studies are properly designed and submitted for independent review • Ensuring studies are managed, monitored and reported as agreed according to the protocol • Providing written procedures, training and supervision • Taking action if misconduct or fraud is suspected • Promoting a quality research culture.
Organisation providing care/ responsible care professional	• Arranging for an appropriate person to give permission for research involving their patients, service users, carers or staff before the research starts • Ensuring any such research is conducted to the standards set out in the Research Governance Framework • Requiring evidence of ethical review before recruitment to any research that effects their duty of care • Before recruitment to trials with medicines, responsible for ensuring there is evidence of a positive ethical opinion and Clinical Trial Authorisation • Retaining responsibility for the care of participants to whom they have a duty of care.

Adapted from: Research Governance Framework (2002)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 24 November 2015**

Title: **To consider the report of the Quality Assurance Committee**

Lead Director: **Hugh Griffiths, Non-Executive Director**

Report for: **Assurance/Information**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	
To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users	✓	Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs	✓	Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse	✓	Cleanliness and infection control	✓	Management of medicines	✓
Safety and suitability of premises	✓	Safety, availability and suitability of equipment	✓		
Suitability of staffing					
Requirements relating to workers	✓	Staffing		Supporting workers	
Quality and management					
Statement of purpose	✓	Assessing and monitoring quality of service provision	✓	Complaints	✓
Notification of death of a person who uses services	✓	Notification of death or AWOL of person detained under MHA		Notification of other incidents	✓
Records	✓				
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 24 November 2015**

Title: **To consider the 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 5 November 2015.

2. BACKGROUND INFORMATION

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 is also considered.

3. KEY ISSUES

The Committee received the bi-monthly updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from Forensic Services and the North Yorkshire localities.

3.2 Forensic Services LMGB – where key issues raised were:

1. Modelling the future bed reconfiguration and development and funding of community models to support the Fast Track initiative. There would be an allocation of funding for the North East and Cumbria region of £1.432m, for transition costs and community infrastructure, however the CCGs were still in discussions around the allocation of this funding.
2. The central management of the Datix system and recent changes to processes had impacted on local analysis, reporting and management within Forensic services.
3. The development of CRES plans without reducing IP staffing - it was noted that 94% of the CRES budget proposals were around IP services.

3.3 North Yorkshire LMGB – where key issues raised were:

1. Risk associated with long term sickness amongst medics in Scarborough and a recent reduction in Consultant cover for the telephone on call rota. This would be monitored by QuAG

2. Reduction to bed capacity during the works to be carried out on Ward 14 at Northallerton. This would be exacerbated by a lack of beds across North Yorkshire.

3. A lack of education provision to Tier 4 CAMHS by Middlesbrough Local Authority.

4. QUARTER 2 QUALITY ACCOUNT UPDATE

1. The Trust was on track to deliver against the quality priorities (85%), 23 out of 27 quality metrics for 2015/16.
2. The Trust had scored 40%, 4 of the quality metrics in quarter 2, with 5 reporting as red relating to unexpected deaths, patient falls, length of stay, completed clinical audits and resolution of complaints.
3. There was a small amount of risk to be highlighted around the recovery project and mandatory training, which was currently being re-written.
4. There were also significant pressures on social care and nursing homes across Teesside with some homes having closed leading to fewer places being available to discharge patients.

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.

5.1 Clinical Effectiveness Group

1. Improvements were being noted in recording 6 of the physical healthcare parameters (Lester tool) which would be monitored in preparation for the National CQUIN audit taking place in December 2015.
2. There had been deterioration in compliance levels around HDAT audit results. These had been escalated to SDGs and QuAGs. A Kaizen event would be led by the Chief Pharmacist informed by these audit results.
3. There had been amber rating following an audit of compliance with medicines management practical assessment of in-patient registered nurses. It was felt that this issue may, in part, relate to lack of awareness of the annual requirement to undertake this assessment.

5.2 Patient Safety Group

1. Since the launch of the new Datix system there had been more accurate and timely reporting, together with the backlog of incidents cleared. Issues had been raised by clinical teams mainly relating to information not being easily accessed from IIC. A comprehensive action plan was taken to EMT with plans and timescales to address all issues. This will continue to be monitored.
2. The Harm Minimisation (previous suicide prevention), project plan would be submitted to EMT in November 2015, with a full progress update would be provided to the November 2015 Patient Safety Group meeting

5.3 Patient Experience Group

1. Modern Matrons and the Head of Nursing were working with staff to look at staffing, handover and shift management, effective leadership and enhanced observations, following 2 complaints at Westerdale South.

5.4 Patient Safety & Patient Experience Data Report

The number of serious untoward incidents for Q2 was 18 which was a reduction of 7 compared to the previous quarter. Complaints had reduced to 46 in Q2 compared to

54 in Q1. PALS activity had remained static at 268. The number of episodes of seclusion had increased during Q2, with 24 compared to 20 in the previous quarter. The Quality Assurance Committee would give some consideration to combining the data from report with the Patient Experience Group and Patient Safety Group reports in future.

5.5 Equality, Diversity & Human Rights Steering Group Report

1. Work was ongoing to improve the levels of data completeness on PARIS, which were below the levels agreed by QuAC.
2. 95% of Trust staff had undertaken equality and diversity training, including bullying and harassment, which was in line with mandatory training needs.
   On this matter it was noted that e-learning had improved the training compliance and there were other options available, such as face to face. Some improvements to the e-learning training were also being worked through.
3. Working experience issues raised in the staff survey were being looked into, in particular bullying and harassment.

5.6 Drug & Therapeutics Report

The Trust would be going smoke free from March 2016. There not been an overall decision reached following a debate about the use of E-cigarettes, however in principle it had been agreed there may be a place for E-cigarettes within TEWV and a further discussion would take place at EMT. Draft documents with details of prescribers for E-cigarettes would be submitted in final format to the December 2015 Drug and Therapeutics Group meeting.

5.7 Safeguarding Children and Adults

The Committee had considered the 6 monthly update reports for both Children and Adults.

1. The Trust had continued to achieve compliance levels around Children's safeguarding training.
2. The safeguarding service in Hambleton & Richmondshire would be taken over by the Trust shortly following agreement at EMT.
3. The compliance around level 1 Adult training was 93.78% and 75.91% for level 2 training. It was anticipated that there would be 95% compliance by January 2016.
4. The domestic abuse agenda continued to grow, with increased referrals to MARAC. During Quarters 1 and 2 there had been more cases discussed at MARAC than for the whole of 2014/15.
5. There had been a risk identified following the inability of the Trust to meet the demands of meetings and sub group attendance from the 4 Safeguarding Adult Boards.

6. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

6.1 Compliance with CQC Registration Requirements, including Mental Health Act visit feedback summary report.

1. There had been a CQC inspection at Bootham Park on 8 and 9 September 2015 where concerns had been identified with the environment leading to patients being transferred to other units.
2. On 1 October 2015 York and Selby services had transferred to TEWV with the exception of Bootham Park.

3. On 2 October 2015 TEWV had submitted a request to the CQC to register non in-patient services at Bootham Park, including outpatient services, ECT, the Clozaril clinic and Section 136 Place of Safety.
   Following works to make the 136 suite fit for purpose a re-opening date had been fixed for 16 December 2015 – this will be dependent on CQC approval.
4. Mental Health Act team assessment of the detention papers for York and Selby inpatients/CTO's revealed that 10 patients had a lack of required documentation in their notes. Following an in depth search and after undertaking legal advice the 10 patients had been discharged via a Hospital Managers Panel.
   On this matter assurances were given that each individual patient had been written to with a full explanation and the CQC had been informed.

6.2.1 Health, Safety, Security & Fire Report - There were no matters of risk for the QuAC to note. 50% of staff had undergone training via the e-document version of health and Safety and Security Workbook.

7. IMPLICATIONS/RISKS

7.1 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.

7.2 Financial

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

7.3 Legal and Constitutional

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

7.4 Equality and Diversity

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

8. CONCLUSIONS

The Quality Assurance Committee received and approved all the corporate assurance and performance reports that were considered.
All risks highlighted were being addressed with proposed mitigation plans or where they were currently being managed, additional information and assurances were requested.

9. RECOMMENDATIONS

That the Board of Directors note the issues raised at the QuAC meeting and the confirmed minutes of the meeting held on 1 October 2015, (appendix 1).

Dr Hugh Griffiths, Non-Executive Director (Chairman of QuAC)

Appendix 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 1 OCTOBER 2015, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2PM

Present:
Mr Richard Simpson, Acting Chairman
Mrs Lesley Bessant, Chairman of the Trust
Mr Brent Kilmurray, Chief Operating Officer
Dr Nick Land, Medical Director
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr David Jennings, Non-Executive Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing and Governance, (for minutes)
Mrs Karen Atkinson, Head of Nursing
Mr Louis Bell, Back care Advisor, Quality and Risk,(for minute 15/175)
Dr Lenny Cornwall, Deputy Medical Director for Teesside
Mr Stephen Davison, Force Reduction Project Manager, (for minute 15/176)
Mrs Jo Dawson, Acting Director of Operations, Durham & Darlington, (for minute 15/164)
Miss Alexia Hardy, Project Manager, Quality & Risk, (for minute 15/167)
Mrs Jennifer Illingworth, Director of Quality Governance, (for minutes 15/166 & 15/168)
Mr Mark Lovell, Consultant Psychiatrist - Children & Young People Services (CYPS)
Ms Christine McCann, Associate Director of Nursing
Mrs Donna Oliver, Deputy Trust Secretary
Dr Ingrid Whitton, Deputy Medical Director (for minute 15/169)

Andrew Ellis, Jacqueline Sibanda, Jessica Shaw, Wallis Stabler and Lianne Savage - Students, University of Teesside.

15/161 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr Martin Barkley, Chief Executive, Mrs Barbara Matthews, Non-Executive Director, Mr Jim Tucker, Non-Executive Director and Dr Hugh Griffiths, Chairman of the Committee.

15/162 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 3 September 2015 be approved and signed by the Chairman of the Committee, subject to the following amendments:

(i) *Mr Richard Simpson, be added to those in attendance.*
(ii) *15/151, Patient Safety and Patient Experience Data Report. The next report would be presented to the **November 2015** QuAC meeting.*

15/163 ACTION LOG

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

The following updates were noted:

15/55 "Assurance measures and KPIs to be developed for the Physical Healthcare and Wellbeing Working group"
This matter was covered in minute 15/167.
Completed

15/81 "The Force Reduction Report would come back to QuAC every 6 months"
This matter was covered in minute 15/176.
Completed

15/114 "Update on 'off the record' discussions with other providers to check if the Trust was an outlier".
Completed

15/115 "Locality reports to include the top 3 concerns and assurances around these".
The locality reports now included this information.
Completed

15/117 "Clinical Effectiveness Report to include more information around levels of assurance as well as information".
This matter was covered under minute 15/166.
Completed

15/125 "Workforce Staffing Report to go to QuAC quarterly, with the first report focusing on recruitment and retention".
This matter was covered under minute 15/174.
Completed

15/136 "Report to go to Board of Directors detailing the current position for Children's Services in North Yorkshire".
Mrs Coulthard would be taking a report to the October 2015 Board of Directors meeting on this matter.
Completed

15/140 "Clinical Effectiveness Group reports to include clear statement position at the beginning of the report and appendices to be presented in a different format".
Completed

15/141 "Patient Safety Group Report – explanation required around the 96 outstanding Datix.
This matter was covered under minute 15/168.
Completed

15/142 "Investigate the spike in complaints received by AMH (54)".
Mrs Whitton reported that there were no specific issues to report in relation to this spike in complaints.
Completed

15/143 "Carer Support Strategy"
Further work would be needed to scope out the correct strategy and metrics for a Carer Support Strategy, along with leadership and milestones and an update would come back to QuAC in March 2016.

15/144 "Any correlation between the outbreak of D&V on Springwood and the nil return of audits for 2 months".
It had been confirmed by email following the October 2015 QuAC meeting, that there had been no essential steps data submitted for April and May 2015

from Springwood Malton and the outbreak of D&V occurred in May 2015. The IPC team would be conducting a further audit at Springwood on 8 October 2015 and the Modern Matron for the service would be informed. The outcome of this would then go to the Infection Prevention and Control Committee on 20 October 2015.

15/145 "Procedures – further discussion around the terms of reference for QuAC and the approval of clinical policies".
The outcome of these discussions would come back to the QuAC meeting in December 2015.

15/149 "CQC Compliance – discussion required at Board of Directors meeting in September 2015 around Bootham Park".

Completed

15/156 "Quarterly Force Reduction Report to be presented to October 2015 QuAC".
This was reported under minute 15/176.

Completed

15/164 DURHAM & DARLINGTON LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Durham & Darlington Services LMGB Governance report.

Mrs Dawson highlighted the top 3 concerns at present, which were:

1. A difficult and challenging complainant from a community team, which had included the use of social media and threatening language directed at members of staff by name. The police had been involved.
   On this matter it was noted that things had settled down, however this had taken up a considerable amount of time and energy for staff.

2. The demand for services across CYPS and AMH. There were actions in place to address this, including discussions with Commissioners.
3. Recruitment continued to be a challenge, in particular for C&YPS Band 6 posts and an ED Community consultant.

Arising from the report it was noted that:

(a) Fast track plans for the implementation of Transforming Care were currently underway, looking
at local plans and contingency services that would be needed in the community.
(b) There had been a very positive MHA review on Birch Ward, on 20 August 2015, with some positive feedback from patients.
(c) The crisis team had effectively dealt with some recent challenges, including a patient that had turned up to services in the early hours of the morning.
(d) There had been a case in the press recently regarding an NHS homicide review of a patient charged with the death of a lady in a home of residence.
(e) Care Plan scrutiny had revealed that 78 out of 166 patient records had been reviewed, however not in the previous 12 months and 22 of these records had no Care Plans, with only 50% including a Risk Assessment.

On this matter it was noted that there had been some further exploratory work undertaken by the service to check the validity of the data.

Following discussions it was noted that:

(i) Recruitment initiatives for CAMHS services in Peterlee for Band 5 and 6 posts were currently out to advert to recruit to vacant and temporary additional posts, with some re-training also being considered.
On this matter it was noted that some work was underway to look at how posts could be made more attractive for the future.

(ii) There was currently an issue in relation to a mismatch between those staff that had undertaken Safeguarding children training and methods of data collection. The data would be unpicked, as it was anticipated that the levels of compliance with this training was much higher.

(iii) There were currently delays for patients securing wheelchairs as there were pressures on the adaptation services.
The Trust Occupational Therapy lead was working actively with community services to try and come up with some solutions.

(iv) Training around Paris version 6 now included Clinicians in order to help with implementation and further support would be given to services, where staff would be guided in using Paris to ensure learning of the adaptations.

(v) Covert medication had been raised as an issue following a MHA report at Ceddesfeld MHSOP services.
This had been an isolated incident, which was disappointing; however an action plan had been developed.

15/165 TEES LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Tees Locality Governance Report.

Dr Cornwall highlighted that the top 3 concerns at present were:

1. Capacity and demand – There were increased referrals to both access and affective services, particularly in SouthTees after TEWV had ceased the IAPT services at the end of June 2015.
Current activity levels would be compared with future demands and discussed with Commissioners. On this matter it was noted that some staff might have to be re-deployed.

2. Issues with access to EMI nursing beds due to long waiting lists in Hartlepool and the impact on MHSOP services. There were currently 2 EMI nursing homes closed to admissions; however 1 was expected to re-open shortly.

3. There had been significant improvement in waiting times in Stockton, however the key issue would be around sustaining these improvements with demand.

Following discussion it was noted that:

(a) There had been a collective grievance submitted from staff at Roseberry Park concerning staff breaks.

On this matter it was noted that this had now been dealt with and new rest break guidance had been issued to staff, this had been agreed at EMT, however had not been agreed with Staff Side. A proposal had been put forward that nurses could take a break away from the main clinical area or just off the Ward, whilst maintaining responsibility for the keys.

(b) There had been pressures on Westerdale South, due to vacancies and sickness.

Mrs Bessant suggested that more work should be done to address staff fatigue and this should be re-visited. Mrs Atkinson, Head of Nursing would be supporting staff going forward.

(c) The health quality framework, which was 100 pages in length, for proposed outcome measures would be reduced to a more practical size.
(d) The inpatient work from Bootham Park had effectively been absorbed by TEWV, which clearly demonstrated the hard work and commitment of staff, which should be recognised.
(e) The Trust had scored lowest in England regarding levels of "paired measure completion and consent being confirmed on Paris"
This related to Children's IAPT services and the impact on data. Paris would be checked to ensure there would be no further duplication.
(f) It was anticipated that the imminent plans to close the steel works on Teesside would have some impact on services, which would be absorbed in the normal workload in IAPT services.
(g) There had been a deterioration in resuscitation following some new guidelines and changes to training.

15/166 CLINICAL EFFECTIVENESS GROUP ASSURANCE REPORT

The Committee received and noted the Clinical Effectiveness Group Assurance Report for August 2015.

It was highlighted from the report that Baseline audits had revealed low compliance with recording the 6 physical healthcare parameters, which were a requirement of the Lester tool and would be monitored as part of the national audit in December 2015 for CQUIN 4a.
The extensive Physical Healthcare Project would continue across the Trust and Specialties would facilitate clinical actions to mitigate identified risks.

Arising from discussion it was noted that:

(a) There were currently discussions underway around an effective strategic framework for monitoring NICE guidelines in the Trust.
(b) Items 4 and 6 in the report around strategic objective scorecard progress and monitoring of key performance indicators should include narrative and explanation to provide more assurance.
On this matter the Committee were assured that any matters not resolved would be brought back to QuAC for further consideration.

15/167 PHYSICAL HEALTH CARE AND WELLBEING REPORT

The Committee received and noted the Physical Healthcare and Wellbeing Group report for the period April to August 2015.

Arising from the report it was noted that:

1. One of the issues raised at the quarterly Physical Healthcare and Wellbeing Group was the need to develop an SBARD around an agreed data set for taking patient blood tests on admission to ensure standardisation.
2. The Procedures around the Early Detection and Management of the Deteriorating Patient had been updated.
3. Following recommendation by QuAC in April 2015 consideration had been given to developing some KPIs for the Physical Healthcare and Wellbeing Group; however it

was not felt that this would be appropriate for this particular Sub group of the Quality Assurance Committee.

On this matter it was noted that:

(a) A review of this group, along with other Sub-groups of QuAC had commenced and would take place over the autumn months of 2015, with an anticipated outcome intended for December 2015/January 2016. It would be important to refresh the purpose of the Sub-groups in accordance with governance regulations, in order that they could report through and give assurance to the Committee.
(b) Consideration and debate had been given to the complexity in the detail around levels of assurance and providing 'safe' care for patients.

Following discussion it was noted that:

(h) With around 300 incidents reported onto Datix per month, it would be important to ensure that trends were examined, supportive action plans were in place and that lessons were being learned and shared.
(i) The guidance for the Trust set out in the key lines of enquiry provided definition around what is meant by 'safe' and well led and this would be the starting point for defining the Sub-groups.

15/168 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee considered and noted the report of the Patient Safety Group from the period August to September 2015.

Arising from the report it was highlighted that:

1. There were currently major changes taking place to the Datix system to improve the ability to give assurance and for analysis of any patterns and trends.
2. Following discussion by the Group to resolve outstanding Datix the Director of Quality Governance would be taking any issues to OMT with an up to date position provided by the Quality Team.
3. All outstanding incidents on Datix had now been cleared and the focus would be on monitoring the actions in place.
4. There was ongoing debate around SUIs and the need for clear and concise information to be entered onto Paris. All incidental findings would be reviewed by the Head of Nursing in localities to identify any patterns, which would be fed into Trust wide quality improvement work.
5. KPIs would now be managed within the Quality Data Team; however there was some question as to whether these were still the appropriate indicators to use.
6. The Patient Safety Bulletin, September 2015 had been included with the report, setting out incidents of patients care, (themes) and messages from lessons learned. This would be reviewed regularly to provide the current set of themes and messages, intended to change behaviours and improve patient care.
7. There would now be a separate allegation stream within the Datix system. This would prevent it being reported to NRLS or IIC until it became a proven incident.

Following discussion it was noted that the Patient Safety bulletin had been well received by the Committee. Members had found it to be very informative, especially since challenging issues around Westwood had been picked up.

15/169 PATIENT EXPERIENCE GROUP ASSURANCE REPORT

The Committee received and noted the Patient Experience Group Assurance Report for the period 18 August to 18 September 2015.

Arising from the report it was highlighted that:

1. The outstanding actions around complaints had steadily decreased, with no overdue outstanding action plans in September 2015. 1 overdue complaint in Durham was currently being resolved by the Complaints Manager.
2. All Wards had achieved 100% Friends and Family results for 2 consecutive months, 5 CMHTs had achieved 100% and 1 at 90%.

15/170 SAFEGUARDING CHILDREN EXCEPTION AND ASSURANCE REPORT

Mrs Agar provided a verbal update around Safeguarding Children.

There were 5 ongoing serious case reviews that the Trust was involved in, 3 in Redcar around sexual exploitation and 2 in Durham, 1 which was almost complete involving the crisis team and a young baby.

A 'Review of health services for Children Looked After and Safeguarding in Middlesbrough' had been published on 15 September 2015 with a recommendation for TEWV and the CCG, which was to ensure that early help services for children requiring access to Tier 1 and 2 services for emotional health and well-being were strengthened'.
On this matter it was noted that CAMHS had submitted their action plan and good evidence had been found around multi-agency working, with positive feedback around adult mental health services.

15/171 SAFEGUARDING ADULTS ASSURANCE REPORT

Mrs Agar provided a verbal update on safeguarding adult issues:

The incident in Hartlepool involving 2 young girls and a vulnerable adult had been delayed to February 2016, due to social media issues around the trial.
For the teams working to support adults and children the workload had been increasing around domestic abuse, together with a large number of individuals known to the Trust that were reported on.

15/172 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee considered and noted the position of compliance with Care Quality Commission registration requirements.

Arising from the report it was highlighted that:

1. The Trust awaited the full report following the CQC compliance inspection at Bootham Park, however there had been concerns identified around safety and environmental issues and patients had subsequently been moved to other Hospitals.
2. The formal agreement from the CQC had been received to register application for 7 services in the Vale of York, (except Bootham Park).
3. The report included a Mental Health Act Bulletin setting out specific topics around physical healthcare, medicines management and bed management.
4. There were ongoing CQC regulation breaches in connection with mixed sex accommodation at Acomb Garth, AMH rehabilitation Ward in York and Selby. Plans

were in place to address these environmental issues, which also included ligature points.

5. A publication had been issued for consultation seeking views on the new 'National Guardian for the NHS', which the Trust would respond to in due course.

Following discussion it was noted that there had been some excellent feedback in recent MHA reports and staff should to be commended on their hard work.
On this matter it was noted that staff were emailed any positive feedback and some staff put forward for team of the week award.

15/173 FUNDAMENTAL STANDARDS PATIENT AND CARER GROUP REPORT

The Committee considered and noted the Fundamental Standards Patient and Carer Reference Group.

From the report it was highlighted that the programme of mock inspections had continued and members of the Group had been included in the inspections.

15/174 WORKFORCE STAFFING REPORT (RECRUITMENT & RETENTION)

The Committee considered and noted the Workforce Staffing Report focusing on recruitment and retention.

The report included a covering paper with 3 appendices, which were:

(1) The recruitment and retention report.
(2) Springwood Workforce Information.
(3) The medical staffing report for the period 1 April to 31 August 2015.

Mr Levy drew attention to the following from the report:

(a) Recruitment of nurses was an ongoing issue for the Trust. The number of newly qualified registered nurses appointed in the reporting period had fell by 31% and further work would be undertaken to understand the impact on services.

On this matter it was noted that between August 2014 to July 2015, 5 advertisements for staff nurses had resulted in 4 of the appointments not being made. Private Healthcare providers located in the York area were competitors for nursing vacancies and the messages coming into the Trust were that York offered an attractive working environment for nurses.

(b) A nurse recruitment plan for York services would be developed following the transfer of these services to TEWV.
(c) The Trust did not believe that paying recruitment and retention premiums for nurses should be pursued at the present time.
(d) It was recognised that International recruitment of nurses was proving difficult for Acute Trusts to gain sponsorship, however should recruitment prove increasingly difficult for TEWV then this would be considered.
(e) A publication 'Mind the Gap' highlighted the expectations of new nurses and the Trust would need to respond to these in order to recruit and retain nurses in the future.
It was clear that nurses expected more work life balance, with job sharing and flexible working and at the present time 30% of the Trust workforce was working part time hours.

Following discussion it was noted that:

(i) The Trust would work towards a nursing recruitment strategy, taking into account career frameworks, in partnership with local Universities.
(ii) A centralised recruitment process would enable the Trust to appoint people that had been interviewed on a "call off list".
(iii) Over appointing and employing 2 suitable candidates from 1 interview round would support the overall recruitment problems.
(iv) The nursing recruitment project would be discussed further with Nursing and Governance

Action: Mrs C McCann/Mr D Levy

15/175 MEDICAL DEVICES COMMITTEE REPORT

The Committee considered and noted the Medical Devices and Clinical Procedures Working Group for the period January to May 2015.

It was highlighted from the report that:

(1) SBARDS had been issued in relation to using needles and recording medication details in Care Records.
(2) Safer sharps would now have to be ordered through Cardea.
(3) A recent audit had identified that quality control checks in relation to the blood monitoring audit tool were not being completed. In response to this all in patient areas would be audited against the audit tool and the Infection Prevention and Control Nurses (IPCNs) would carry out validation checks as and when necessary for 2015/16.
(4) Audit North had completed the planned audit of medical devices management and the final report would be discussed at the Medical Devices Committee meeting in October 2015.

15/176 QUARTERLY FORCE REDUCTION REPORT

The Committee considered and noted the Force Reduction Project report.

It was highlighted from the report that:

(1) The project overall, whilst being challenging in some areas, had remained on track and was progressing well.
(2) Some tweaks had been made to the application of the project in Westwood, with more intense support for staff due to the complexity of patient care. This had given a better understanding of the depth of the issues that surround this work.
(3) Implementation of the original objectives had seen some positive results in the reduction of C&R in pilot areas where PBS and Safe wards had been introduced. Regular and transparent reporting was now also in place.
(4) There was currently a review underway to look at training models and policy, which would be key priorities for the project team.
(5) It was pleasing to note that the project team had been invited to present at the European Conference for Restraint Reduction in November 2015.
(6) A key element of the Project would be about identifying the best standardised process of debriefing, both for staff and patients following the use of restrictive intervention.
A working group was currently developing a draft process on debriefing that could be used across services.

Further to discussions it was noted that it was difficult to establish any direct correlation between the statistics that demonstrated seclusion going up, rapid tranquilisation and restraint going down.
This was being monitored closely and compared to the national picture.

Agreed: To make some comparisons with pilot sites and similar types of wards elsewhere in order to interpret the data more meaningfully.

Action: Mr S Davison

15/177 EXCEPTION REPORTING (LMGBs, QAC sub groups)

There was nothing to note under this item.

15/178 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD

The matter of recruitment should be escalated to the Board Planning Day.

15/179 ANY OTHER BUSINESS

There was no other business to note.

15/180 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 5 November 2015,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 4.45pm

……..

Dr Hugh Griffiths
CHAIRMAN
5 November 2015

ITEM 8

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 24 November 2015**

Title: **To consider the "Hard Truths" monthly Nurse Staffing Update Report**

Lead Director: **Elizabeth Moody, Director of Nursing and Governance**

Report for: **Information and assurance**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of our communities	
To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse	✓	Cleanliness and infection control	✓	Management of medicines	✓
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers	✓	Staffing	✓	Supporting workers	✓
Quality and management					
Statement of purpose	✓	Assessing and monitoring quality of service provision	✓	Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS EXECUTIVE SUMMARY

Date of Meeting: **Tuesday, 24 November 2015 – Referring to October 2015 data**

Title: **To consider the "Hard Truths" monthly Nurse Staffing Update Report**

1.0 Introduction

To advise the Board 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 October 2015 data.

1.1 Summary of Key Issues

- The month on month trend for October only shows one of those indicators as 'red' whilst other fill rates are reporting as 'green'.
- The number of wards showing as 'red' has increased in October when compared to the previous month. This could be in relation to the additional York and Selby inpatient wards that have been added to the report this month. Durham & Darlington have the lowest number of red wards. Forensic services have the highest number of red wards although there is a reduction this month.
- The staffing fill rates has highlighted Jay Ward as having the lowest fill rate this month as a result of sickness and maternity leave.
- The highest fill rate and high bank usage was identified as Westerdale South during the reporting period
- Worsley Court was identified as having the highest agency usage due to being short staffed.
- In terms of the triangulation:
  - Westwood have had a level 3 incident, high staffing fill rate and incidents requiring control and restraint
  - Bransdale have had complaints, a low staffing fill rate and bank usage in excess of 50%.

1.2 Significant Risk

Triangulation of staffing and quality data has not identified any direct risks or implications to patient safety or experience within the reporting period.

1.3 Recommendations

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

Emma Haimes
Head of Quality Data
November 2015

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 24 November 2015 – Referring to October 2015 data**

Title: **To consider the "Hard Truths" monthly Nurse Staffing Update Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board 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 October 2015 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 65 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

Work continues to rationalise the report to ensure that the monthly report focusses exclusively on providing assurance that the staffing levels were safe.

This month's report incorporates the York and Selby inpatient wards. The information has been provided to us by Leeds Partnership Trust in the absence of the inpatient areas being on our HealthRoster system. Agency usage has been difficult to obtain and at the time of reporting this report the bank usage was not available. All of this may have impact on the overall staffing fill rates for York and Selby.

3. KEY ISSUES:

3.1 Safe Staffing Fill Rates

3.1.1 The daily nurse staffing information aggregated for the month of October 2015 is presented in Appendix 1 and 2, with locality information in Appendix 3.

The total number of rosters during the month of October 2015 equates to 72 as a result of the York and Selby inpatient wards. This is an increase of 7 wards from the previous month.

Abdale House moved into The Orchard on the 3rd August 2015 however, the electronic roster has not been amended to reflect this change therefore throughout this report the unit will be referred to as Abdale House.

3.1.2 The month on month trend report shows a continued improvement with 3 of the 4 metrics. Registered nurse on day shifts is the only one showing as 'red' all other metrics are showing 'green' when compared to the previous month:

Month	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Sep-15	90.3	↑	113.6	↑	98.20	↑	112.6	↑
Oct-15	89.7	↓	116.9	↑	100.30	↑	112.9	↑

The position in October was that there were 49 wards who had fill rates of less than 89.9% (shown as red) across both staff groups for all shifts. This is an increase of 6 on the previous month as illustrated below:

Month	October	September	August	July	June	May
No. of Red Wards	49	43	49	41	38	36

The majority of the red wards fall into the Registered Nurse on Day shifts category where there were 35 wards shown as red in October compared to 33 in September 2015.

3.1.3 A deterioration can be observed in Teesside and North Yorkshire with the number of red wards increasing. The forensic services although they have the highest number of red wards with 14 this is a reduction on the previous month whereby there were 20 red wards. The table below shows the split across all localities over the last 6 months with the full detail available in appendix 3 of this report:

Locality	Number of wards red across all metrics						Trend on previous month
	Oct-15	Sept-15	Aug-15	Jul-15	Jun-15	May-15	
Durham and Darlington	5	5	6	3	3	3	→
Teesside	10	8	9	10	6	6	↗
North Yorkshire	13	10	10	11	8	7	↗
Forensics	14	20	24	17	21	20	↘
York and Selby	7	N/A	N/A	N/A	N/A	N/A	

3.1.4 The lowest staffing fill rate relates to Jay Ward who are reporting 55.3% for Registered Nurse on Day Shifts during October. The breakdown over the last 6 months is as follows:

	Oct-15	Sep-15	Aug-15	Jul-15	Jun-15	May-15
Jay Ward	55.3%	80.2%	72.2%	78.2%	84.7%	85.2%

The ward has articulated that the low fill rate was in relation to sickness and maternity leave. To mitigate this the ward has advised that they have used additional HCA to cover some of the shortfall. This is evident in the fill rates in that the HCA day figure is 121.0%.

The second lowest fill rate relates to Cedar (NY) for Registered Nurse on Nights which has been at this position for a couple of months. The October position shows an increase to 56.6% when compared to 47.8% in September as outlined below:

	Oct-15	Sept-15	Aug-15	Jul-15	Jun-15	May-15
Cedar (NY)	56.6%	47.8%	54.2%	48.0%	106.9%	115.8%

The ward has articulated that the low fill rate was in relation to 1 qualified only working a night duty and the electronic roster is currently set up for 2 RN's to work nights. The HCA fill rate for days (153.6%) would suggest that they have flexed the staff to cover some of the shortfall.

The third lowest fill rate relates to Bransdale (RN on Day Shifts) which is reporting at 57.2% which is a decrease on the previous month whereby this was reporting at 68.6%. The 6 month trend for Bransdale is as follows:

	Oct-15	Sept-15	Aug-15	Jul-15	Jun-15	May-15
Bransdale	57.2%	68.6%	69.3%	63.7%	69.9%	78.5%

The ward has articulated that the low fill rate was in relation to 1 registered nurse on long term sick and another on an alternative to suspension. It is evident that they have flexed their staffing to cover the shortfall (HCA fill rate for days equates to 178.0%) utilising bank workers.

There were 5 other wards that had low fill rates between 61.8% and 69.9%, interestingly all of these were in relation to RN Day Shifts as articulated below:

	Oct-15	Sept-15	Aug-15	Jul-15	Jun-15	May-15
Oak Ward	61.8%	46.8%	75.9%	85.0%	79.8%	95.2%
Overdale Ward	64.2%	61.3%	68.0%	68.2%	79.7%	58.4%
Bilsdale	68.0%	81.6%	63.6%	68.8%	75.3%	83.6%
Ward 15	69.5%	65.1%	77.6%	75.2%	81.0%	66.2%
Newbery Centre	69.9%	62.6%	76.0%	70.2%	81.6%	87.1%

3.1.5 It is also important to review the fill rates that exceed their budgeted establishment (shown in blue). During the month of October there were 51 metrics that had staffing in excess of their planned requirements to address specific nursing issues. This is an increase when compared to September where there were 39.

Westerdale South saw the highest fill rate indicators during the month of October (321.2% and 253.3%). This is now the third month in a row they have been in this position. October fill rate is as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westerdale South	87.3%	321.2%	100.0%	253.3%

The ward has reported that the excess was used to cover enhanced observations and high levels of sickness.

The second highest fill rate indicator was Cedar ward with 206.9% as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Cedar	115.0%	206.9%	103.3%	169.6%

Feedback from the ward was not available at the time of writing this report to advice of the reasons for over staffing the ward.

Westwood Centre had the third highest fill rate of 206.5% during the reporting period as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westwood Centre	102.3%	118.9%	104.8%	206.5%

Westwood has advised that the blue metric are reflective of the ongoing level of enhanced observations, patient transfers, outpatient appointments and increased acuity on the ward.

From those wards that had blue fill rate indicators during the reporting period the majority were for unregistered day shifts.

3.1.6 Appendix 6 highlights the usage of Bank Staffing, as a proportion of actual hours. These are 'RAG' rated independently of the overall fill rate. At the time of writing the report we did not have the York and Selby data. Those wards using greater than 50% bank staffing to deliver their fill rates are identified below:

Locality	Ward	Bank Usage	Comments
Teesside	Westerdale South	87%	Increase on the previous month whereby bank was 74%
Durham & Darlington	Cedar Ward	66%	Increase on previous month whereby bank was 52%
Forensic Services	Merlin	62%	Decrease on the previous month whereby bank was 66%
Teesside	Bransdale	53%	Increase on the previous month whereby bank was 35%
Teesside	Bedale	51%	Increase on the previous month whereby bank was 39%

40 wards were reported as Amber (between 10 and 40%), this is a reduction on the previous month of September (47 wards) and August (43 wards).

From those wards highlighted this month as the biggest users of bank, the month on month trend is identified as follows:

	October	September	August	July	June	May
Westerdale South	87%	74%	74%	73%	50%	45%
Cedar Ward	66%	52%	52%	57%	55%	57%
Merlin	62%	66%	66%	46%	28%	43%
Bransdale	53%	35%	20%	29%	27%	27%
Bedale	51%	39%	44%	59%	41%	44%

As noted in previous reports there are risks in high use of bank staffing, these are mitigated by the use of regular bank staff who know the clinical areas, through previous regular bank work, being permanent staff working extra hours or previously employed staff/students. There is work ongoing to ensure all bank workers have had the required competencies assessed and passed.

3.1.7 When considering staffing levels it is also important to consider the amount of agency worked within the reporting period. During October there was a total of

238,510.32 hours worked across the trust of which 1,421.50 were agency hours, equating to 0.60% of the total hours worked.

The table below shows the breakdown of agency hours worked by locality and ward:

Locality	Ward	Total Agency Hours	Reason for using Agency
York and Selby	Worsley Court	720.00	Short staffed
North Yorkshire	Springwood	269.0	Enhanced Observations and Training
York and Selby	Peppermill	176.0	Short staffed
North Yorkshire	Rowan Ward	95.5	Sickness and Escort
York and Selby	Cherry Tree	84.0	Not known
York and Selby	Meadowfield	58.0	Not known

It is positive to note that the agency numbers are extremely low within the Trust, it is important to continue monitoring this on an ongoing basis due to the potential risks that high agency working has on clinical areas

3.1.8 The triangulation of the staffing data against a range of quality metrics has been a feature of this monthly report for several months now and to date it has not identified any direct risks or implications to patient safety or experience. On this basis a summary of the triangulation of data will be included in the monthly report and the more detailed analysis will be included in the 6 and 12 month reviews.

The quality metrics have been included within the appendices of this report and to summarise the following is of relevance:

- There were 4 SUI's that occurred within the reporting period from 4 different wards. One of these occurred on Rowan Ward and Springwood, both of which has been identified within the report in relation to agency usage.
- There were no level 4 and 6 level 3 incidents occurred during October. 2 were in relation to Ward 15 who were identified earlier in relation to a low staffing fill rate. Another incident was in relation to Westwood who was identified as having a high staffing fill rate.
- There were 7 complaints that occurred within the reporting period of which 1 was in relation to Rowan Ward who was highlighted in terms of agency usage; another was in relation to Bransdale who were highlighted due to low staffing and bank usage; and one was in relation to Cedar (NY) who were highlighted due to low staffing levels
- There were 22 PALS related issues raised during October of which the following is of relevance:
  - 1 X Rowan Ward - highlighted due to agency usage
  - 1 X Bedale Ward - highlighted due to high bank usage
  - 1 X Bilsdale Ward - highlighted due to a low staffing fill rate

- 1 X Newberry – highlighted due to a low staffing fill rate
- 1 X Merlin – highlighted due to high bank usage
- 1 X Overdale – highlighted due to a low staffing fill rate

- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was Westwood with a total of 40 incidents requiring control and restraint (3 of which required the use of PRO restraint), Westwood was highlighted as having staffing levels in excess of the budgeted establishment. Cedar Ward also had 20 incidents involving control and restraint as well as having staffing levels in excess of the budgeted establishment. The final ward that was highlighted in this report was Cedar (NY) as having a low staffing fill rates and 19 incidents that required control and restraint.

3.1.9 Although the Board did not agree to a dedicated Safe Staffing project for this year's Annual Plan (2015/16), this piece of work will be managed under business as usual with the following key objectives:

- To 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

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.

3.1.10 The Chief Nursing Officer has issued further directives regarding the Safe Staffing returns in relation to the direct clinical contact time nursing staff spend with patients. A number of tools have been suggested for use to produce data that is required to be included in the six monthly Board reports to demonstrate contact time. These will be explored as part of the Safe Staffing review.

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 the following is of relevance:

- There was a deterioration across all indicators in relation to the month on month trend.
- The number of wards showing as 'red' is increasing month on month
- Durham & Darlington have the lowest number of red wards however they are showing a deterioration on last month. Forensic services have the highest number of red wards
- The lowest fill rate is in relation to Jay Ward as a result of sickness and maternity leave.
- The highest fill rate and high bank usage was identified as Westerdale South during the reporting period
- Worsley Court was identified as having the highest agency usage due to being short staffed.
- In terms of the triangulation:
    - Westwood have had a level 3 incident, high staffing fill rate and incidents requiring control and restraint
    - Bransdale have had complaints, a low staffing fill rate and bank usage in excess of 50%.

4.2 Financial

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 next 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

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. Information published on the Trust website will assist with provision of contextual information. NICE are expected to publish further guidance on evidence based approaches to staffing by the end of this year 2015

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 review of safe staffing will be undertaken during the financial year 2015/16 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 trend or impact.

6.2 It is difficult to draw any meaningful conclusions from the data presented within this report.

7. RECOMMENDATIONS

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

Emma Haimes
Head of Quality Data
November 2015

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN October

				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)
Abdale House	North Yorkshire	Adults	9	132.4%	83.9%	89.6%	185.6%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	13	96.3%	106.2%	116.7%	88.5%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	13	89.8%	120.8%	103.2%	98.4%
Bedale Ward	Teesside	Adults	10	72.7%	204.3%	100.6%	132.6%
Bilsdale Ward	Teesside	Adults	14	68.0%	141.6%	87.1%	98.4%
Birch Ward	Durham & Darlington	Adults	15	119.9%	140.3%	100.0%	148.5%
Bransdale Ward	Teesside	Adults	14	57.2%	178.0%	87.7%	139.3%
Cedar Ward	Durham & Darlington	Adults	10	115.0%	206.9%	103.3%	169.6%
Cedar Ward (NY)	North Yorkshire	Adults	18	87.9%	155.9%	56.6%	153.6%
Earlston House	Durham & Darlington	Adults	15	99.9%	111.9%	100.0%	100.0%
Elm Ward	Durham & Darlington	Adults	20	96.3%	155.1%	100.0%	130.6%
Farnham Ward	Durham & Darlington	Adults	20	102.2%	108.3%	96.8%	100.0%
Lincoln Ward	Teesside	Adults	20	101.3%	102.3%	94.8%	110.1%
Lustrum Vale	Teesside	Adults	20	100.2%	131.1%	100.3%	101.6%
Maple Ward	Durham & Darlington	Adults	17	106.3%	113.4%	119.4%	145.2%
Overdale Ward	Teesside	Adults	18	64.2%	172.5%	100.0%	100.0%
Park House	Teesside	Adults	14	98.8%	100.7%	100.0%	101.3%

Primrose Lodge	Durham & Darlington	Adults	15	82.1%	104.2%	103.0%	100.0%
Stockdale Ward	Teesside	Adults	18	86.8%	126.4%	100.6%	102.0%
Tunstall Ward	Durham & Darlington	Adults	20	98.6%	114.3%	100.0%	111.5%
Ward 15 Friarage	North Yorkshire	Adults	14	69.5%	115.8%	96.8%	104.8%
Willow Ward	Durham & Darlington	Adults	15	89.3%	157.0%	100.0%	100.0%
Baysdale	Teesside	CYPS	6	127.4%	96.6%	100.0%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	116.4%	125.6%	100.0%	100.0%
Newberry Centre	North Yorkshire	CYPS	14	69.9%	117.0%	92.6%	90.2%
The Evergreen Centre	North Yorkshire	CYPS	12	97.2%	124.0%	100.0%	100.0%
Westwood Centre	North Yorkshire	CYPS	12	102.3%	118.9%	104.8%	206.5%
Clover/Ivy	Forensics	Forensics LD	12	93.0%	106.9%	100.0%	100.0%
Eagle/Osprey	Forensics	Forensics LD	10	95.0%	93.7%	100.0%	98.9%
Harrier/Hawk	Forensics	Forensics LD	10	75.1%	102.9%	96.8%	100.0%
Kestrel/Kite	Forensics	Forensics LD	16	85.2%	93.6%	100.0%	97.8%
Kingfisher/Heron/Robin	Forensics	Forensics LD	14	85.4%	85.9%	97.5%	96.9%
Langley Ward	Forensics	Forensics LD	10	71.8%	93.5%	102.0%	100.0%
Northdale Centre	Forensics	Forensics LD	6	87.5%	91.9%	100.0%	96.1%
Oakwood	Forensics	Forensics LD	8	88.9%	96.1%	100.0%	100.0%
Thistle Ward	Forensics	Forensics LD	5	80.5%	115.6%	100.0%	107.3%
Brambling Ward	Forensics	Forensics MH	13	81.7%	124.8%	114.3%	109.8%
Fulmar Ward.	Forensics	Forensics MH	12	101.3%	99.8%	107.9%	101.6%
Jay Ward	Forensics	Forensics MH	5	55.3%	121.0%	104.4%	103.2%
Kirkdale Ward	Forensics	Forensics MH	16	92.9%	102.3%	101.1%	100.0%
Lark	Forensics	Forensics MH	15	74.6%	118.1%	97.6%	100.1%
Linnet Ward	Forensics	Forensics MH	17	91.6%	125.6%	101.8%	100.0%
Mallard Ward	Forensics	Forensics MH	16	82.4%	127.7%	97.6%	133.0%
Mandarin	Forensics	Forensics MH	16	92.0%	105.2%	100.9%	100.0%
Merlin	Forensics	Forensics MH	10	94.7%	171.8%	83.1%	180.4%

Newtondale Ward	Forensics	Forensics MH	20	97.0%	98.0%	96.1%	96.8%
Nightingale Ward	Forensics	Forensics MH	16	94.6%	104.8%	97.1%	100.3%
Sandpiper Ward	Forensics	Forensics MH	8	91.9%	117.5%	96.8%	137.1%
Swift Ward	Forensics	Forensics MH	10	79.9%	120.4%	96.2%	118.0%
Aysgarth	Teesside	LD	6	113.3%	145.0%	103.3%	105.0%
Bankfields Court Unit 2	Teesside	LD	5	119.6%	101.3%	100.0%	109.7%
Bankfields Court	Teesside	LD	12	86.6%	120.6%	98.2%	101.1%
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	107.6%	100.6%	100.0%	103.1%
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	95.7%	145.5%	100.0%	100.0%
Hamsterley Ward	Durham & Darlington	MHSOP	10	82.9%	146.1%	100.2%	103.4%
Oak Ward	Durham & Darlington	MHSOP	12	61.8%	100.9%	96.8%	100.0%
Picktree Ward.	Durham & Darlington	MHSOP	10	101.5%	177.2%	100.0%	135.5%
Roseberry Wards	Durham & Darlington	MHSOP	15	84.4%	104.0%	100.0%	98.4%
Rowan Lea	North Yorkshire	MHSOP	20	80.9%	109.7%	109.9%	101.8%
Rowan Ward	North Yorkshire	MHSOP	12	94.9%	78.2%	138.8%	88.0%
Springwood Community Unit	North Yorkshire	MHSOP	14	83.7%	112.9%	100.0%	148.1%
Ward 14	North Yorkshire	MHSOP	9	77.1%	126.4%	100.6%	98.7%
Westerdale North	Teesside	MHSOP	18	101.1%	134.8%	106.2%	111.2%
Westerdale South	Teesside	MHSOP	14	87.3%	321.2%	100.0%	253.3%
Wingfield Ward	Teesside	MHSOP	9	81.2%	116.4%	94.2%	100.7%
Meadowfields	York and Selby	MHSOP	18	71.3%	105.1%	104.1%	100.0%
Oak Rise	York and Selby	LD	8	122.9%	84.3%	100.0%	100.0%
Peppermill Court	York and Selby	MHSOP	14	71.0%	102.5%	87.0%	122.1%
Recovery Unit Acomb	York and Selby	Adults	16	98.2%	111.5%	154.8%	88.7%
White Horse View	York and Selby	LD	8	90.5%	85.5%	100.0%	100.0%
Worsley Court	York and Selby	MHSOP	14	91.2%	101.1%	145.8%	105.6%
Cherry Tree House	York and Selby	MHSOP	16	79.5%	116.7%	131.8%	114.5%

Appendix 2

October	TRUSTWIDE DAILY POSITION –all wards	
	Difference between what was planned on roster and actually worked – RNs	Difference between what was planned on roster and actually worked – HCAs
1	-3%	15%
2	-8%	14%
3	-6%	16%
4	-4%	20%
5	-3%	16%
6	-3%	18%
7	-5%	18%
8	-5%	15%
9	-8%	17%
10	-6%	19%
11	-6%	20%
12	-7%	13%
13	-3%	15%
14	-9%	18%
15	-7%	15%
16	-6%	12%
17	-4%	15%
18	-5%	20%
19	-6%	12%
20	-4%	13%

21	-11%	16%
22	-6%	13%
23	-10%	18%
24	-10%	16%
25	-9%	16%
26	-9%	13%
27	-9%	13%
28	-11%	14%
29	-8%	14%
30	-14%	11%
31	-14%	12%

Appendix 3

DURHAM & DARLINGTON LOCALITY REPORT - October 2015										AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Birch Ward	15	882.5	372	1008	742.17	1058.47	372	1414.29	1102.17	119.9%	100.0%	140.3%	148.5%
Elm Ward	20	867.5	371.33	732	744	835.34	371.33	1135.5	972	96.3%	100.0%	155.1%	130.6%
Maple Ward	17	876.17	372	744	744	931.76	444	844	1080	106.3%	119.4%	113.4%	145.2%
Farnham Ward	20	909	372	720	744	929.13	360	780	744	102.2%	96.8%	108.3%	100.0%
Tunstall Ward	20	852	372	731	732	840	372	835.49	816	98.6%	100.0%	114.3%	111.5%
Willow Ward	15	909	372	732	744	812	372	1149	744	89.3%	100.0%	157.0%	100.0%
Earlston House	15	895.67	372	737.67	744	895.17	372	825.67	744	99.9%	100.0%	111.9%	100.0%
Primrose Lodge	15	874.33	372	732	744	717.5	383.33	762.5	744	82.1%	103.0%	104.2%	100.0%
Holly Unit	4	373.26	199.5	463.29	199.5	434.58	199.5	581.86	199.5	116.4%	100.0%	125.6%	100.0%
Cedar Ward PICU	10	822.5	360	732	1104	946	372	1514.83	1872	115.0%	103.3%	206.9%	169.6%
Ceddesfeld Ward	10	909	372	537	744	869.67	372	781.5	744	95.7%	100.0%	145.5%	100.0%
Roseberry Wards	15	893.34	372	774	744	754.08	372	804.67	732	84.4%	100.0%	104.0%	98.4%
Oak Ward	12	908.29	372	744	744	561.34	360	750.34	744	61.8%	96.8%	100.9%	100.0%
Picktree Ward.	10	909	372	649.67	744	922.66	372	1151.18	1008	101.5%	100.0%	177.2%	135.5%
Hamsterley Ward	10	909	372	541.5	744	753.5	372.67	791.27	769.33	82.9%	100.2%	146.1%	103.4%
Bek, Ramsey, Talbot Wards	16	874.5	372	3108	1560	941.33	372	3126.33	1608	107.6%	100.0%	100.6%	103.1%

FORENSICS LOCALITY REPORT - October 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Lark	15	857.75	348.75	1025.48	697.5	639.55	340.5	1211.37	698.25	74.6%	97.6%	118.1%	100.1%
Brambling Ward	13	855.75	348.75	952	697.5	699.25	398.73	1187.75	766	81.7%	114.3%	124.8%	109.8%
Fulmar Ward.	12	858.75	348.75	1286.95	697.5	870.28	376.25	1284.5	708.75	101.3%	107.9%	99.8%	101.6%
Jay Ward	5	854.5	348.75	1061.5	697.5	472.25	364	1284.55	720	55.3%	104.4%	121.0%	103.2%
Kirkdale Ward	16	810	348.75	1280.5	697.5	752.5	352.75	1309.5	697.5	92.9%	101.1%	102.3%	100.0%
Linnet Ward	17	860.37	348.75	1001.25	697.5	788.17	355	1258.05	697.5	91.6%	101.8%	125.6%	100.0%
Mallard Ward	16	859.75	348.75	1287.25	697.5	708.08	340.5	1644.25	928	82.4%	97.6%	127.7%	133.0%
Mandarin	16	857	348.75	1017.05	697.5	788.5	351.75	1070.3	697.5	92.0%	100.9%	105.2%	100.0%
Merlin	10	858.25	694.25	1038.5	697.5	813	576.75	1784.5	1258.25	94.7%	83.1%	171.8%	180.4%
Newtondale Ward	20	851.25	697.5	1614	697.5	826	670	1582	675	97.0%	96.1%	98.0%	96.8%
Nightingale Ward	16	860.5	348.75	1007.25	697.5	814	338.5	1055.25	699.5	94.6%	97.1%	104.8%	100.3%
Sandpiper Ward	8	858.75	689.75	1626	697.5	789.5	667.75	1911	956.3	91.9%	96.8%	117.5%	137.1%
Swift Ward	10	859.25	348.75	1290.5	697.5	686.67	335.5	1553.34	823.25	79.9%	96.2%	120.4%	118.0%
Clover/Ivy	12	761.75	348.75	2106.09	1046.25	708.5	348.75	2252.09	1046.75	93.0%	100.0%	106.9%	100.0%
Eagle/Osprey	10	871.08	348.75	1747.25	1046.25	827.12	348.75	1636.5	1035	95.0%	100.0%	93.7%	98.9%
Harrier/Hawk	10	806.25	353.25	2078.42	1046.25	605.5	342	2137.67	1046.25	75.1%	96.8%	102.9%	100.0%
Kestrel/Kite	16	888.17	348.75	2076.39	1046.25	757.08	348.75	1942.69	1023.75	85.2%	100.0%	93.6%	97.8%
Kingfisher/Heron/Robin	14	789.01	348.5	1564.26	731.25	674.17	339.75	1344.42	708.75	85.4%	97.5%	85.9%	96.9%
Northdale Centre	6	850.75	348.75	2438.06	1395	744.32	348.75	2240.39	1341	87.5%	100.0%	91.9%	96.1%
Oakwood	8	856.12	348.75	692.5	348.75	761.5	348.75	665.25	348.75	88.9%	100.0%	96.1%	100.0%
Thistle Ward	5	789.17	348.75	1020.5	697.5	635.08	348.75	1179.75	748.5	80.5%	100.0%	115.6%	107.3%
Langley Ward	10	863.66	348.75	970.25	348.75	619.68	355.75	907.5	348.75	71.8%	102.0%	93.5%	100.0%

NORTH YORKSHIRE LOCALITY REPORT - October 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Ayckbourn Unit Danby Ward	13	868.5	330	734	671	836	385	779.5	594	96.3%	116.7%	106.2%	88.5%
Ayckbourn Unit Esk Ward	13	1026.5	341	745	682	921.5	352	900.25	671	89.8%	103.2%	120.8%	98.4%
Ward 15 Friarage	14	1022.5	348.75	696	697.5	710.75	337.5	806	731.25	69.5%	96.8%	115.8%	104.8%
Cedar Ward (NY)	18	1072.5	666.5	976.5	659.75	942.41	377	1522.33	1013.67	87.9%	56.6%	155.9%	153.6%
Abdale House	9	717.75	471	411	363	950	422	345	673.75	132.4%	89.6%	83.9%	185.6%
Newberry Centre	14	1329.67	343	1305.51	679	929.73	317.75	1526.99	612.45	69.9%	92.6%	117.0%	90.2%
Westwood Centre	12	1349	609.5	1610.75	713	1379.5	638.5	1915.75	1472	102.3%	104.8%	118.9%	206.5%
The Evergreen Centre	12	1165.47	356.5	1385.15	713.66	1132.97	356.5	1717.33	713.33	97.2%	100.0%	124.0%	100.0%
Rowan Lea	20	1064.33	372	1336.66	1116	860.66	408.83	1466.84	1136.5	80.9%	109.9%	109.7%	101.8%
Rowan Ward	12	1067.5	372	744	744	1013.5	516.5	581.5	655	94.9%	138.8%	78.2%	88.0%
Springwood Community Unit	14	982.5	348.75	930	697.5	822.41	348.75	1050.19	1033.25	83.7%	100.0%	112.9%	148.1%
Ward 14	9	936.5	348.75	596.25	697.5	721.75	350.75	753.68	688.25	77.1%	100.6%	126.4%	98.7%

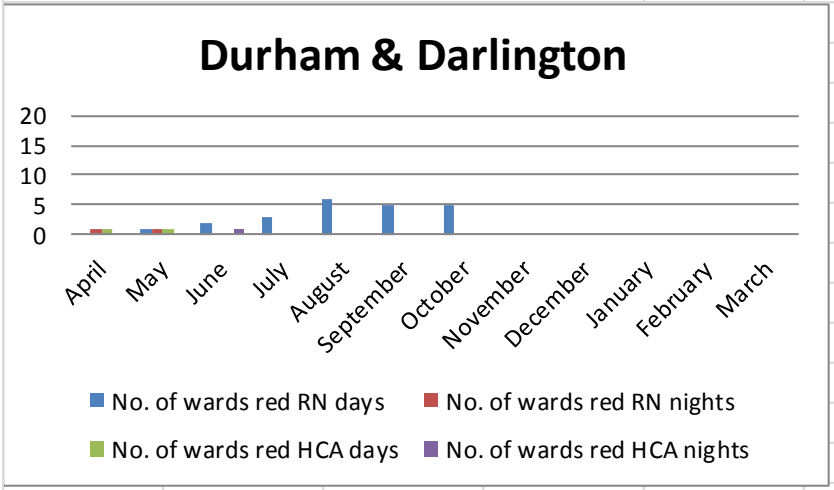
TEESSIDE LOCALITY REPORT - October 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Bedale Ward	10	844	356.5	713	1069.5	614	358.5	1456.5	1418.5	72.7%	100.6%	204.3%	132.6%
Bilsdale Ward	14	830.48	357.5	708	713	564.48	311.5	1002.5	701.5	68.0%	87.1%	141.6%	98.4%
Bransdale Ward	14	856.5	356.5	713	713	489.5	312.5	1269.25	993	57.2%	87.7%	178.0%	139.3%
Lincoln Ward	20	833.5	387.5	1183	713	844	367.17	1210	785.33	101.3%	94.8%	102.3%	110.1%
Lustrum Vale	20	802	356.5	693	713	803.25	357.5	908.5	724.5	100.2%	100.3%	131.1%	101.6%
Overdale Ward	18	856.5	356.5	825	713	549.5	356.5	1423	713	64.2%	100.0%	172.5%	100.0%
Park House	14	731.5	345	713.25	713	722.75	345	718.5	722	98.8%	100.0%	100.7%	101.3%
Stockdale Ward	18	810.5	356.5	806	667	703.25	358.5	1019	680.5	86.8%	100.6%	126.4%	102.0%
Baysdale	6	530.69	346.27	921.91	692.23	676.11	346.27	890.98	692.07	127.4%	100.0%	96.6%	100.0%
Westerdale North	18	866.5	356	712	713	875.98	378	960	792.5	101.1%	106.2%	134.8%	111.2%
Westerdale South	14	831.5	356.5	693.25	690	726	356.5	2226.73	1748	87.3%	100.0%	321.2%	253.3%
Wingfield Ward	9	692	387.5	614	713	562	365	715	718	81.2%	94.2%	116.4%	100.7%
Aysgarth	6	530	300	812	310	600.42	310	1177.5	325.5	113.3%	103.3%	145.0%	105.0%
Bankfields Court Unit 2	5	510.67	310	1064.98	310	610.6	310	1078.55	340	119.6%	100.0%	101.3%	109.7%
Bankfields Court	12	1474	742.5	3712.5	2232	1276.07	729.33	4478.37	2257.5	86.6%	98.2%	120.6%	101.1%

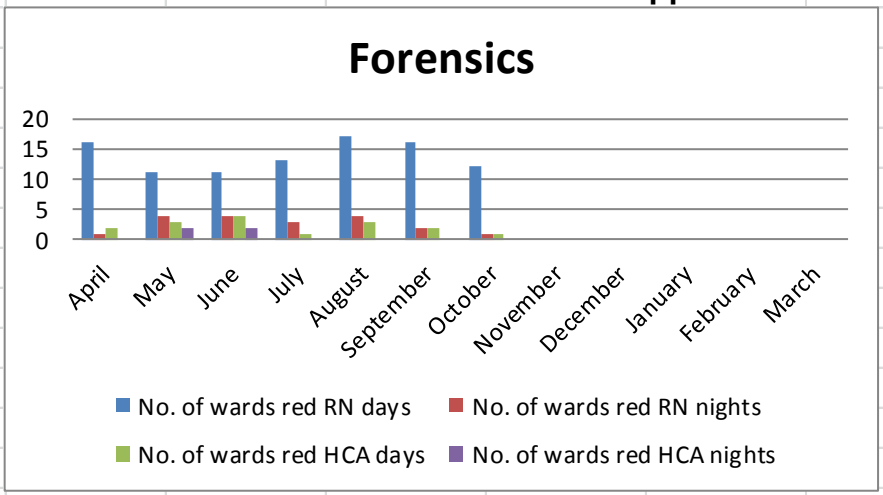
YORK AND SELBY LOCALITY REPORT - October 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Meadowfields	18	922.5	341	1380	682	658	355	1451	682	71.3%	104.1%	105.1%	100.0%
Oak Rise	8	929	333.25	922	664	1141.79	333.25	777.3	664	122.9%	100.0%	84.3%	100.0%
Peppermill Court	14	922.5	678.5	1620	663.5	655	590	1660	810	71.0%	87.0%	102.5%	122.1%
Recovery Unit Acomb	16	915	341	917.5	682	898.5	528	1023	605	98.2%	154.8%	111.5%	88.7%
White Horse View	8	691	333.25	1624	666.5	625.5	333.25	1389	666.5	90.5%	100.0%	85.5%	100.0%
Worsley Court	14	900	308	1387.5	662.5	821	449	1402.98	699.5	91.2%	145.8%	101.1%	105.6%
Cherry Tree House	16	872.5	264	1428	836	694	348	1666.83	957	79.5%	131.8%	116.7%	114.5%

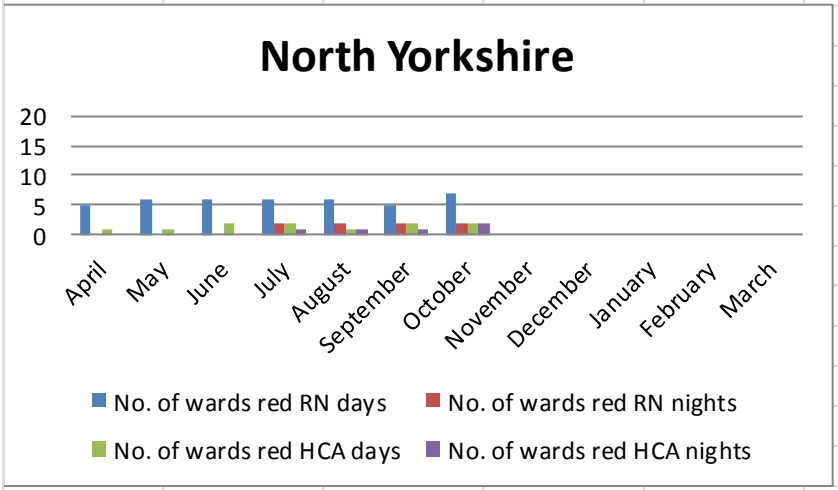
TEWV TOTAL - Month on Month Trend **Appendix 4**

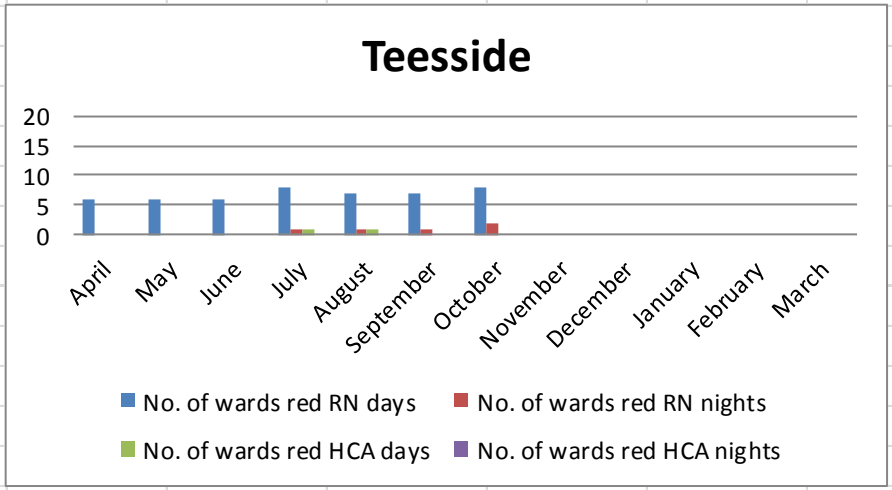
Month	Draft Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
May-14	65.90		86.20		96.30		99.90	
Jun-14	94.15	↑	109.00	↑	100.80	↑	113.00	↑
Jul-14	90.75	↓	110.00	↑	99.68	↓	111.00	↓
Aug-14	85.75	↓	107.14	↓	99.60	↓	109.00	↓
Sep-14	92.99	↑	105.27	↓	99.67	↑	109.43	↑
Oct-14	92.63	↓	108.82	↑	99.09	↓	108.67	↓
Nov-14	91.84	↓	109.38	↑	99.41	↑	108.98	↑
Dec-14	90.79	↓	102.47	↓	98.22	↓	107.13	↓
Jan-15	92.54	↑	105.31	↑	98.91	↑	108.42	↑
Feb-15	92.65	↑	107.14	↑	102.52	↑	109.17	↑
Mar-15	91.99	↓	106.64	↓	100.62	↓	110.48	↑
Apr-15	93.12	↑	111.42	↑	101.19	↑	111.20	↑
May-15	93.00	↓	110.34	↓	102.27	↑	110.09	↓
Jun-15	93.12	↑	109.50	↓	100.62	↓	112.27	↑
Jul-15	90.80	↓	114.10	↑	99.40	↓	115.30	↑
Aug-15	87.90	↓	112.60	↓	98.10	↓	110.10	↓
Sep-15	90.3	↑	113.6	↑	98.20	↑	112.6	↑
Oct-15	89.7	↓	116.9	↑	100.30	↑	112.9	↑

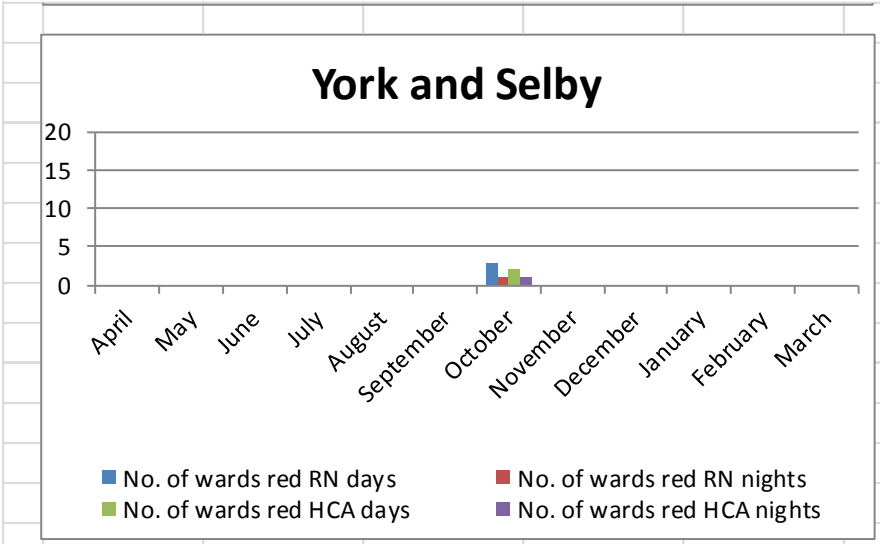
Number of Red Wards by Locality **Appendix 5**

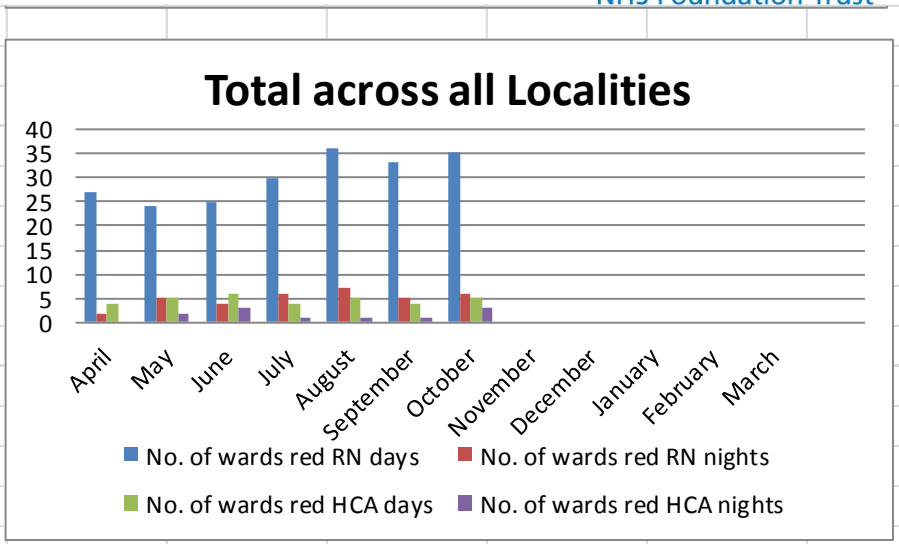









York and Selby
20
15
10
5
0
April
May
June
July
August
September
October
November
December
January
February
March
No. of wards red RN days
No. of wards red RN nights
No. of wards red HCA days
No. of wards red HCA nights


Total across all Localities
40
35
30
25
20
15
10
5
0
April
May
June
July
August
September
October
November
December
January
February
March
No. of wards red RN days
No. of wards red RN nights
No. of wards red HCA days
No. of wards red HCA nights

Appendix 6

Scored Fill Rate compared to Quality Indicators - OCTOBER					Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total score	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4 Incidents	Level 3 (Sem-Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Aysgarth	Teesside	LD	6	11	2413.42	541.75	22%						1	0	1	1
Tunstall Ward	Durham & Darlington	AMH	20	12	2863.49	288	10%			1			5	0	10	10
Westerdale South	Teesside	MHSOP	14	8	5057.23	4415.93	87%									
Earlston House	Durham & Darlington	AMH	15	12	2836.84	343.5	12%						1	1	4	5
Bankfields Court Unit 2	Teesside	LD	5	12	2339.15	426.46	18%									
Holly Unit	Durham & Darlington	CAMHS	4	11	1415.44	73.67	5%									
Lincoln Ward	Teesside	AMH	20	12	3206.5	476	15%						1	0	1	1
Westerdale North	Teesside	MHSOP	18	11	3006.48	124	4%						2	0	2	2
Westwood Centre	North Yorkshire	CAMHS Tier 4	12	11	5405.75	1553	29%			1			40	3	75	78
Farnham Ward	Durham & Darlington	AMH	20	12	2813.13	168	6%						1	0	2	2
Hamsterley Ward	Durham & Darlington	MHSOP	10	9	2686.77	177.5	7%						1	0	1	1
Mallard Ward	Forensics	FMH	16	8	3620.83	1016	28%					1	6	0	6	6
Rowan Ward	North Yorkshire	MHSOP	12	7	2766.5	528	19%	1			1	2	4	0	4	4
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	11	2767.17	267.5	10%						9	0	14	14
Elm Ward	Durham & Darlington	AMH	20	10	3314.17	736.33	22%						3	0	5	5
Stockdale Ward	Teesside	AMH	18	9	2761.25	600	22%					2	3	0	4	4
Northdale Centre	Forensics	FMH	6	10	4674.46	1523.25	33%					2	11	0	14	14
Bedale Ward	Teesside	AMH	10	8	3847.5	1980.5	51%					1	9	0	12	12
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	12	6047.66	481.54	8%						17	0	23	23

Brambling Ward	Forensics	FMH	13	9	3051.73	1404	46%			1			23	1	37	38
Bransdale Ward	Teesside	AMH	14	6	3064.25	1620	53%				1					
Lustrum Vale	Teesside	AMH	20	11	2793.75	674.5	24%									
Bilsdale Ward	Teesside	AMH	14	7	2579.98	734.5	28%					1				
Birch Ward	Durham & Darlington	AMH	15	10	3946.93	1894.6	48%									
Cedar Ward (NY)	North Yorkshire	AMH	18	6	3855.41	440.25	11%				1		19	1	41	42
Eagle/Osprey	Forensics	FLD	10	12	3847.37	601.5	16%									
Maple Ward	Durham & Darlington	AMH	17	11	3299.76	1050.5	32%				2	1	7	1	8	9
Picktree Ward.	Durham & Darlington	MHSOP	10	10	3453.84	1732.53	50%	1					2	0	4	4
Primrose Lodge	Durham & Darlington	AMH	15	10	2607.33	120	5%									
Newberry Centre	North Yorkshire	CAMHS Tier 4	14	10	3386.92	410	12%					1	1	0	1	1
The Evergreen Centre	North Yorkshire	CAMHS Tier 4	12	11	3920.13	824.06	21%					1	27	1	33	34
Ward 14	North Yorkshire	MHSOP	9	9	2514.43	83.25	3%						1	0	1	1
Willow Ward	Durham & Darlington	AMH	15	9	3077	441	14%									
Baysdale	Teesside	CAMHS	6	11	2605.43	69.86	3%									
Langley Ward	Forensics	FLD	10	10	2231.68	130.34	6%									
Merlin	Forensics	FMH	10	8	4432.5	2742	62%					1	1	0	2	2
Oak Ward	Durham & Darlington	MHSOP	12	10	2415.68	153.34	6%									
Oakwood	Forensics	FLD	8	10	2124.25	102	5%									
Bankfields Court	Teesside	LD	12	9	8741.27	1510.17	17%						38	0	55	55
Park House	Teesside	AMH	14	12	2508.25	184	7%									
Cedar Ward	Durham & Darlington	AMH	10	10	4704.83	3112.98	66%						20	5	46	51
Fulmar Ward.	Forensics	FMH	12	12	3239.78	747.75	23%					1	1	0	1	1
Jay Ward	Forensics	FMH	5	9	2840.8	903.25	32%						2	0	2	2
Kingfisher/Heron/Robin	Forensics	FLD	14	8	3067.09	848.75	28%				1					
Nightingale Ward	Forensics	FMH	16	12	2907.25	504	17%									
Sandpiper Ward	Forensics	FMH	8	11	4324.55	1771.6	41%						5	2	13	15

Springwood Community Unit	North Yorkshire	MHSOP	14	9	3254.6	754.17	23%	1					10	0	11	11
Thistle Ward	Forensics	FLD	5	10	2912.08	598.75	21%						11	0	30	30
Ward 15 Friarage	North Yorkshire	AMH	14	10	2585.5	352.5	14%			2			2	0	2	2
Overdale Ward	Teesside	AMH	18	9	3042	713	23%					2	7	0	10	10
Linnet Ward	Forensics	FMH	17	11	3098.72	764	25%									
Swift Ward	Forensics	FMH	10	9	3398.76	1399.25	41%						17	0	27	27
Ayckbourn Unit Esk Ward	North Yorkshire	AMH	13	9	2844.75	328.5	12%			1	1	2	1	0	3	3
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	13	10	2594.5	262.5	10%									
Clover/Ivy	Forensics	FLD	12	12	4356.09	1329.67	31%						1	0	3	3
Kirkdale Ward	Forensics	FMH	16	12	3112.25	696.75	22%					1				
Roseberry Wards	Durham & Darlington	MHSOP	15	10	2662.75	142.82	5%						3	0	3	3
Lark	Forensics	FMH	15	10	2889.67	584.75	20%									
Wingfield Ward	Teesside	MHSOP	9	10	2360	58.5	2%						2	0	5	5
Kestrel/Kite	Forensics	FLD	16	10	4072.27	681.25	17%					2				
Abdale House	North Yorkshire	AMH	9	6	2390.75	59.5	2%									
Mandarin	Forensics	FMH	16	12	2908.05	506	17%									
Rowan Lea	North Yorkshire	MHSOP	20	10	3872.83	393.01	10%	1					11	0	16	16
Newtondale Ward	Forensics	FMH	20	12	3753	735.75	20%									
Harrier/Hawk	Forensics	FLD	10	10	4131.42	722	17%						1	0	4	4
Meadowfields	York & Selby	MHSOP	18	10	3146	0										
Oak Rise	York & Selby	LD	8	9	2916.34	0										
Peppermill Court	York & Selby	MHSOP	14	7	3715	0										
Recovery Unit Acomb	York & Selby	Adults	16	9	3054.5	0										
White Horse View	York & Selby	LD	8	10	3014.25	0										
Worsley Court	York & Selby	MHSOP	14	11	3372.48	0										
Cherry Tree House	York & Selby	MHSOP	16	9	3665.83	0										

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 24 November 2015**

Title: **To consider the report of the Mental Health Legislation Committee**

Lead Director: **Richard Simpson, Non-Executive Director**

Report for: **Assurance/Information**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of our communities	
To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users	✓	Consent to care and treatment	✓		
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises	✓	Safety, availability and suitability of equipment	✓		
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose	✓	Assessing and monitoring quality of service provision	✓	Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA	✓	Notification of other incidents	
Records	✓				
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 24 November 2015**

Title: **To consider the report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 2, 2015-16; through consideration of the work of the Mental Health Legislation Committee, which is a Standing Committee of the Board.

2. BACKGROUND INFORMATION

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

3. KEY ISSUES

At the meeting held on 26th October 2015:

3.1 The minutes of the Committee meeting held on 27th July 2015 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 13 visits in the quarter. This is compared to 4 in the previous quarter and the increase is probably due to the CQC having completed their reconfiguration and the visit numbers returning to a more usual level for the Trust. There were no significant issues identified in relation to the MHA or MCA specifically and a lot of the issues were around the availability and display of information.

3.3 The Admissions, Changes and Detentions Themes Report was presented. The increase in activity in terms of MHA use has been sustained and following the peak of 114 admissions under the MHA in July 2014 and the subsequent levelling to between 77 and 92 to the end of quarter 3, the figures for July, August and September this year were 107, 98 and 108 respectively which demonstrates activity on a par with the period immediately post the Cheshire West judgment. Similar activity in terms of section 2 usage is also apparent.

3.4 The Section 136 report was presented. In total there were 188 uses of section 136 across the whole Trust area (an increase from 166 in the previous quarter) of which 158 were brought to a Trust place of safety which means 84% were brought to a MHBPOS, the same as the previous quarter. Within the Cleveland Police area, which is the highest user of s136, there was an increase from 10 to 12 of those taken to a police station as a place of safety and which equates to 13% of the total meaning 87% were brought to Roseberry Park.

In terms of Street Triage activity there were 107 contacts in the quarter in Teesside, of which none resulted in the use of section 136, and in Scarborough there were 101 contacts of which 3 resulted in the use of section 136.

There was discussion around the hours worked by street Triage, ie not 24/7, and how the use of Street Triage seems to have a positive effect on the reduction in the use of section 136. There was also discussion around the potential to place mental health workers within Police control rooms as part of the Crisis care Concordat action plan.

Within the Crisis Assessment Suite at Roseberry Park activity has been significant with 597 assessments undertaken in the quarter. 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 July there were 27 s136s and 47 accompanied by police, in August 25 s136s and 70 accompanied and in September 27 s136s and 68 accompanied by police.

This report provides assurance that the Place of Safety continues to be appropriately used and there is now the ability to manage those who self-present or attend voluntarily more effectively since the opening of the staffed Crisis Assessment Suite.

3.5 There is no seclusion report for this quarter as we are awaiting the production of a report by the Information Team 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.

3.6 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. There were 152 Hospital Managers reviews held and 1 patient was discharged. There were 153 FTTs held in quarter 2 compared to 140 in quarter 1. The Tribunal ordered 10 absolute discharges (4 of which were patients subject to a CTO), 2 conditional discharges and 1 deferred discharge. All off the discharges were from Adult Services and the 2 conditional discharges from Forensic mental health. In terms of FFTs this equates to an approximate 8.5% discharge rate and the Committee has asked, if possible, for a comparison to be provided against either national statistics or comparable providers.

The absolute discharges all occurred against the recommendations of the clinical team; some patients remained informally for a period and were discharged from hospital at a later date. None of the discharged patients had the same Responsible Clinician or Care Co-ordinator.

3.7 A verbal update was given in terms of the status of MHA and MCA within York and Selby. There were several issues with MHA documentation within the original files, either missing or incorrectly completed, for which legal advice had been sought with regard to the consequences. Access to Paris was now

available but the use of Paris was very limited and the care record did not contain all information in relation to the MHA recording. Access to Paris is hosted by LYPFT which means that all patients subject to the MHA are visible to both Trusts and the version of Paris available does not support the recording of MHA information in the same way or as comprehensively as the TEWV version does. The Committee were assured that every effort was being made to bring the MHA records to the standard across the other localities within TEWV and that going forward the sort of issues encountered should not reoccur.

In terms of DoLS, the MHL Team have been provided with a list of patients subject to DoLS authorisations and their current status and this would be fully evaluated with any necessary actions implemented.

At the time of the Committee we were still awaiting copies of the CQC MHA visit reports and associated action plans dating back to April to enable us to ensure that any necessary actions were either completed or are on track.

3.8 The Trust response to the Law Commission consultation around the Deprivation of Liberty Safeguards was shared with the Committee. Some minor amendments were agreed and the response would go to the Board of Directors on 27th October for final approval prior to submission on 2nd November.

3.9 It was agreed that the practice of the RC making an entry on Paris of the capacity assessment carried out at the first administration of medication for mental disorder for a detained patient, which is then printed off and placed with the drug kardex to enable the CQC to find it easily would cease. In place of this, the entry would be made on the MHA tab only within Paris and clearly identified as a 'capacity assessment' which should enable its easy location. If needed the location of the entry could be aided by reference to the date that the medication was first administered to assist with the date when this entry should have been made. A long run in period for this change to take place was agreed and a date of April 2016 set.

3.10 The draft Section 117 Policy was shared with the Committee. The policy does not contain the appendices from the Local Authorities and CCGs as the statutory after-care bodies regarding local implementation/interpretation and the policy of more of a statement of law with some associated guidance. The Committee concluded that the document should be renamed as a 'Guidance' document and go to the Clinical Leaders Board for approval and on to EMT for ratification.

4. IMPLICATIONS

4.1 **Quality:** The MHL Administration team continue to work closely with operational services to ensure any further service development plans are communicated in order to assess the possible impact on capacity and increased workload for the team. The impact of the Supreme Court judgment remains tangible not just in terms of an increase in numbers but also the

significant amounts of time being taken up with specialist advice in order to assure compliance with legislation.

4.2 **Financial:**
No new implications.

4.3 **Legal and Constitutional:**
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. In terms of York and Selby there have been some issues regarding compliance with the MHA and MCA which have been rectified and the CQC have been informed of the issues **(Appendix 3 has more details).**

4.4 **Equality and Diversity:**
No new implications.

4.5 **Other implications:**
In terms of York and Selby the administration of the MHA and the Paris care record in use in the York and Selby locality for the MHA are potential areas of concern until at least March when it is anticipated that the Paris version will align with what is available across the rest of the Trust. There is currently no dedicated member of MHL administration staff for York and Selby, a person has been appointed and is working notice currently, however, they will require significant training and until February the MHA will continue to be administered via staff from the Middlesbrough MHL team with the associated travel and capacity issues.

5. RISKS

The MHA issues identified in York and Selby which have been rectified may give rise to legal challenge from the affected service users or their legal representatives. Whilst the issues arose prior to our involvement, we allowed a period of time for York and Selby to attempt to locate missing information and from the period of our identification of the issues to the ending of the MHA use for those service users for whom we could not satisfy ourselves of the continued legality of their section, TEWV may hold a level of accountability.

6. CONCLUSIONS

6.1 At their meeting in October 2015, 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, other than the issues identified from 1 October in York and Selby. This assurance is externally supported by the feedback from the CQC Mental Health Act inspections and also from the Trust CQC inspection in January.

6.2 There are a number of ongoing actions and workstreams that are aiming for improvements to provide enhanced assurance and to maintain the operational requirements to support the legislative requirements.

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 27th July 2015 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 27 JULY 2015 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 11.00AM.

Present:
Mr R Simpson, Non-Executive Director, (Chairman of the Committee)
Mr B Kilmurray, Chief Operating Officer
Dr N Land, Medical Director
Mrs C Stanbury, Director of Nursing and Governance
Ms J Clark, Public Governor

In Attendance:
Ms P Griffin, Mental Health Legislation Advisor
Mr D Jennings, Non-Executive Director
Mrs E Moody, Director of Nursing and Governance, (Designate)
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation

Apologies:
Apologies for absence were received from Mrs L Bessant, Chairman of the Trust, Mrs J Illingworth, Director of Quality Governance, Mr K Marsden, Public Governor and
Dr H Griffiths, Non-Executive Director.

The Committee welcomed Mrs Elizabeth Moody as the new Director of Nursing and Governance from 31 July 2015 and thanked Mrs Chris Stanbury for her contribution to the MHLC. The Committee wished Mrs Stanbury a happy retirement.

15/18 MINUTES

Agreed – *That the minutes of the last meeting held on 27 April 2015 be approved as a correct record and signed by the Chairman.*

15/19 ACTION LOG

The Committee updated the Action log taking into account the relevant reports provided to the meeting.

Arising from the Action log:

14/32 "Future reports to include more trends/graphs for Children and Young People's services, particularly Newbury and Evergreen".
Mrs Illingworth had been working through the data for the MHLC, as well as Trust wide data and this action would be deferred until standardisation of reporting was resolved.

Completed

15/11 **"**Review of leaflets in distribution across the Trust and report back to MHLC".

This action remained outstanding. Mrs Stanbury had logged a query with the lead for patient information. This would be brought back to the MHLC meeting in October 2015 for an update.

Action: Miss Wilkinson

15/12 "Conflict between approach on restrictive practices by the CQC, which was different from the Code of Practice".
The CQC had picked up with the Trust issues around the use of blanket restraint, however the Code of Practice had highlighted that there might be blanket restrictions on some wards with enhanced security. Forensic services had undertaken a piece of work to identify for each ward which restrictions would apply.

Completed

15/12 "Training to be provided around the Code of Practice".
This action related to 2 hour roadshows for staff on the new Code of Practice, which had been put on hold due to staffing pressures and workload in the MHL team.

15/13 "MHA performance reports – graphs for admission to include 2013/14, 2014/15 data, together with Q1 2015/16 for comparison, together with bed numbers for detained patients on ward".
This had been included in the report (see minute 15/21)

Completed

15/13 "Discussion outside the meeting on whether graphs were meaningful and report back to next meeting".

This would be addressed with the work that Mrs Illingworth was undertaking to standardise data reporting.

15/13 (1)"Investigate the low percentage of detained informal patients on Danby ward and feed back to next meeting".
There had been no significant trend found for the low percentage figures of detained patients on Danby ward, as the figures had gone up in the last quarter.

Completed

15/13 (4) "Need to include in Discharges and Detention report trends or patterns on discharge
against clinical recommendation".
This had been included in the report (see minute 15/21).

Completed

15/13 (5) "Ambulance delays – issues around first medical assessor delays and ambulance delays
to be escalated to the CCG".

Completed

15/14 "Roadshows to raise awareness for staff around the Code of Practice, hard copies to all wards and teams across the Trust".

Completed

15/15 "Revised Hospital Managers Policy".
This matter would be dealt with under minute 15/23.

Completed

15/17 "Terms of reference to be updated to include the new Director of Nursing and Governance".
It was noted that the terms of reference for the MHLC, and other Committees of the Trust would be reviewed during September 2015 and taken to the Board of Directors following that for formal approval.

Action: Mrs D Oliver

15/20 CARE QUALITY COMMISSION (CQC) FEEDBACK SUMMARY REPORT

The Committee considered and noted the Care Quality Commission (MHA) visit feedback summary report for 1 April 2015 to 30 June 2015.

Arising from the report it was noted that:

(1) There had been 4 MHA visits from 1 April to 30 June 2015 to Bek Ward, Ceddesfield, Park House and Lanchester Road Hospital LD forensic services, compared to 18 in the same Quarter of 2014.
(2) Reports had been received on 2 out of the 4 visits, setting out 9 actions to be addressed.
(3) The key areas for action were around admission to the ward, leave of absence, consent to treatment, patient issues and respect, participation and restriction. These actions were being addressed.

Following discussion it was noted that:

(a) All inspectors now had compliance powers. The frequency of visits had picked up in pace from 0 in April and May, then 3 during June 2015.
(b) Lessons could be learned from a very positive MHA visit to Westerdale South, where there had been a faultless inspection.
(c) There needed to be clarity on the processes around ensuring that appropriate information on capacity and consent is obvious to CQC inspectors.
(d) The timeliness of moving from recording in cardex to using the tab for the Mental Health Act on Paris was awaited.

Agreed: That there should be a further discussion around the evidence of the recording of capacity assessments at the October 2015 MHLC meeting, led by Dr N Land.

Action: Dr N Land

15/21 MHA PERFORMANCE REPORTS

The Committee considered and noted the Admissions, Changes and Detention Themes Report.

Arising from the report it was highlighted that:

(1) There had been a significant degree of variation in activity across the localities.
(2) Since the Cheshire West Judgement had been delivered on 19 March 2014 there had been a significant impact on the number of people who were now defined as being deprived of liberty and this had led to increased admission rates under the MHA.

There would be further impact on the admission figures once the Vale of York had been incorporated into the statistics.

Arising from discussion it was noted that:

(a) There seemed to be an unwillingness to admit patients under a section 3 as some patients, known to the Trust were being admitted under a section 2. This decision ultimately impacted upon the patient's family involvement, as well as causing considerable administration time, which distracted from the clinical input.
(b) Bed occupancy on Bilsdale showed 20/14 beds on 31 January 2015 and 20/14 beds on Lustram Vale on 31 March 2015.

This would be investigated by the Head of Service.

Action: Mr B Kilmurray

The Committee considered and noted the Section 136 Report.

Arising from the report it was noted that:

(1) The use of Section 136 had been used significantly more by Cleveland Police than by any other police force sending patients to TEWV as a place of safety.
(2) It was interesting to note from the Scarborough Street Triage information that significant numbers seen by the Team were already known to TEWV and out of 128 people seen, 107 of them were already known to services.
(3) The total number of individuals made subject to Section 136 across the Trust area had increased to 76 in June 2015, compared with 44 in April 2015.
(4) There had been a spike of 34 individuals subject to Section 136 brought to Roseberry Park in June 2015, compared to 17 in May 2015.

These statistics would be validated as this seemed like a very large increase.

Action: Ms P Griffin

(5) There had been a 37% increase in the last quarter on the use of Roseberry Park for a place of safety.
(6) Street triage had been introduced in Teesside in 2012, however not until 2014 for Scarborough. The teams were collecting data differently, which caused some issues with presenting and comparing data and there were also variances in the commissioning around street triage.

Following discussion it was noted that:

(a) The duration of police presence was an issue in some Trust places of safety, resulting in some Police Officers remaining in a place of safety for significant periods.

(b) The number of people attending on a voluntary basis at Roseberry Park had risen significantly since the opening of the Crisis Assessment Suite, from 75 in April 2015 to 101 in May 2015, however there had been a recent decrease in June 2015 to 41.

(c) It was not clear whether voluntary attenders who then returned home were being returned home with our without follow up. This information would be requested from the CAS Team staff and added to the report for future.

Action: Ms P Griffin

The Committee considered and noted the Seclusion Report.

Arising from the report it was noted that:

(1) There had been 10 episodes of seclusion in April 2015, 4 in May 2015 and 7 in June 2015, ranging from 15 minutes to 327 hours.
(2) Examples of the reasons for seclusion were set out in the report, including hostile violent behaviour, escalation in behaviours and verbal aggression.

Following discussion it was noted that:

(a) It was extremely important for the escalation of behaviours of patients to be captured and recorded at the appropriate time.
(b) It was anticipated that the recording of seclusion data would be improved with the installation of the seclusion module on Paris.
(c) Forensic Services had been looking at individual patients where there had been long periods of seclusion.

This would be picked up through the Force Reduction Group, who would be given the Seclusion Report from this meeting for consideration.

Action: Miss M Wilkinson

The Committee considered and noted the Discharges from Detention Report.

Arising from the report it was noted that:

(1) There were 11 discharges by the First tier Tribunal and no discharges by the Hospital Managers.
(2) There had been 140 tribunals held in the Quarter and 11 patients discharged.
(3) Several of the discharged patients had remained on the ward as informal patients and were discharged a couple of weeks later. None had been readmitted.
(4) It was clear that the First Tier Tribunal panel, despite reading the reports, hearing verbal evidence and questioning the clinical team could still not agree with the clinicians in a small amount of cases.

Following discussion it was noted that:

(a) There had been 0 patients discharged by Hospital Managers for the second Quarter. Assurance was provided to the Committee that the MHL Officers did read every decision and Hospital Managers were not 'rubber stamping' cases.
(b) The MHL Department would continue to monitor the instances when the first tier Tribunal or the Hospital Managers discharge detained patients.

The Committee considered and noted the Hospital Managers' Report.

Arising from the report it was noted that:

(1) There had been 4 discharges from detention during 2014 – 2015 by the Hospital Managers' Panels.
(2) There were 38 Hospital Managers, (including Non-Executive Directors), 19 of whom also 'Chair' review panels. There were however, very few in the North Yorkshire area.
(3) The Chairman of the Trust and 2 Non-Executive Directors were currently involved in some training around the role of Hospital Manager.

Following discussion it was noted that:

(a) The Chairman of the Trust had requested that more Hospital Managers were recruited urgently, since this role took up a huge amount of time for the Non-Executive Directors involved.
(b) There had been a discussion at the EMT meeting around the resources available for the Hospital Managers expenditure in light of the impact of the Vale of York tender, as the current budget was already overstretched.

15/22 CODE OF PRACTICE UPDATE – IMPLEMENTATION PLAN

The Committee considered and noted the action plan on the Code of Practice Update.

It was highlighted from the report:

(1) That the first 4 actions were completed around producing a news item for e-bulletin, making the revised Code of Practice available to all Wards and teams, ensuring that changes were embedded in the rolling programme of mental health legislation training and reviewing any Trust policies.
(2) Policies had been sent to Jo Flintoff, Information, Risk and Policy Manager to ensure they had been communicated to policy leads, updated and distributed across the Trust.
(3) An action outstanding for completion by the end of September 2015 was to provide a series of briefing sessions (maximum 2 hours) across all localities in the Trust.

15/23 REVISED ASSOCIATE HOSPITAL MANAGERS POLICY

The Committee received the noted the revised draft of the Associate Hospital Managers policy, which would now go to EMT meeting for formal ratification.

Arising from discussion it was noted that:

(1) There was a query at section 4.8, Three Year Review, stating, *"the Non-Executive Director with responsibility for the MHA will hold an individual review of continuing suitability with each Associate Hospital Manager once every three years"*. However, it was pointed out that the statement should read – "The Non-Executive Director with responsibility for the MHA (or designated deputy)".

    This was to ensure that it did not become onerous to the Non-Executive Director and member of the MHL Team could take on this role.

15/24 DELIRIUM IN THE ACUTE HOSPITAL AND DEPRIVATION OF LIBERTY

Dr Land gave a verbal update on the document 'Delirium in the Acute Hospital and Deprivation of Liberty'.

It was highlighted that:

(1) A number of Liaison Psychiatry colleagues had identified concerns that there were large numbers of people in acute Trusts thought to be deprived of their liberty; however this was not being recognised by the acute Trusts.

(2) Guidance provided by Dr Land was that If a patient had been seen by the Liaison team and there were concerns regarding deprivation of liberty, then the team would be required to raise those concerns. If, however, the liaison team were aware of potential issues in relation to patients that they had no involvement with then they could not be expected to intervene. It must be remembered that the acute Trust was responsible for their patients and any potential unlawful deprivations of liberty.

Agreed: that this issue should be raised with Executive peers.

Action: Mr B Kilmurray/Dr N Land

15/25 DEPRIVATION OF LIBERTY SAFEGUARDS CONSULTATION

Miss Wilkinson gave a verbal update around the Law Commission Deprivation of Liberty Safeguards Consultation.

It was noted that:

(1) The consultation period for this document, published in July 2015 would end in November 2015.
(2) The document was very lengthy and quite radical setting out the different levels of 'Protective Care'.
(3) One major change was the proposal to extend the MHA to cover compliant incapacitated patients to remove the question of whether it should or should not be DoLS. Extending the MH~~A~~ would allow patients to be detained, however there would not be the power to treat.
(4) The document was clearer and removed ambiguity in terms of patients in mental health settings.
(5) Other recommendations in the document looked at issues such as when deprivation might start with a patient with underlying physical health problems.

Following discussion it was agreed that the Trust would respond to the consultation, which would go to the Board of Directors meeting in September 2015.

15/26 PROCEDURES

The Committee considered and approved the following procedures:

1. Consent to Examination or Treatment.
2. Death of a Patient subject to the MHA.
3. Independent Mental Health Advocacy.
4. Patients' Correspondence – section 134 MHA 1983.

5. Section 132/132A MHA – providing information to patients and patients' nearest relatives.
6. Seclusion and Segregation.

Agreed: that these procedures would go onto InTouch.

ANY OTHER BUSINESS

The meeting concluded at 12.15pm

_____

Richard Simpson
Chairman – Mental Health Legislation Committee
26 October 2015

Appendix 3

Issues pertaining to York and Selby

On the transfer of York and Selby Mental Health Services to Tees, Esk and Wear Valleys NHS FT 1st October 2015 MHA files for each patient subject to the Act were received and explored to assure ourselves of the legality of each CTO or detention.

A number concerns about missing documents, incorrectly completed documents or omissions in completion of documents were noted, contact was made with LYPFT to request all missing information be forwarded as soon as possible.

The concerns were:

- No evidence of the Hospital Managers hearing at the renewal of detention or CTO (required by Sections 20(3) and 20A(5) of the Act).
- AMHP applications for detention with missing back page (AMHP signature and date).
- Medical recommendation from April 2015 Incorrectly dated had not been identified or corrected under Section 15 within 14 days
- Undated CTO1, incomplete CTO7.

The Legal advice sought about these concerns stated that if the relevant documents, missing or corrected, could not be located within a reasonable period of time the safest course of action would be to end the relevant section.

The time frame given for LYPFT to produce the information was 2nd November 2015 by which time some missing documents from archive files were received. Where this was not the case a Hospital Managers panel was held to hear the cases; there were 10 sections - 4 CTOs and 6 detentions discharged by a panel.

The relevant RCs were informed on 30th October 2015 that they would be required to verbally notify each detained patient affected, re-assess them and if appropriate a fresh application made. With regard to the CTO patients any future relapse would be managed by a MHA assessment for detention as the power of recall was no longer available.

To minimise any disadvantage to re-detained patients a Hospital Managers hearing will be held at the point where their detention would have been renewed. A fresh T2 or T3 from the RC or SOAD has been requested from the point of detention rather than at 3 months, to allow for an immediate eligibility for an application to the First Tier Tribunal.

Each RC was emailed the outcome of the Hospital Managers hearing and provided with a copy of the letter sent to each patient; CTO patients were notified by a CPN. All patients affected were written to on 2nd November 2015 with a copy to their nearest relative.

A number of late hearings have now been held and the remaining are being arranged as soon as it is practicably possible. For those patients who had not had

their case referred to the First Tier Tribunal (as per Section 68(2)) these patients will have their referrals progressed as a priority.

FOR GENERAL RELEASE **ITEM 10**

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 24 November 2015**

Title: **Progress Report on Francis 2 Action Plans**

Lead Director: **Martin Barkley, Chief Executive**

Report for: **To consider**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services		Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 24 November 2015**

Title: **Progress Report on Francis 2 Action Plans**

1. INTRODUCTION AND PURPOSE

1.1 The purpose of this report is to update the Board of Directors on progress with implementing the action plans arising from the Francis Report, for the period up to 31 October 2015

2. BACKGROUND INFORMATION

2.1 The Board of Directors approved action plans in response to the Francis Report itself as well as separate action plans following staff and stakeholder engagement discussions.

3. KEY ISSUES

3.1 Progress continues to be made, as can be seen on the progress report attached as Annex 1. There are no serious exceptions or delays to highlight, albeit some slippage has occurred on some of the elements of the action plan.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** Implementing the action plans will improve the quality of care provided
4.2 **Financial:** None identified
4.3 **Legal and Constitutional:** None identified
4.4 **Equality and Diversity:** None identified
4.5 **Other Risks:** None identified

5. CONCLUSIONS

5.1 The attached progress update confirms progress with implementation of the action plans.

6. RECOMMENDATIONS

6.1 The Board of Directors is asked to receive and consider this report.

Martin Barkley,
Chief Executive

ANNEX 1

REPORT OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY – RECOMMENDATIONS ACTION PLAN EXCEPTION REPORT AS AT 30 JUNE 2014

ACTION PLAN RESPONSE TO FRANCIS REPORT JULY 2013 – SEPTEMBER 2013

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
	Patient, public and local scrutiny			
	Openness, transparency and candour **Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.** **Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.** **Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.**			
174 Chapter 22	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	Agreed. The Trust is currently reviewing how it can provide better support to relatives of service users who have died through self injury. The Trust held a Kaizen event in March 2013 where a revised system for relative contact and support was agreed with a group including bereaved carers and family members. The new support arrangements are being gradually introduced with serious untoward incidents that occur since 1 July 2013. **Action: Dir of N&G - July**	**YES**	The new arrangements have not been effective. New arrangements will be developed by December 2014. The new arrangements (Version 2) started March 2015. **Completed – the new arrangements with full time Reviewers is proving effective in engaging relatives.** **Full implementation**

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
				of national SI Framework completed by December 2015.

ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT JULY 2013 – SEPTEMBER 2013

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
Culture							
37	Learning lessons from when things have gone wrong.	• To ensure that all actions in SUI & complaint action plans are SMART. • To implement escalation arrangements to help ensure that action plans are completed on time. • To carry out a sample audit of completed actions to test for their efficacy. • To review the ways in which lessons learned from complaints and SUI investigations are shared and learnt from.	Ian Parker Review Action Plan	EMT Directors Director of Nursing & Governance Director of Nursing & Governance Director of Nursing & Governance	From July 2013 From September 2013 From October 2013 ~~March 2014~~ March 2016	**YES** **YES** **YES** ~~**YES**~~ **PARTIAL**	Review has been completed but has revealed significant change is required. This is the focus of a significant project. Project report October. Implementation November - March.

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
		• To review the methodology of investigation of Level 5 SUIs to ensure that real lessons are learnt as a consequence of the findings of the investigation.		Director of Nursing & Governance	~~March 2014~~	**YES**	**The new arrangements with full time Reviewers are working well.**

ACTION PLAN RESPONSE TO FRANCIS REPORT JANUARY 2014 – MARCH 2014

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
	Caring for the elderly **Approaches applicable to all patients but requiring special attention for the elderly**			
238 Chapter 25	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. • Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives. • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.	• The review of nursing allocation systems will include observation of the therapeutic milieu within the inpatient areas and the levels of interaction between nurses, their patients, relatives and carers. Recommendations to improve therapeutic interaction will result from that review. • The current methods of communication both with relatives and with General Practitioners at point of discharge are subject to current development work. **Action: COO - completion**	**YES** **NO** **YES** The new arrangements have been substantially rolled out and	Observation complete. Re inpatients. The community discharge letter template was developed in an RPIW in April. South Durham Affective Team were involved in the

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
		date Quarter 4 2013/14	the project team is monitoring and supporting the new way of working	RPIW and piloted the template. The RPIW was reviewed up to the 90 day point and it was agreed the template could be rolled out. Further work has been done with other services – Redcar and Cleveland AMH Teams (Mark Rushforth), Tees CAMHS Teams (Brian Cranna), Northallerton West CMHT (Joanne Fawcett). Dr. Jane Leigh (who is leading this project) has been called back to the South Durham Team to discuss some concerns they now have about the letter template. Their principal issue was the time taken to find some of the information required for the template within PARIS. Feedback from South Durham GPs has been universally positive – with 100% expressing satisfaction with the template letters. Likewise the feedback from patients has also been good, with service

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
				users reporting they find their copy letter understandable and helpful. The template has (in October 2014) been developed by Dr. Jane Leigh and IT to enable a range of the appropriate information to be electronically pulled through into the template – saving clinical time. This goes most of the way to addressing the concerns of the South Durham Team. Dr. Jane Leigh and her team have a roll-out plan that will enable delivery of the template letter to all teams by March 2015. This involves face-to-face training, follow up visits and audit and review. The community discharge documents are fully electronic and sent via email to most surgeries within two working days. Service users are offered a copy.

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
		• Information and progress updates on patient care are included in the development work to implement the findings of the 2011/12 CPA review. **Action: COO - 2014**	~~**PARTIAL –** Not yet 100% but much improved, remains part of the CPA project~~ **YES**	Stage one of the community roll-out plan is completed (39 community teams trained) and Stage two will be commencing in August 2015. Care plans have been issued or re-issued on yellow paper to enhance the visibility and recognition for service users. To date over 4,000 yellow care plans have been issued in AMH services with other specialties following this initiative. The team is no longer counting the numbers issued as this involved a manual count by each team (this was necessary for 2013/14 Quality Account). **Completed – The three year CPA Project is now at an end. The standard of service users having a copy of their care plan is / should be part of routine practice which is subject of audit and**

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
				supervision. **The evidence from the latest Community Services Patient Survey supports the view that the sharing of care plans is now more embedded than previously.**

ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT JANUARY 2014 – MARCH 2014

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
HR and organisational development							
26	Improve the effectiveness of supervision and annual appraisals leading to the development of effective Personal Development Plans which are acted upon.	To review clinical supervision arrangements and staff appraisal arrangements and consider the introduction of 360° feedback every three years for managers and leaders.	Not Applicable	Director of Nursing & Governance and ~~Deputy~~ Director of Human Resources & Organisational Development	March 2016 The EMT in June 2015 agreed the basis for changing and implementing new Clinical Supervision arrangements	**NO**	**Report to Board of Directors 27 October 2015 Trust Policy position has been amended.** **A Trust-wide implementation plan to include the final policy amendments, the development of standard documents, baseline scoping of clinical supervisory capacity requirements, baseline supervisor competency assessment, top-up**

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
							training for supervisors, briefing and spot audit will be progressed during 2016/17.
					The new appraisal system has been agreed and will be implemented Directorate by Directorate before 31 March 2016	**YES** **YES** **YES**	Review complete and implementation proposals endorsed by EMT. 360°. Staff appraisal.
Culture							
38	The Trust should take more steps to share best practice through, for example, networking.	To carry out a review of existing networks to identify what additional networks would be helpful.	Not Applicable	Chief Executive (with Service Development Managers)	March 2014	**Work in progress**	Proposed list of Learning Sets developed as basis for discussion. Agreed. Will start to be implemented in Q3 2014. Subsequent consideration deferred until July 2015.

ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT APRIL 2014 – JUNE 2014

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
Recovery Approach							
11	The Trust should place more emphasis on preventing service users' mental health deteriorating.	To embed early warning practice within clinical processes.	CPA Project	~~CPA Project Manager~~ Chief Operating Officer and CPA Project Manager	~~October 2014~~ March 2016	**PARTIAL**	With the emphasis on staying well and identification of early warning relapse indicators a service user workbook, "Staying Well Plan" has been developed and is being implemented with service users in Psychosis and EIP services in Stockton AMH and North Durham. This will be implemented in Hartlepool Psychosis Team commencing October 2014 and will continue with the roll-out of Model Line. The Staying Well Plan is a service user held workbook that individuals complete with support from MH staff. The version of PARIS will go live from March 2016. This practice will

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
							be fully embedded as part of that roll-out. As part of the Model Line roll-out this practice is being embedded in Psychosis teams. The rest of the teams will be live with this from March 2016.
Service user and carer involvement							
14	Ensure that users and carers (groups) are involved appropriately at a strategic level.	To review how users and carers are engaged in strategic and governance groups in the Trust.	Not Applicable	Chief Executive	June 2014	**PARTIAL** Quotations obtained to advise on AMH arrangements in D&D and Tees and review of arrangements in NY already underway	Review completed. Significant gaps in AMH in all three localities which will be addressed in 2015. **Due to report before Christmas.**
Staff feedback and involvement (including staffing reviews)							
44	Clarify roles and expectations of Ward Managers.	This piece of work is underway and will be implemented.	Project being established	Chief Operating Officer	~~June 2014~~ September 2015	~~**PARTIAL** PM3 agreed~~ **YES**	This project is now under way. A role description, revised skills matrix and a programme of standard work development has been developed. The clarification of roles has been delivered as part of this work. **This has been cascaded through the recently**

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
							established Ward Manager Forum and will be further embedded by the Locality Heads of Nursing.
47	Ensure that Modern Matrons have sufficient time to focus on professional nursing issues.	To review individual jobs of Modern Matrons to identify if there are any duties they have that can be better done by others to free up time.	Modern Matron Workplan	~~Deputy~~ Director of Nursing & Governance	March 2015	**~~PARTIAL~~ YES**	Review complete and recommendations made – will be progressed with the work on the standardisation of the role of ward managers.
48	Lack of consistent leadership model of community teams including Advanced Practitioner role.	To establish a leadership model for community teams.	Not Applicable	Chief Operating Officer	~~June 2014~~ March 2016	**PARTIAL** Draft PM3 rejected and basis of revised version to be agreed	Leadership model has been developed and the project has begun roll-out in Durham and Darlington. Events are planned to expand this to other localities during 2015/16.

ACTION PLAN RESPONSE TO FRANCIS REPORT OCTOBER 2014 – DECEMBER 2014

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
194 Chapter 23	As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	The Trust is currently awaiting guidance from the Nursing and Midwifery Council regarding the proposed nursing revalidation process. The current annual performance appraisal focuses on the requirements of each nursing post in relation to the knowledge and skills framework for that post. The appraisal process will be further developed to integrate the values based performance monitoring recommended by this report. **Action: Dir of HR and Dir of N&G - April 2016**	~~**NO**~~ **PARTIAL** The Trust's new appraisal system has been agreed and is being implemented over the next 9 months	**The NMC and NHS England have confirmed that Revalidation for Nurses will come into effect on 1 April 2016. Regional and local steering groups continue to meet on a regular basis and progress continues to be maintained aligned to PM3.**

ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT OCTOBER 2014 – DECEMBER 2014

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
7	Develop on-line methods that enable patients and carers to more easily give feedback.	To develop apps and on-line solutions via the Trust's website for patient and carer feedback.	Knowledge Management Project	Patient Experience Lead Nurse	March 2016	**NO**	This cannot be implemented with our existing website's lack of functionality. In addition the development of the Business Case re. Apps, etc. has been postponed to the summer. Therefore

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
							need to agree revised date of March 2016. The requirements regarding functionality of the website have been fed into the KMS project.
Recovery Approach							
13	Lack of service user involvement in recruitment and selection of new staff.	This will be rectified as part of the Embedding Recovery Approach project.	Embedding Recovery Approach project	Recovery Approach Project Manager	~~December 2014~~ October 2016	~~**NO**~~ **PARTIAL**	There is evidence of some participation in recruitment by service users. This is not as yet systematic. Standards for the routine involvement of service users will be drawn up and agreed by HR.
CPA							
16	In the context of reducing paperwork completed by clinicians, etc. review whether the skill-mix is correct in community and ward teams between clinical staff and admin staff.	Agreed review to be undertaken.	CPA project Model Lines Project	Chief Operating Officer	~~Dec 2014~~ March 2016	~~**NO – MAINLY**~~ **PARTIAL** ~~This is being revisited in the context of Digital Dictation~~	**Shortened standard care documentation is being agreed through SDGs and Clinical Effectiveness Group as part of the Purposeful and Productive Community Services Project. The Harm Minimisation Project will also contribute to the ongoing review of documentation. All documents are being reviewed as part of the Paris Version 6 roll-out which will commence in**

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
							March 2016.
Staff feedback and involvement (including staffing reviews)							
46	Invest in skills of staff of de-escalating challenging behaviour and management of challenging behaviour.	The current LD challenging behaviour pathway is being adapted via an RPDW to be used in each Service division within the trust and staff provided with the skills to practise in this way.	Violence and Aggression Workstream	Deputy Director of Nursing	October 2014	~~NO~~ **PARTIAL**	The Force Reduction Project is on track and is achieving all targets. New skills in PBS are being rolled out and the training for management of violence and aggression is being reviewed with regard to developing new training to meet the Restrictive Practice requirements set by the DH. The challenging behaviour pathway is being spread as part of the project supported by a commissioner CQUIN this year. **The Force Reduction Project remains on track for implementation by June 2016.** **Reviews of training model complete. Proposed alternatives for training, to include de-escalation and debrief training, have been developed and are currently awaiting review with OMT and EMT.**

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
							Standardised processes for the development of behaviour support plans and staff and patient debrief tools are now completed and ready to pilot. **The Safe Wards approach is now being used with 30 inpatient services and the project team are developing a training resource to develop a "train the trainer" approach across the rest of the organisation.**

ACTION PLAN RESPONSE TO FRANCIS REPORT 2015 AND BEYOND + ONGOING ITEMS

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
	Information			
244 Chapter 26	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry. • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. • Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.	Agreed. **Action: DoF - milestones up to March 2015**	**PARTIAL ONGOING**	The Trust continues to develop its electronic patient record (PARIS) and planned improvements will encompass a number of the points detailed in the recommendation. In addition the embedding of agreed patient pathways within PARIS together with the IIC development will provide a series of prompts, defaults and alerts which will contribute to safe and effective care. Development of the PARIS system continues with the Board of Directors agreeing in June to further investment to secure additional enhancements and improvements to the system. **The recommendation is always going to be relevant and we work with CIVICA to**

Rec. No. (Chapter No.)	Recommendation	Trust Response	Completed Yes / No	Comments
				continually improve PARIS. This is going to be never ending. Thus suggest this is removed now from this action plan.

ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT 2015 AND BEYOND + ONGOING ITEMS

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
Patient outcomes & Clinical outcomes (PROMS & CROMs)							
2	Ensure that effective use is made of the patient outcome reports.	To develop standard methodology for patient reported outcome measures to be reported back to services and other governance groups.	PBR Workplan	Director of Finance	December 2015	**PARTIAL ONGOING**	This information is now available to each member of staff and Team Manager. Further work is taking place to encourage staff to use this information. Also consideration needs to be given to the role of management and the Board in this context. Work continues to embed the use of Outcome measures within the Trust principally through reporting of CROM and PROM information via IIC. **Because this is never ending, again suggest this is removed from action plan.**

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
Recovery Approach							
10	Improve patient outcomes by widespread use of the Recovery Approach.	To implement the Embedding the Recovery Approach project.	Embedding Recovery Approach Project	Recovery Approach Project Manager	3 year project commencing Sept 2013	**PARTIAL**	Project on track.
CPA							
17	Improve the effectiveness of the CPA process.	To implement the existing CPA project.	CPA project	CPA Project Manager	2 year project commencing Oct 2013	~~**PARTIAL**~~ **YES**	**The CPA project closed September 2015 with a PM4 scheduled for EMT in November 2015 outlining outcomes and achievements.**
18	Ensure that no unnecessary information is requested to be collected by frontline staff.	To review all present requests for data collection.	CPA project	CPA Project Manager	2 year project commencing Oct 2013	**PARTIAL Contingent on the Paris Programme**	**The CPA project has linked in with the Paris Programme and Information Team to develop a more streamlined and effective information flow throughout the electronic patient record. This work is also aligned to IIC developments to ensure all information is directly collected from Paris.**
19	Ensure there is a clear understanding and expectation of the role of the Care Co-ordinator.	This work is being undertaken as part of the CPA project.	CPA project	CPA Project Manager	2 year project commencing Oct 2013	~~**PARTIAL**~~ **YES**	**The new CPA Policy framework clearly outlines the role and expectations of the Care Co-Ordinator. This is supported by e-learning training and audited via**

	Issue identified	Summary action	Link to existing work stream	Who	When	Completed Yes / No	Comments
							the CPA audit.
20	Staff in specialist services such as ADHD, Eating Disorders, Autistic Spectrum should take on care co-ordination role when appropriate to do so.	This is being addressed as part of the CPA project.	CPA project	CPA Project Manager	2 year project commencing Oct 2013	~~**PARTIAL**~~ **YES**	**This has been made explicit in the new CPA policy and reinforced within locality services via the CPA Steering Group.**
HR and organisational development							
29	Identify people with an interest in moving to positions of management and leadership.	This is being addressed as part of the introduction of talent management arrangements in the Trust.	Talent Management Workstream	Chief Executive	March 2015	**PARTIAL**	60% of talent conversations have taken place for Band 7s and above and TM training now being provided for similar conversations to be had with Band 6s.

FOR GENERAL RELEASE **ITEM 11**

BOARD OF DIRECTORS

Date of Meeting: 24th November 2015
Title: Waiting Times Report
Lead Director: Brent Kilmurray
Report for: Information

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing	✓	Supporting workers	
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision	✓	Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes		**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **24th November 2015**

Title: **Waiting Times Report**

1. INTRODUCTION & PURPOSE

1.1 During 2014/15 the Board requested that an action plan be developed to address the persistent difficulty there has been in achieving the Trust's waiting time target. There has been a great deal of improvement over recent years, when waiting times were as high as more than 18 weeks. However the Trust has never achieved the ambitious target it set itself of 98% of patients being seen within 4 weeks of referral.

1.2 The contractual requirement with CCGs is that 98% of patients are seen within **9 weeks** of referral. Whilst this has been delivered consistently for Adult Mental Health services there have been breaches of this indicator in 2014/15 within Children and Young People's services.

1.3 In July 2014 the Board approved an action plan that set out to address the underlying issues that were judged to have prevented the achievement of the target.

1.4 Whilst the position has shown some improvement, there are issues with variation across teams and in some cases the sustainability of the improvements. Therefore there remain concerns about the waiting time position for both Adult Mental Health (AMH) services and for Children's and Adolescent Mental Health Services (CAMHS), this paper seeks to provide an update on the position.

1.5 There are action plans in place in each locality. The sections below provide a commentary on the current situation across the Trust and give a view of the actions under way.

2. BACKGROUND INFORMATION

2.1 Locality Contract and Performance Groups have been monitoring action plans to address the situation. The Performance Improvement Group also discusses these plans on a monthly basis.

2.2 The resolution of long waiting times is the highest performance priority for services at present.

2.3 Despite a range of initiatives (including those covered in the action plan) performance has not yet met the target. There has been some improvement in the position, however there is variation between teams and some issues with sustainability of improvements.

3. KEY ISSUES:

Appendix 1 shows the update against the original action plan that was developed for

Adult Mental Health Services which was focused on ensuring appropriate levels of staffing were available within the teams, working with referrers to ensure they know how the obtain help and guidance in managing their patients in primary care where appropriate and increasing capacity within the teams . Whilst progress against this has been made as shown in the Appendix individual teams are also taking action to address issues that are specific to them. Included below is a commentary by Locality on the current key issues and the actions being taken locally. Unless stated otherwise the positions reported relate to September 2015.

3.1 Durham and Darlington

AMH

In September, Durham and Darlington AMH services saw 77.88% of patients referred within 4 weeks. This equates to 405 out of 520 patients waiting. This is a decrease compared to August when D&D AMH achieved 80.95%. However, the position for October (IIC data as at 16 November 2015) shows a position of 82.07% (412 of 502 patients waiting).

At the monthly AMH performance meeting each Team reports their position against this target and gives reasons for any breaches. Reduced levels of access documentation were implemented following a Kaizen Event. A further Kaizen Event was held at the end of October with access leads and representatives from all teams and the impact of this will be monitored over the next 30, 60 and 90 days. This Kaizen Event included metrics around quality of/triage of referrals, documentation and 5S of process.

The caseload management work is being revisited in the context of the Purposeful and Productive Community Services. There is also a review of the visual control boards in teams linked to this work. Another key feature of the plan to promote productivity is the introduction of job plans for all members of the multi-disciplinary team.

The current average waiting time for secondary care is 3.4 weeks and for primary care is 2.8 weeks.

The main areas of underperformance in September are in our access teams as the capacity continues to struggle meeting the high level of demand:

- Derwentside and CLS Access - 43.75% (14 out of 32 patients). This is an improvement from the August position largely due to more directive input from the locality management team and the efforts of a new Leadership Team. Additional access appointment slots have been identified, controls put in place in the team to ensure compliance with existing standard work and daily review is in place. Performance in October increased slightly to 49.12% (28 of 57 patients) – although this is a small increase, it does reflect a doubling in the volume of access appointments available.

- Darlington Access – 49.33% (37 out of 75 patients), which is a deterioration from the previous month. The Darlington team have a range of challenges at present

and are managing a higher than normal level of staff turnover and sickness, including the access lead post, which has directly impacted on their capacity to manage the continued high volume of referrals. The move away from integration (to a co-location model) with the local authority continues to have an impact on capacity to manage the volume of work in the team. An action plan is in place and performance has increased to 74% in October. Detailed work is being undertaken in the team, led by the Acting Head of Service and Locality Manager, to ensure that this progress continues. This includes weekly monitoring of progress, daily review and support by the Assistant Locality Managers and additional medical access slots being identified.

- Wear Valley Dales Access – 58.07% (23 of 39 patients). There has been some sickness, compounded by annual leave. It is expected that this position will be recovered within the next month.

- Easington Affective – 60.71% (17 of 28 patients) due to an unusual level of sickness within the team. Performance in October has improved to 90%.

- Sedgefield Access – 76.19% (32 of 42 patients). Again this is a slight deterioration from August's performance but the October position does show some improvement. Appointment of the additional access post to this team was unsuccessful therefore recruitment has commenced again. In the meantime, the leadership team are monitoring the position on a daily basis and identifying additional access slots to meet demand

- Durham City Access – 82.22% (74 of 90 patients). This is a slight decrease from the August position of 89.29%, and a decrease from the June position where 97.26% was achieved. However, the team had an incredibly high volume of referrals during September and the dip in performance reflects this. The Team Manager continues to manage this on a daily basis.

CYPS

In September D&D saw 43.82% patients within 4 weeks, this equates to 110 patients seen within 4 weeks out of 251. This is an increase compared to August when D&D CYPS achieved 42.13%. The position for October shows 55.34%. The biggest impact on these figures is primary mental health who, in September, achieved 28.65% which equates to 55 out of 192 patients seen within 4 weeks.

This service did not achieve the contract target of seeing patients within 9 weeks of external referral in DDES and North Durham CCGs in April, May, June and July 2015 and in Darlington CCG in April and June. The service therefore focussed attention on achieving this target and achieved target in all 3 CCGs August and September, with the September position showing that, 96.73% in North Durham CCG, 94.02% DDES CCG and 100% of patients in Darlington CCG were seen within 9 weeks.

The service made significant improvements towards achieving the target in the summer; however there have been difficulties with sustaining the position. This has been largely as a result of demand. The detailed capacity work undertaken earlier in

the year has been revisited and from the New Year there should be an improvement in the trajectory toward the 4 week target.

However, in October the position for 9 weeks is as follows:

North Durham – 89.41%
DDES – 86.49%
Darlington – 100%

Currently in Durham and Darlington CYPS the average weeks waiting is 5.3 weeks.

3.2 **Teesside**

AMH

In September Tees reported that 93.28% of AMH patients were seen within 4 weeks. This equates to 526 patients seen within 4 weeks out of 562. This is a decrease compared to August when Tees AMH achieved 96.99%. However, the position for October (IIC last refreshed on 28th October) shows 96.93%

The main area of under performance against the waiting time target is AMH is Stockton Access. In September they saw 55.36% of patients within 4 weeks (31 patients out of 56). This has increased in October to 83.61% (51/61). To address this situation an increased number of appointment slots are being offered and the Head of Service has instigated a weekly telephone conference with the Team Manager to monitor the situation. Currently IIC is showing that 3 patients are showing as 4 week waiters. The average waiting time on IIC for this team is 1.4 days.

At the monthly AMH performance meeting each Team reports their position against this target and gives reasons for any breaches.

CYPS

In September Tees reported that 57.89% of CYPS patients were seen within 4 weeks. This equates to 132 patients seen within 4 weeks out of 228. This is a decrease compared to August when Tees CYPS achieved 71.78%. The position for October shows 67.40%.

This service did not achieve the contract target of seeing patients within 9 weeks of external referral in Hartlepool and Stockton CCG in April, May and June 2015. The service therefore focussed attention on achieving this target and achieved the target in July, August and September, with the September position showing that 98.64% of patients were seen within 9 weeks.

In September the targeted teams where the majority of the external referrals are received recorded the following percentages against the 4 week target:

Middlesbrough Targetted	60.00%
Redcar Targetted	28.00%

Hartlepool Targetted	8.57%
Stockton Targetted	32.50%

However, in October the position is as follows

Middlesbrough Targetted	66.67% (it is projected that the 4 week standard will be met in January)
Redcar Targetted	10.00% (it is projected that the 4 week standard will be met in February)
Hartlepool Targetted	55.56% (it is projected that the 4 week standard will be met in January)
Stockton Targetted	16.13% (it is projected that the 4 week standard will be met in March)

The service has implemented shorter assessment slots to try and reduce the waiting times.

3.3 **North Yorkshire**

AMH

In October 82.3% of external referrals were seen within 4 weeks. This is an improving position from September (77.23%). The following measures are being undertaken in North Yorkshire:

- Full pathway action plan in development for Harrogate which should improve management of referrals, caseload management and reviewing visual control boards.
- Performance Clinics are being introduced for team managers
- Case load review across all teams has begun as part of community productivity programme.
- Looking at possible pilot in Harrogate combining IAPT, Primary care and Primary care counselling.
- Reviewing the access model across each of the localities for North Yorkshire as one of the AMH priority actions.
- Establishing a more consistent approach to managing waiters across the Locality including giving admin responsibility for reviewing any waiters on a weekly basis and making sure that any that are due to data errors are rectified ASAP.

The position by team is as follows:

<u>Scarborough, Whitby Ryedale CMHT</u>

- Whitby has no waiters
- Scarborough CMHT has 2 waiters both of whom DNA'd original appointment and have a second scheduled within 28 days- The team are piloting having an assessment worker from the first of December which they anticipate will remove all future waiters
- The PCMH team is of most concern, both referrals and caseloads have increased since June, coinciding with a reduction in workforce by 1.0wte in

Scarborough. A new worker starts on 17th November and the team are introducing a new assessment allocation system which again is expected to have the impact of removing or all but, future waiters. All current waiters are due to be seen by the 27th November

Harrogate CMHT

- Ripon has the most waiters - 10, but all will be seen by the 19th November. The commencement of the new Team leader (last week) should help improve this situation
- There are a combined total of 6 waiters across PCMH and the CMHT and all will be seen by the 17th November.

Hambleton and Richmondshire CMHT

Significant improvement in reducing the waiters in primary care over the past 8 months following the introduction of a waiting list initiative and 1.2wte additional staff (until February 2016). As of 16th November they have 8 waiters, none longer that 6 weeks and all have appointments, the majority are waiting for counselling. The CMHTs have 1 each.

CYPS

The number of patients waiting over 4 weeks in Scarborough has been impacted by long-term sickness and the inability to secure a locum, however the post holder returns at the end of November. There have been no waiters over 9 weeks since July.

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Northallerton capacity has been impacted by their staff turnover, all new post holders commenced in early November which will recover the access position for this team.

Caseload management using a more consistent approach to discharging patients to create capacity to seen new patients has also demonstrated benefits.

The single point of access is having a positive impact on referrals and we are seeing the numbers increase across teams – work is being done to plan capacity and capability to respond within 4 weeks

MHSOP

Hambleton and Richmondshire

This team has 48 patients waiting over 4weeks for an appointment. Three are for care home and 45 waiters over 4 weeks are for the Memory service.

All those being referred now are being offered appointments within 9 weeks, home visits are generally seen within 4 – 6 weeks.

When patients are seen in clinic they receive diagnostic feedback that day- within the 11 weeks feedback standard.

Harrogate

19 patients have appointments booked for this month (latest date: 8/12 due to patient asking to rearrange) are over the 4 week standard. Of these 16 have appointments and will be seen within 6 weeks of referral. Of the others appointments are being made.

4. IMPLICATIONS / RISKS:

4.1 **Quality:**
Waiting times are an indication of service quality and are linked to the Patient Experience Framework, which is part of the Trust's Quality Strategy.

4.2 **Financial:**
Any additional resources set out in this paper and attached action plan have been covered through business planning and contracting processes.

4.3 **Legal and Constitutional:**
None identified.

4.4 **Equality and Diversity:**
None specific identified.

4.5 **Other Risks:**
None specific identified.

5. CONCLUSIONS

Services have developed action plans to address the numbers of long waiters within Adult Mental Health services in Durham and Darlington and Hambleton and Richmondshire. This is one of the services' highest performance priorities. Plans will deliver a range of initiatives to create more capacity, improve efficiency and make services more resilient to the pressures of current demand.

6. RECOMMENDATIONS

To note the progress made against the original action plan and that additional issues and actions identified.

Brent Kilmurray
Chief Operating Officer

STANDARD ACTION PLAN ITEM 11 APPENDIX 1

PLAN LOCATION/TEAM: Adult MH Waiting Times **PLAN DEVELOPED BY: Paul Newton & Adele Coulthard**
DATE PLAN AGREED: November 2015

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
1	Referrals have increased by over 100% in the last 4 years	Increased capacity to meet demand	Employ an additional access worker in each affective team to increase capacity	Jo Dawson	July 2015	Recruitment proforma Staff in post	**Recruitment Complete**
2	Too much time and recording is undertaken at assessment phase	Reduced recording from 3hours to 1 hour	Implement Standard Work documentation through Paris V6 Hold a Kaizen event to reduce recording time	~~Paul Newton~~ Jo Dawson	From Sept 2015 December 2015	AMH using standard care docs Kaizen Document	**Shortened documents agreed. Introduced following kaizen event October. Will be embedded in Paris v6 from March 16** **Kaizen in work plan**

3	Up to 50% of people assessed are signposted to other services	Reduce the number of people who are referred to secondary care review could be signposted earlier.	Undertake a Kaizen looking at the destination of patients signposted following an access assessment Work with CCG to implement Attached Professionals pilots Evaluate impact of Attached Professionals on referral rates	~~Paul Newton~~ Jo Dawson	December 2015 ~~Sept 2015~~ April 2016 ~~March 2016~~ October 2016	Kaizen Document First Attached professionals in place and working with GPs Report on impact of the new role and recommendations on way forward	**Kaizen in work plan** **Did not proceed as stated in action plan. Work underway with CCG and GP feds in DDES.**
4	GP's appear to be sending in referrals when advice or guidance is what they require	Offer GP's alternative routes for receiving advice, guidance or simple review.	Hold a Kaizen event to develop alternative methods	~~Paul Newton~~ Jo Dawson	December 2015	Kaizen Document	**Kaizen in work plan**

5	Hambleton and Richmondshire Primary Mental Health Team has a large number of long waits	To reduce waiting times to below 4 weeks	Through active waiting list management the Team manager is allocating cohorts of patients systematically to caseloads	Tania Tulloch/~~Carlie Johnston~~ M. Spencer	September 15	Waiting times are consistently reported as less than 4 weeks	**Ongoing. At end October 2015 there were 11 patients waiting over 4 weeks.**

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

BOARD OF DIRECTORS **Item 12**

Date of Meeting: **24TH November 2015**

Title: **To receive and note a progress report on the Trust's Composite Staff Action Plan.**

Lead Director: **DAVID LEVY**

Report for: **Information**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	
To continuously improve the quality and value of our work	√
To recruit, develop and retain a skilled and motivated workforce	√
To have effective partnerships with local, national and international organisations for the benefit of our communities	
To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	√

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services		Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing	√	Supporting workers	
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	√	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: 24th November 2015

Title: To receive and note a progress report on the Trust's Composite Staff Action Plan.

1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to provide Directors with an update about progress made with implementation of Trust-wide and locality actions arising from the 2014 staff opinion survey, Staff Friends and Family Test results and the 2014 Investors in People assessment report, known as the Trust Composite Staff Action Plan.

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2. BACKGROUND INFORMATION

2.1 The Trust Composite Action Plan was agreed by Directors at the May 2015 meeting of the Board of Directors. Locality and corporate directorate action plans have been in place since June 2015.

3. KEY ISSUES:

3.1 Appendix 1 provides a description of progress made with implementation of the Trust Composite Action plan as at the end of Quarter 2 of 2015/16. A summary of the position in respect of local action plan implementation is provided in Appendix 2, rather than an action by action update, given the large number of actions.

3.2 The Trust plan identified twenty seven actions to be completed by Q2 and of these actions twenty have been implemented as planned. Of the remaining seven actions all are now expected to be completed during Q3. Implementation of actions has been affected to some extent by the impact upon working arrangements of preparing for the Vale of York transfer of services.

3.3 Within the local action plans all but nine of Q1 and Q2's one hundred and twenty seven actions have been implemented. Appendix 2 provides examples of local actions that have been implemented.

3.4 The Trust Investors in People Leads Group, that include locality and corporate directorate representatives, has met on a regular basis and has provided a good means of monitoring and considering progress made with implementing action plans in addition to looking at wider staff engagement issues.

3.5 The forty three actions that are within the Trust plan are based upon a total of seven themes arising from the 2014 staff opinion survey results, the Staff Friends and Family Test results and the 2014 Investors in People assessment. This compares to the previous year's plan that had twelve themes and fifty actions. It is believed that taking a more focused approach to key issues will lead to better outcomes.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** There is increasing evidence that positive staff engagement leads to better patient care. Addressing the shortcomings highlighted by the 2014 staff opinion survey results, the Staff Friends and Family Test results and the Investors in People assessment ought to help us to improve the experiences of our staff and patients.

4.2 **Financial:** None identified.

4.3 **Legal and Constitutional:** None identified.

4.4 **Equality and Diversity:** The need to successfully address the continuing disparity in the experiences of disabled and BAME staff continues to be a subject of particular attention.

4.5 **Other Risks:** None identified.

5. CONCLUSIONS

5.1 Progress made to date with implementing the Trust and locality action plans has been good. A significant amount of work remains to be completed as 7 actions have been carried over from Q2, for completion in Q3, and a further 16 actions are due for completion during Q3 and Q4.

6. RECOMMENDATIONS

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

David Levy
Director of Human Resources and Organisational Development

Background Papers:
Please list any source documents used in the preparation of the report.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1

TRUST COMPOSITE STAFF ACTION PLAN 2015-2016 – UPDATE AS OF END OF QUARTER 2 (In response to the Investors in People Report, Staff Survey 2014 Results and Staff Friends and Family Test results)

NO.	THEME	INTENDED OUTCOME/ RESULT	SOURCE OF ACTION			ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
			IIP	SS	SFFT					
1	Improve high workload/ work pressure demands placed on managers and staff	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.	X	X	x	1. Communicate Trust Performance Management Framework to all staff within the Trust. 2. Produce guidance for managers and staff relating to 'no request without explanation'. 3. Identify any waiting lists and activity increases for staff support services to establish if there is a problem. 4. IiP links to promote the range of staff support services in their area. 5. Implement the technical solution for ESR and Healthroster to avoid duplication of effort for managers. 6. Understand more about the root causes of sickness absence and review how much we can do as an organisation. 7. Understand the impact of 12 hour shifts further. 8. Review the Return to Work mechanisms for community team staff V ward based staff and identify any recommended changes. 9. Improve the length of time and experience of the disciplinary process by: a. Establish an investigations team to reduce the length of time of an investigation b. EMT to agree the reviewed Disciplinary Process c. Implement the reviewed Disciplinary Process d. Review the support available to staff during the disciplinary process.	Sarah Theobald Julie Jones Sheila Jones IiP links Lorraine Sellers Lesley Hodge Deborah Newman Lesley Hodge/Helen Cooke David Levy Sheila Cowan Sheila Cowan Sheila Cowan	Q2 Q2 Q2 Q2 Q1 Q3 Q4 Q3 Q2 Q2 Q3 Q2	Emails received. Local plans. Sickness inputted onto Health Roster for clinical staff. Team appointed.	**Not completed due to Vale of York impact. Move to Q3** **Not completed due to Vale of York impact. Move to Q3** **Completed** **Completed** **Completed** **Completed** **Not completed. Move to Q3.** **Timescale may need adjusting** **Completed**
2	Improve the experience of staff during organisational change	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.	**X**	**X**	**X**	1. Review the Business Planning guidance in relation to involving staff in developing the local Business Plans and sharing the final plan with them. 2. Undertake the Organisational Change Policy Kaizen event including the importance of high quality, timely information. 3. Produce guidance for managers regarding effective communication in organisational change 4. Implement the changes from the Organisational Change Policy Kaizen event. 5. Review the effectiveness of the Local Consultative Committees in implementing organisational change.	Chris Lanigan David Levy Sheila Cowan David Levy David Levy	Q3 Q1 Q2 Q3 Q2	Event took place 30/4/15 & 1/5/15 As above.	**Completed** **Completed** **Move to Q3**
3	Improve access to training and development opportunities and the evaluation of e learning	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.	X	X	X	1. Consider the opportunity for staff to book face to face training via ESR at the Staff Domain Group and RAADA. 2. If agreed, restructure OLM to accommodate. 3. Scope the possibility to facilitate community teams to undertake their mandatory/statutory training within their geographical area by closing the team to undertake the training. 4. If agreed, commence roll out to community teams.	Susan Leightley Susan Leightley Susan Leightley Susan Leightley	Q1 Q3 Q1 Q2	Discussed at relevant groups. Scoping exercise undertaken. Commenced.	**Completed** **Completed** **Completed**

						5. Identify if there have been any risks associated with e-learning and a lack of knowledge content of that e- learning package. 6. Look at ways in which we can survey staff on their opinions of e-learning in relation to knowledge increase. 7. Consider the use of new technologies for training including apps, videos, learning forums and intranet team learning.	Judy Hurst Susan Leightley Judy Hurst	Q2 Q2 Q4	Scoping exercise undertaken. Options considered, survey to be circulated Nov.	**Completed** **Completed**
NO.	**THEME**	**INTENDED OUTCOME/ RESULT**	**SOURCE OF ACTION**			**ACTION**	**ACTION OWNER**	**TARGET DATE FOR ACTION COMPLETION**	**EVIDENCE (TO BE RETAINED BY ACTION OWNER)**	**PROGRESS UPDATE**
4	Improve levels of communication	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.	X	X	X	1. Review and amend team briefing guidance to encourage the discussion and acknowledgement of positive progress and achievement to be discussed and acknowledged during team meetings. 2. Review the Whistle blowing Policy to encourage staff to feel secure in raising concerns about clinical practice. 3. Review what is 'good communication between senior managers and staff' and understand what staff expectations are at local level and take the results and proposed action plan to EMT. 4. Map improvement events with teams and identify where QIS events have not taken place to help engage with hard to reach groups through targeted involvement. 5. Report on the evaluation of the Facilitators programme. (Carried over from 14/15)	Julie Jones David Levy Julie Jones Maureen Raine Michelle Brown	Q2 Q1 Q4 Q2 Q2	 Review underway Mapping exercise complete Evaluation Survey results obtained	**Not completed due to Vale of York impact. Move to Q3** **Completed** **Completed** **Completed**
5	Reduce levels of staff experiencing physical violence from patients/relatives or the public AND reduce levels of staff experiencing harassment, bullying or abuse from patients, relative or the public.	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.		X	X	Complete the implementation of the agreed action plan in the Trust's new Force Reduction Strategy during 2015/16. This includes: 1. Increase the number of services using the Institute of Psychiatry Safewards approach. 2. Review the effectiveness of the Safewards approach 3. Further development of PBS approaches to reduce challenging behaviour. 4. Review the MoVA training model and present findings to EMT. 5. Participate in the anticipated national benchmarking network on the reduction of Control and restraint and learn from any best practice highlighted in the process. 6. Re-audit changes delivered in the Force Reduction action plan.	Stephen Davison Stephen Davison Stephen Scorer/Stephen D Stephen Davison/Jane Christie Stephen Scorer/Stephen Davison Stephen Scorer	Q1 Q2 Q4 Q1 Q3 Q4	Increased from 10 to 20 Work completed	**Completed** **Completed** **Completed**
6	Reduce levels of staff experiencing harassment, bullying or abuse from staff			X		1. Develop a Trust-wide voluntary binding arbitration model for consideration by EMT. (Carried over from 14/15) 2. Increase leadership and management development programmes focus upon addressing and preventing bullying 3. Develop 'Contact Officer' proposals for consideration by the JCC/EMT	David Levy Michelle Brown David Levy	Q3 Q3 Q3		
7	Improve the appraisal experience	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved	X	X		1. Design a process that will implement the new appraisal system in a less resource intensive way. 2. Implement the new process. 3. Monitor and evaluate the new process.	Angela Collins Angela Collins Angela Collins	Q1 Q2 Q4	Process developed	**Completed** **EMT agreed to move to Q3**

		related feedback in the next IiP accreditation.								
8	Improve staff experience for disabled and Black, Asian and Minority Ethnic (BAME) staff.	Improve related responses in the 2016 Staff Survey results and Staff FFT results Improved related feedback in the next IiP accreditation.		X	X	1. Review the different definitions of 'disabled staff' and agree the definition to be used by the organisation. 2. Identify any statistically significant differences between disabled and non-disabled staff from the staff survey results and make recommendations for improvement. 3. Review datix cases for BAME staff and identify any improvements that can be made. 4. Hold a Kaizen event sponsored by the Medical Director to improve the cultural appropriateness of Induction for doctors from oversees. 5. Agree an action plan of how to implement the findings from the Kaizen event and make recommendations on other HR processes that can benefit from the learning.	Angela Collins/ Simon Marshall Angela Collins/ Simon Marshall Simon Marshall Simon Marshall Simon Marshall	Q2 Q2 Q3 Q3 Q4	Differences identified and recommendations made.	**Not completed. Move to Q3.** **Completed**

As this is a Trust wide action plan each individual action owner requires reasonable cooperation from others across the Trust to ensure that actions can be implemented as effectively as possible.

There will be regular monitoring and reporting of progress made with implementation of the Trust Action Plan and Local Action Plans.

APPENDIX 2
LOCAL ACTION PLAN END OF QUARTER 2 UPDATE

Service Area	Number of Q1 / Q2 Action Areas Covered	Number Green	Number Identified Red	Examples of Actions
1. Durham and Darlington	6 areas covered – approx. 18 actions in total	17	1	Stop the clock events have taken place and have helped caseload management. Staff support mechanisms continue to be promoted with evidence of increased use of mindfulness training. Benefits to individuals have been noticed. Whistleblowing Policy has been cascaded and shared amongst teams. Standard templates are in use for discussion with staff in supervision and will be further developed to raise the profile of the Staff FFT.
2. Teesside	4 areas covered- approx. 4 actions in total	4	0	All staff are made aware of outcomes from Critical Incident Review Meetings. The details of Employee Support and how to access them have been recirculated to staff.
3. North Yorkshire	5 areas covered – approx. 9 actions in total	9	0	The introduction of 'Positive Behavioural Support' to staff on acute wards has been rolled out and has been positively received. Appraisal compliance continues to be monitored through the performance management system and addressed with staff during their supervision sessions.
4. Forensic Services	8 areas covered- approx. 21 actions in total	17 (4 partially completed)	0	Facilitated a 5s 3 day Kaizen Event to review high workload pressures and how they can improve. Participated in the pilot of the new appraisal process which introduced team objectives, quarterly assessments of performance against objectives and the values and behaviours. During the Creating Compassionate Care Work-stream it was established when to involve Organisational Development.
5. Estates and Facilities Management	1 area covered- approx. 2 actions in total.	2 (partially completed)	0	Estates and Facilities staff who carry out appraisals must attend formal appraisal training and ensure that standard appraisal paperwork is completed.
6. Nursing and Governance	5 areas covered- approx. 5 actions in total	5	0	During the April Directorate event each staff member was asked to develop their own individual resilience plans and to share these with their team, this way everyone knows what help and support each individual requires as everyone's needs differ. The Directorate continues to hold events to ensure clear communication is filtered to all staff regarding Directorate and Trust Developments.
7. Planning, Performance and Communications	6 areas covered- approx. 20 actions in total	17	3	The team can now access IIC analysis tools which will reduce time and stress which is associated with developing business cases and bids. The team's Visual Control Board has been revised to increase effectiveness and to monitor busy periods.
8. HR/OD	9 areas covered- approx. 29 actions in total	25	4	Reviewed the support available to staff during the disciplinary process. Guidance pproduced for managers regarding effective communication in organisational change. Scoping exercise undertaken on the possibility of facilitating community teams to undertake their mandatory/statutory training within their geographical area. Directorate staff made aware that the Employee Support Service was available to support them.
9. Finance and Information	11 areas covered- approx. 16 actions in total	15	1	The department now facilitates two mandatory training half days to support staff to complete their mandatory training and ensure they are up to date with all requirements. Following the promotion of the Kaizen culture, all staff are now required to complete QiS training to allow them to understand how their role can become more fit for purpose.
10. Medical Directorate	3 areas covered- approx. 3	3	0	The Medical Development Department have introduced regular workload update meetings for all members of the team. This

	actions in total			meeting provides staff with the opportunity to update their manager with current workload and work pressures and discuss and agree action plans where necessary.

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 24 November 2015**

Title: **NHS England Core Standards for Emergency Preparedness Resilience and Response**

Lead Director: **Brent Kilmurray, Chief Operating Officer**

Report for: **Information**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of our communities	
To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs		Co-operating with other providers	✓
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers	✓	Staffing	✓	Supporting workers	✓
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	✓
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					✓

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 24 November 2015**

Title: **NHS England Core Standards for Emergency Preparedness, Resilience and Response**

1. INTRODUCTION AND 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 (EPRR) and to request ratification of the assessment.

2. BACKGROUND INFORMATION

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.

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.

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 of the self-assessment was September 2015 and therefore does not include the locality of York and Selby.

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 2 which are assessed as not compliant but evidencing progress towards it.

3.4 Actions for the 3 standards rated as Amber have been agreed and will be implemented by the end of December 2015.

3.5 The completed self-assessment has been approved by the Trust's Emergency Planning and Business Continuity Working Group and updated following the completion of the HAZMAT table-tops and exercises and now requires submission to NHS England EPRR division.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** There are no legal and constitutional risks associated with this report.

4.2 **Financial:** There are no financial risks relating to this report.

4.3 **Legal and Constitutional:** There are no risks relating to this report.

4.4 **Equality and Diversity:** There are no equality and diversity issues associated with this report. .

5. CONCLUSIONS

This report was approved by the Executive Management Team at its meeting on 28 October 2015 and provides the Board of Directors with the Trust's Emergency and Business Continuity Planning Working Group's assessment of the compliance of the Trust's management systems with the requirement of NHS England's Core Standards for Emergency Preparedness, Resilience and Response and to request endorsement of this assessment.

6. RECOMMENDATIONS

It is recommended that the Board of Directors receive this report and ratifies the self-assessment ratings.

Brent Kilmurray
Chief Operating Officer

	Core standard	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 have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)	• Ensuring accountaable 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 emergency officer** **EP BCM in post**			
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.		**Annual work plan agreed and monitored via EP Working Group**			
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.		**. Version controlled policies and plans** **. Exercises and tabletops undertaken to test plans** **. Plans amended with lessons learnt**			
4	The accountable emergency officer will ensure that the Board and/or Governing Body will 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.		**. Report on self assessment** **. Report on exercises**			
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.	• 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,	**.BCP's udated on a regular basis with version controls in place** **.Plans readily available and shared with outside agencies**			

	Core standard	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
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.	statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	**LHRP plans available and accessible. Meetings attended by COO and EPBCP Manager**			
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.		**Risks are shared in the working groups of the LHRP and the LHRP themselves eg MOU**			
Duty to maintain plans – emergency plans and business continuity plans						
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	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.	**Risk assessment plans to manage risk** **Plans tested for Transport, Evacuation, MOJ, IPC, HAZMAT**			

Core standard		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
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• 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).	**Version control document approved via agreed governance route Programme of testing of plans**			
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.	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	**Helpline during normal working hours and on call line management process up to Directors is in place. Directors have access to Emergency Control Rooms**			
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.		**Critical activities identified Plans in place and tested**			
12	Arrangements explain how VIP and/or high profile patients will be managed.		**Plans contained in locality BCP's**			
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	• Specifiy who has been consulted on the relevant documents/ plans etc.	**LHRP minutes will evidence the external stakeholder engagement**			
14	Arrangements include a debrief process so as to identify learning and inform future arrangements		**Lessons Learnt report from exercises**			
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.	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	**Resilience tested process in place to receive notice of emergencies or BC incident**	Feasibility of one control number 24/7 being considered as part of switchboard review	**NP**	Mar-16

	Core standard	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
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	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.	**Key staff trained through table tops and exercises undertaken**			
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 .	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/coordination centre and manage any events required.	**In the Directors on call folder and in the Trust BCP as to locations of the three control rooms and how to access them**			
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		**Loggists trained and speciific log books used**			
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.		**Sitreps and updates of sitreps tested in exercises**			
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.		**N/A**			
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;		**N/A**			
Duty to communicate with the public						

	Core standard	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
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	• 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 part of your organisation's warning and informing work.	**Communications BCP in place**			

Core standard		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
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	**Communication BCP in place**			
Information Sharing – mandatory requirements						
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	• 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.	**Sharing protocol with LHRP's and other MH Trusts on best practice with evidence from minutes of meetings**			
Co-operation						
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)	• 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	**COO attends meeting**			
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		**Link with EPU x 2 LHRP's**			
27	Arrangements include how mutual aid agreements will be requested,					
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP)		**N/A**			
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.		**N/A**			
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties					
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		**N/A**			
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		**N/A**			
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		**COO attends**			
Training And Exercising						

	Core standard	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
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	• 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**			
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.		**Exercise programme approved EP Working Group Report from exercises**			
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		**Reports and attending at multi agency exercise**			
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		**Evidenced by attending table tops and exercises**			

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			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**	**Evidence of assurance**				
	Preparedness					
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	**HAZMAT / CBRN Action card included in plans**			
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.		**Action cards in plans available on Intouch**			
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7) • EPRR Risk Register	**Contained in risk aassessment document**			
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.	• Resource provision / % staff trained and available • Rota / rostering arrangements	**N/A**			

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			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**	**Evidence of assurance**				
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.	• Provision documented in plan / procedures • Staff awareness		Action cards to be amended in line with lessons learnt on exercise	LP	Dec-16
	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.	• 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))	**Inventory of Protective Clothing and Consumables**	To be reviewed in line with lessons learnt on exercises	**NP**	Dec-16
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)		**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		**N/A**			

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			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**	**Evidence of assurance**				
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		**N/A**			
47	There are effective disposal arrangements in place for PPE no longer required.		**N/A**			
	Training					
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		**N/A**			
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	**Multi agency Training exercise included HAZMAT / CBRN**			
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.		**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.		**Action card circulated to reception staff**			

	Core standard	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 have updated their pandemic influenza arrangements to reflect changes to the NHS and partner organisations, as well as lessons identified from the 2009/10 pandemic including through local debriefing	• updated planning arrangements reflect changes and learning • version control indicates changes made and timeliness	Documented updated as per DOH framework Document version controlled			
DD2	Organisations have developed and reviewed their plans with LHRP and LRF partners	• indication of the process used to develop updated arrangements, including identification of organisations involved in contributing or commenting on drafts • agendas/ miniutes illustarting where the updated arrangements have been discussed	Document plan assessed by LHRP			
DD3	Organisations have undertaken a pandemic influenza exercise or have one planned in the next six months	• documentation related to exercise since the 2013 publication, including lessons identified OR • invitation letters/ documentation related to exercise scheduled to take place in next six months, including an indication of how lessons identified will be addressed	Exercise planned for November 2015			
DD4	Organisations have taken their plans to Boards / Governing bodies for sign off	• Board/ Governing Body agenda or meeting papers indicating updated pandemic influenza arrangements have been discussed and/ or signed off		Plan to be signed off November 2015		

ITEM 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date: **24 November 2015**

Title: **Finance Report for Period 1 April 2015 to 31 October 2015**

Lead Director: **Colin Martin, Director of Finance**

Report for: **Assurance and Information**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	
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 our communities	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities.	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services		Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose	✓	Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					✓
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **24 November 2015**

Title: **Finance Report for period 1 April 2015 to 31 October 2015**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2015 to 31 October 2015.

2. BACKGROUND INFORMATION

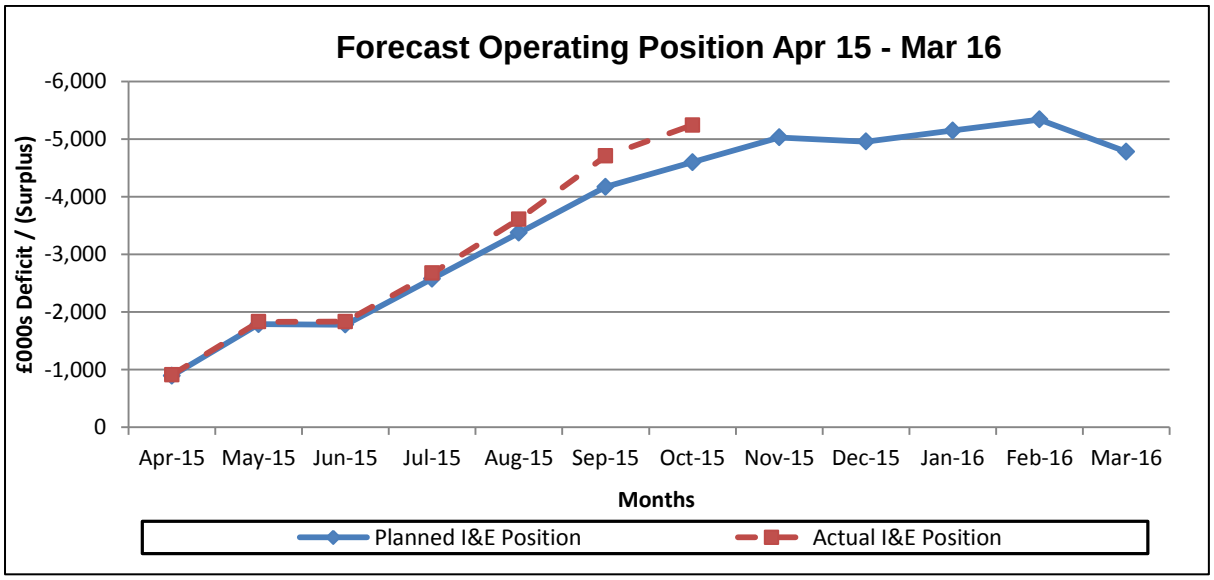
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

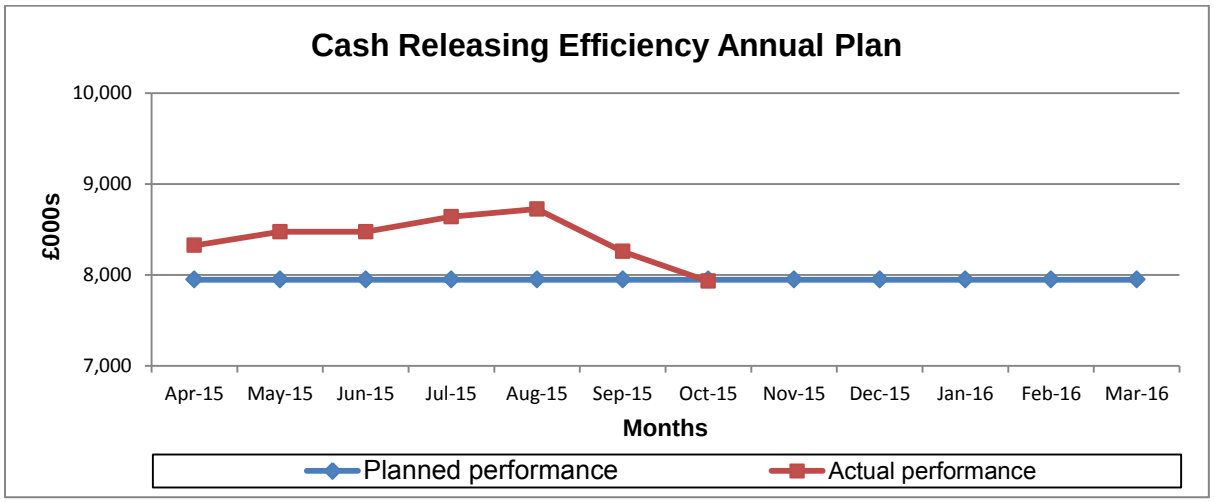
The financial position shows a surplus of £5,244k for the period 1 April 2015 to 31 October 2015, representing 3.1% of the Trust's turnover and is ahead of plan.

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

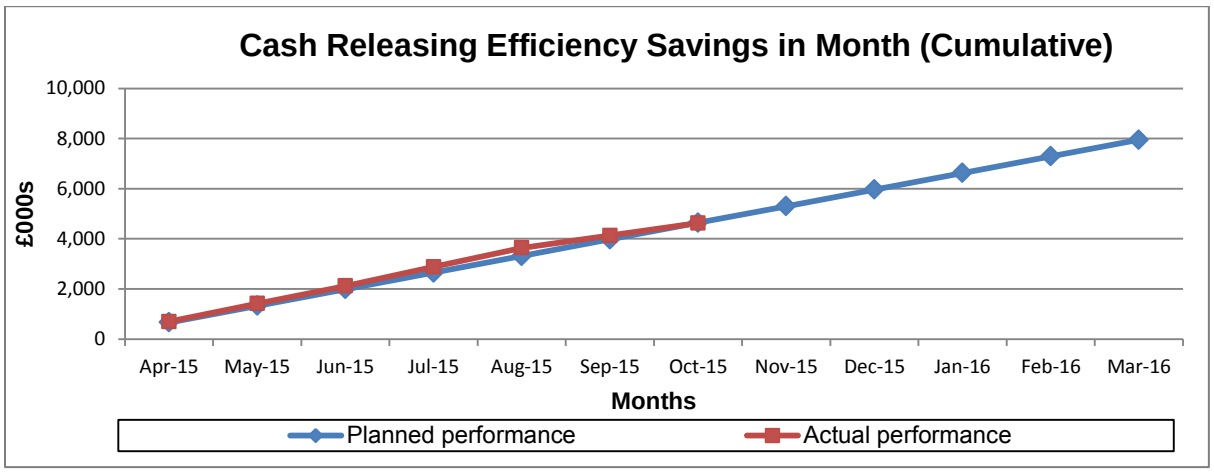


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 October 2015 is £7,930k. The reduction in September and October is due to some schemes being deferred to 2016/17. At this stage it is not anticipated that there will be any further material changes against the CRES plan in 15/16.

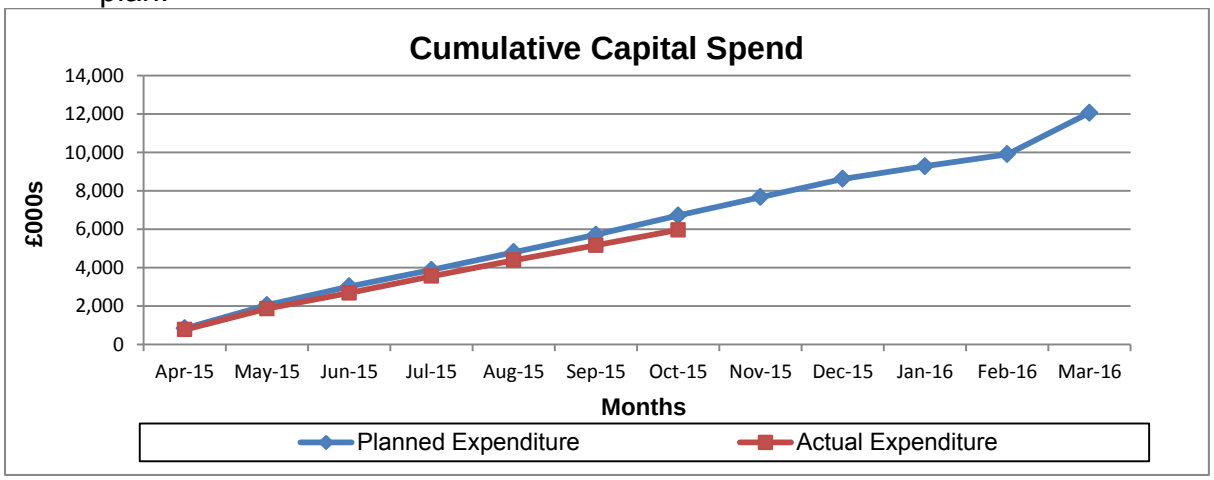


The monthly profile for CRES identified by Localities is shown below.



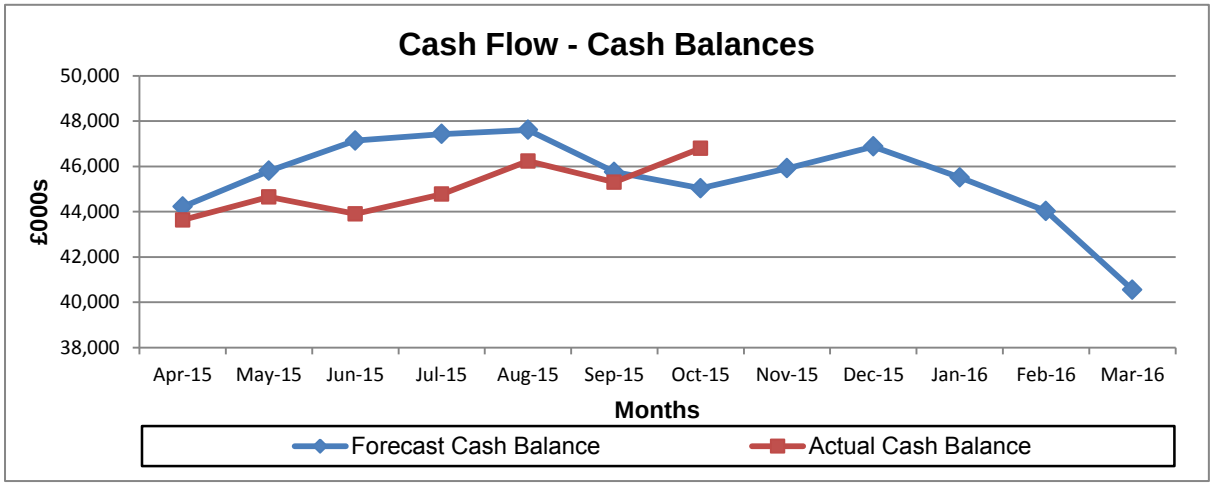
3.3 Capital Programme

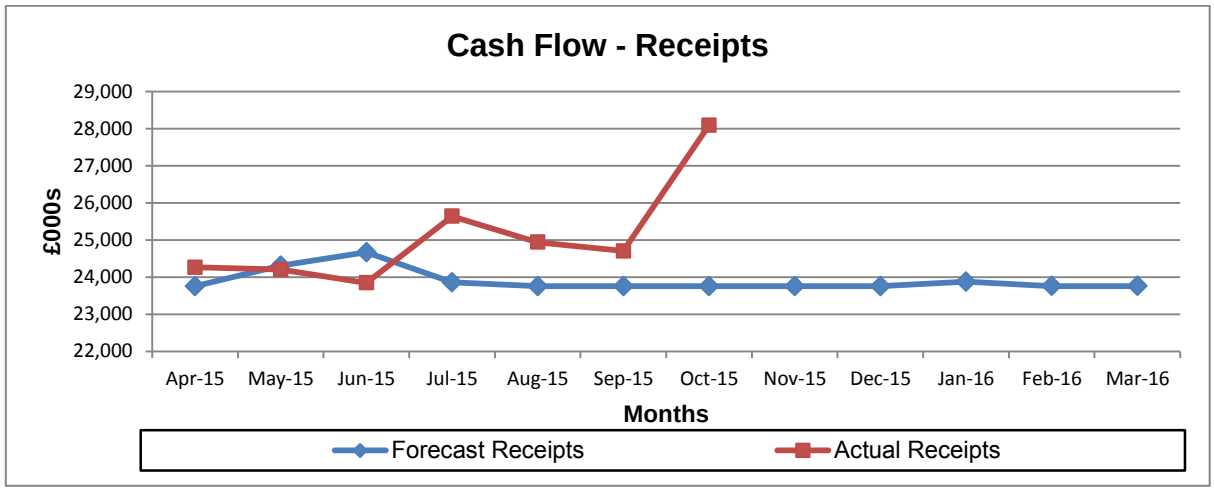
Capital expenditure to 31 October 2015 is £5,965k, which is marginally behind plan.

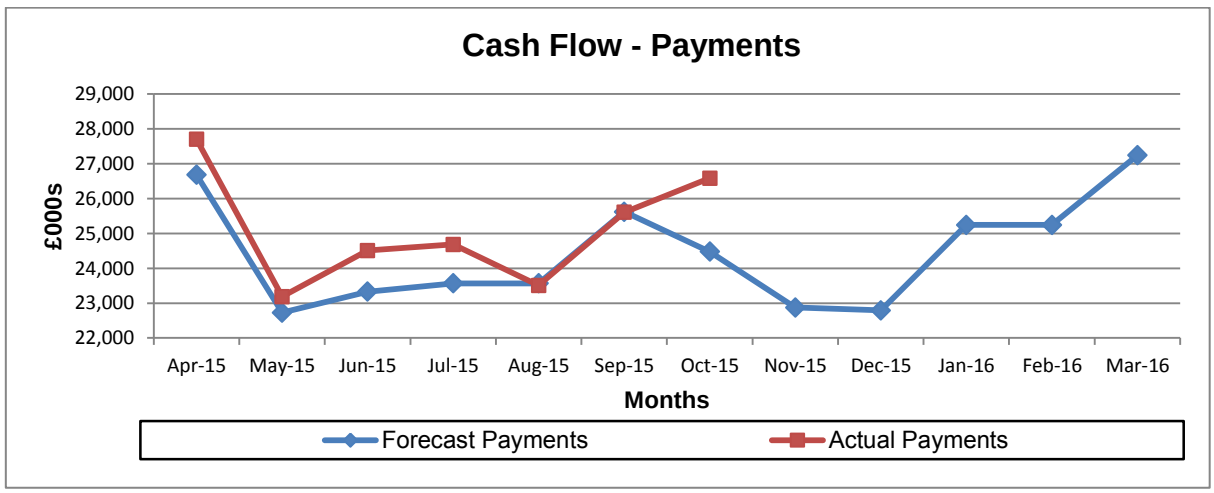


3.4 Cash Flow

Total cash at 31 October 2015 is £46,795k and is ahead of plan due to slippage against capital schemes and working capital cycle variations following the start of the Trust's contract to provide MH & LD Services to the York and Selby locality.



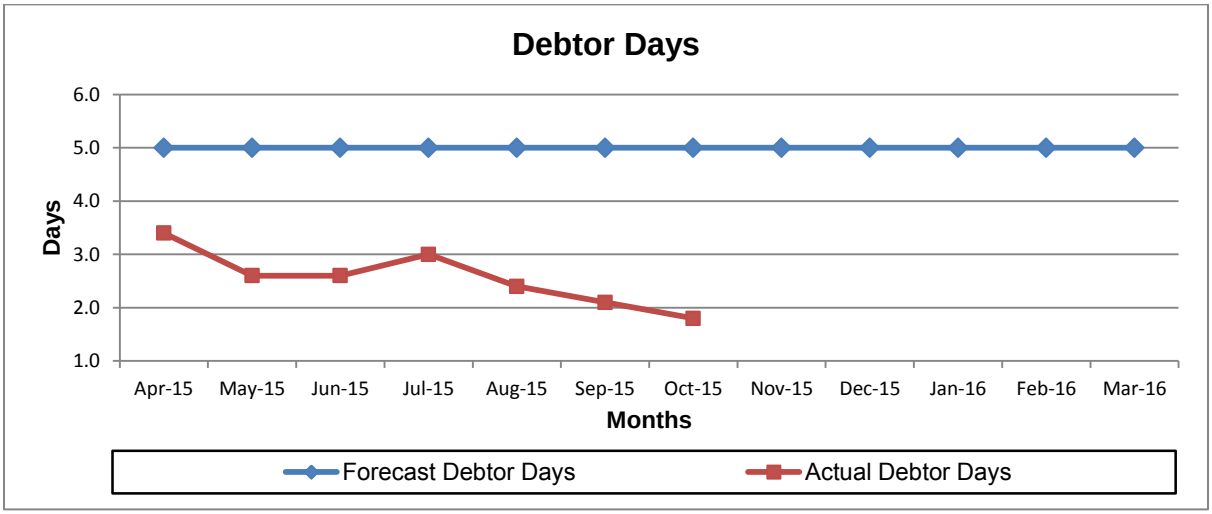




The increase within receipts and payments during October 2015 is due to additional revenue streams related to the York and Selby locality.

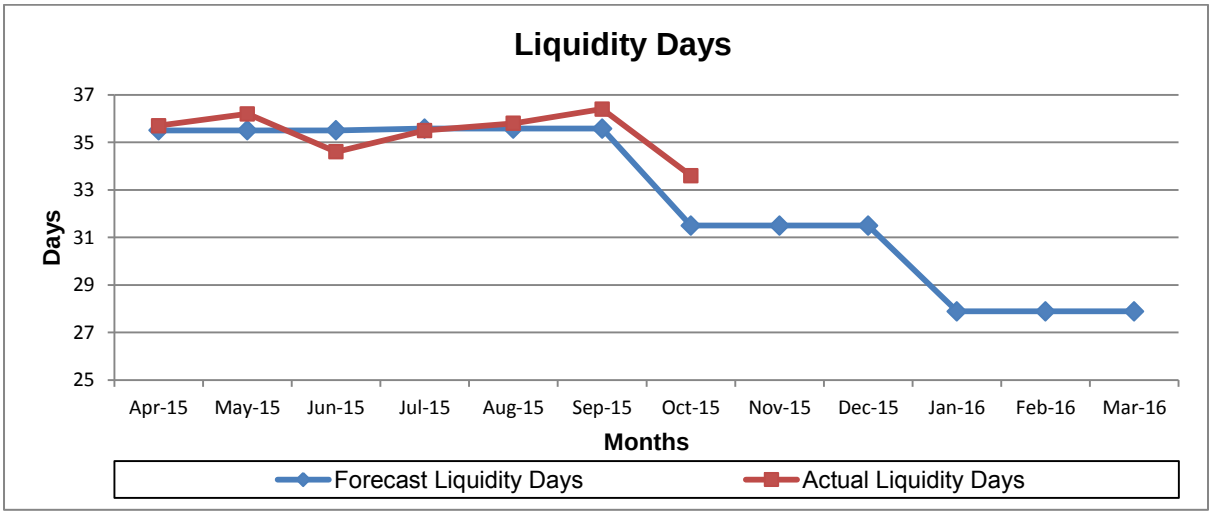
Other payment profile fluctuations over the year are for PDC dividend payments, financing repayments and payments for capital expenditure.
Working Capital ratios for period to 31 October 2015 were:

- Debtor Days of 1.8 days
- Liquidity of 33.6 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 89.47%
  Non NHS 30 Days – 98.16%



The Trust had a debtors' target of 5.0 days and actual performance of 1.8 days, which is ahead of plan.

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



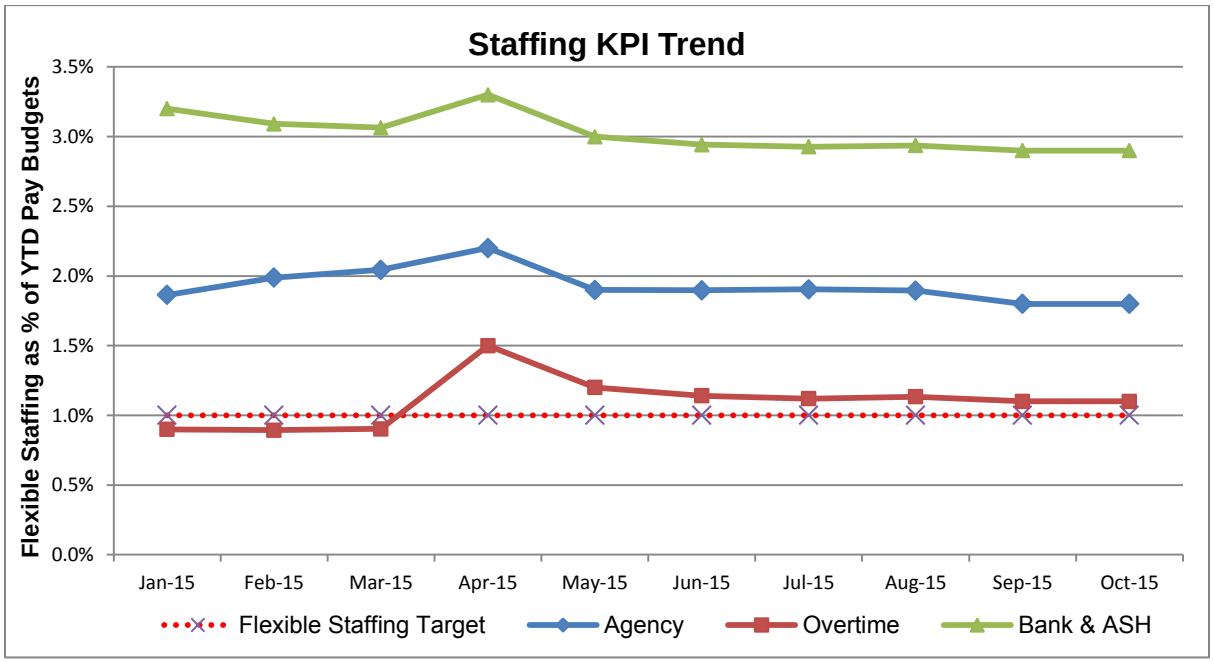
3.5 Financial Drivers

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

Tolerance	Jun	Jul	Aug	Sep	Oct
Agency (1%)	1.9%	1.9%	1.9%	1.8%	1.8%
Overtime (1%)	1.1%	1.1%	1.1%	1.1%	1.1%
Bank & ASH (flexed against establishment)	2.9%	2.9%	2.9%	2.9%	2.9%
Establishment (90%-95%)	93.7%	94.0%	94.3%	94.0%	94.0%
Total	**99.7%**	**100.0%**	**100.3%**	**99.8%**	**99.8%**

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 & ASH. For October 2015 the tolerance for Bank and ASH is 4.0% of pay budgets.

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



Additional staffing expenditure is 5.8% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (45%), enhanced observations (19%) and sickness (17%).

3.6 Monitor Risk Ratings and Indicators

3.6.1 Monitor introduced a revised Financial Sustainability Risk Rating framework from August which incorporates the CoSRR ratings and two further ratings:

- income and expenditure margin;
- variance from plan in relation to I&E margin.

The Financial Sustainability Risk Rating was assessed as 4 at 31 October 2015, and is in line with the restated planned risk rating.

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 1.38x (can cover debt payments due 1.38 times), which is in line with plan and is rated as a 2 in both ratings.

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 33.6 days which is in line with plan and is rated as a 4 in both ratings.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 3.5% 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 0.2% ahead of plan and is rated as a 4.

3.6.6 The margins on Financial Sustainability Risk Rating are as follows:

- Capital service cover - to reduce to a 1 a surplus decrease of £1,309k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £24,991k is required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £4,219k is required.
- Variance from plan – to reduce to a 3 an operating surplus decrease of £427k is required.

Monitors 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
I&E Margin	25	1%	0%	-1%	<=-1%
Variance from plan	25	0%	-1%	-2%	<=-2%

TEWV Performance	**Actual**		**Annual Plan**		**RAG**
	Achieved	Rating	Planned	Rating	**Rating**
Capital service Cover	1.38x	2	1.34x	2	
Liquidity	33.6 days	4	32.8 days	4	
I&E Margin	3.5%	4	3.3%	4	
Variance from plan	0.2%	4	0%	4	

Overall Financial Sustainability Risk Rating	**4.00**

3.6.7 5.7% of total receivables (£122k) are over 90 days past their due date. This is marginally above the 5% finance risk tolerance set by Monitor, but is not a cause for concern.

3.6.8 3.5% of total payables invoices (£371k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance set by Monitor.

3.6.9 The cash balance at 31 October 2015 is £46,795k and represents 63.8 days of annualised operating expenses.

3.6.10 Actual capital expenditure is 89% of planned expenditure to date.

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

4. IMPLICATIONS / RISKS

4.1 There are no direct quality, legal or equality and diversity implications associated with this paper.

5. CONCLUSIONS

5.1 The comprehensive income outturn for the period ending 31 October 2015 is a surplus of £5,244k, which is equivalent to 3.1% of turnover and is marginally ahead of plan.

5.2 Identified Cash Releasing Efficiency Savings at 31 October 2015 are in line with plan.

The Trust continues to identify schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for 2017/18.

5.3 The Financial Sustainability Risk Rating for the Trust is 4 for the period ending 31 October 2015.

6 RECOMMENDATIONS

6.1 The Board of Directors are requested to receive the report, to note the conclusions in section 5 and to raise any issues of concern, clarification or interest.

Colin Martin
Director of Finance

Item 15

BOARD OF DIRECTORS

Date of Meeting: **24th November 2015**

Title: **Board Dashboard as at 31st October 2015**

Lead Director: **Sharon Pickering, Director of Planning, Performance & Communications**

Report for: **Assurance**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users	✓	Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs		Co-operating with other providers	✓
Safeguarding and safety					
Safeguarding people who use services from abuse	✓	Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers	✓	Staffing	✓	Supporting workers	✓
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision	✓	Complaints	✓
Notification of death of a person who uses services	✓	Notification of death or AWOL of person detained under MHA	✓	Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **24th November 2015**

Title: **Board Dashboard as at 31st October 2015**

1 INTRODUCTION & PURPOSE

1.1 To present to the Board the Trust Dashboard **(Appendix 1)** as at 31st October 2015 in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY RISKS/ISSUES

2.1 Key Issues/Risks

The key issues are as follows:

- 10 of the 24 (42%) indicators are being reported as red in October 2015 which is the same position as in September 2015. Of those, 3 are showing an improving trend over the last 3 months.

The key risks are as follows:

- Access - Both waiting time targets (KPIs 1 & 2) continue to show an underperformance as at the end of October however both are showing an improvement compared to the position in September, with KPI1 Percentage of patient seen with 4 weeks from an external referrals being at the highest point in the year to date. The action plans developed by the services are continuing to be implemented and a detailed update against the Trust wide action plan will be presented to the Board in November 2015. Children and Young Peoples' (CYP) services continue to be the area of most concern in all localities. The localities continue to take action to improve the situation however the number of CYP still waiting over 4 weeks at the end of October has increased slightly for the first time since April 2015.

- Psychological Therapies

  18 Week Waiting Time (KPI 5) – We continue to report under target for this indicator but have seen an improvement in performance in October. The Teesside locality continue to be the service furthest away from target however it is expected that this will improve as a consequence of referrals having now ceased to the service allowing resources to be transferred to offering additional treatment slots. If the Teesside service is excluded from the position (given it will not be in place when the target is formally introduced nationally) then the Trust position is one of achieving the target.

Access (KPI 6) - performance has reduced in October although the three month trend is one of improvement. The action plan in North Yorkshire has been revisited and revised and it is expected that this will be signed off for implementation in November. In Durham and Darlington the additional Therapy Support workers are now in post and are beginning to deliver interventions which should improve performance in the coming months.

Recovery Rate (KPI 7) - the Trust has failed to achieve the 50% recovery target; however the position has improved in October. Teesside is the only locality that is achieving target. The significant outlier is the service in Scarborough and Ryedale CCG and discussions are on-going with commissioners in terms of the severity of illness at the point of referral which is much higher than in other areas.

- Out of Locality Admissions (OoL) (KPI 12) – The performance has continued to achieve target in October although it has deteriorate in the month. Only Durham and Darlington have achieved the target with Teesside and North Yorkshire being marginally over target. In total there were 34 actual Out of Locality admissions with the majority of these in being Older Peoples services. KPIs 13, 14 and 15 are not achieving the targets set and this could be contributing to the increase in OoL admission in October, particularly in terms of KPI 13 %age of patient readmitted within 30 days which has been increasing since July. North Yorkshire is a significant outlier compared to the other two Localities in terms of these three indicators although its percentage of OoL admissions was similar to that in Teesside in October.

- Appraisal (KPI 23) – Performance is under target and has deteriorated in October. Whilst this reflects the trend in previous years the level of performance in October 2015 is still higher than in October 2014. Durham and Darlington have the lowest level of performance with Forensic having the highest however all localities have performance above 80%. The withholding of pay progression is continuing. Work continues to look at further development of the IIC in order to support the proactive management of this, and other workforce indicators, is continuing.

2.2 **Appendix 2** outlines the assessment of the level of data quality of the Board Dashboard Indicators. It should be noted that two indicators have a revised data quality assessment score:

- Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral. The Information Products Team has undertaken work with the services to improve reliability; therefore, the score for data reliability has increased. The Trust is still, however, waiting for the national guidance as to how this KPI will be extracted.

- Number of reds on CQC Action Plans (including MHA Action Plans). Contingencies are now in place to ensure data is correctly reported and sourced on time; therefore, the score for data source has increased.

2.3 **Appendix 3** provides further details of unexpected deaths. The breakdown by locality is now included.

3 RECOMMENDATIONS

It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.

Trust Dashboard Summary for TRUST

Strategic Goal 1: To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

	October 2015				April 2015 To October 2015			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	98.00%	85.63%			98.00%	82.20%		98.00%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	86.89%			98.00%	87.18%		98.00%
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	50.00%	73.17%			50.00%	73.64%		50.00%
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	85.33%			75.00%	81.63%		75.00%
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	93.71%			95.00%	93.62%		95.00%
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	15.00%	12.78%			15.00%	13.25%		15.00%
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	48.11%			50.00%	46.66%		50.00%
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	95.00%	96.55%			95.00%	97.38%		95.00%
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.39%			95.00%	97.87%		95.00%
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.35%			98.00%	98.35%		98.00%
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	90.43%			85.00%	89.83%		85.00%

Trust Dashboard Summary for TRUST

Strategic Goal 2: To continuously improve the quality and value of our work

	October 2015				April 2015 To October 2015			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	13.23%			15.00%	15.10%		15.00%
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	29.41%			15.00%	25.68%		15.00%
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	18.00	20.00			123.00	165.00		209.00
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	146.00	111.00			146.00	111.00		146.00
16) Percentage of appointments cancelled by the Trust	0.67%	1.11%			0.67%	1.07%		0.67%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.92			7.00	9.36		12.00
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	77.78%			75.00%	73.61%		75.00%

Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce

	October 2015				April 2015 To October 2015			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	83.52%			95.00%	83.52%		95.00%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	90.03%			95.00%	90.03%		95.00%
21) Percentage Sickness Absence Rate (month behind)	4.50%	4.19%			4.50%	4.47%		4.50%

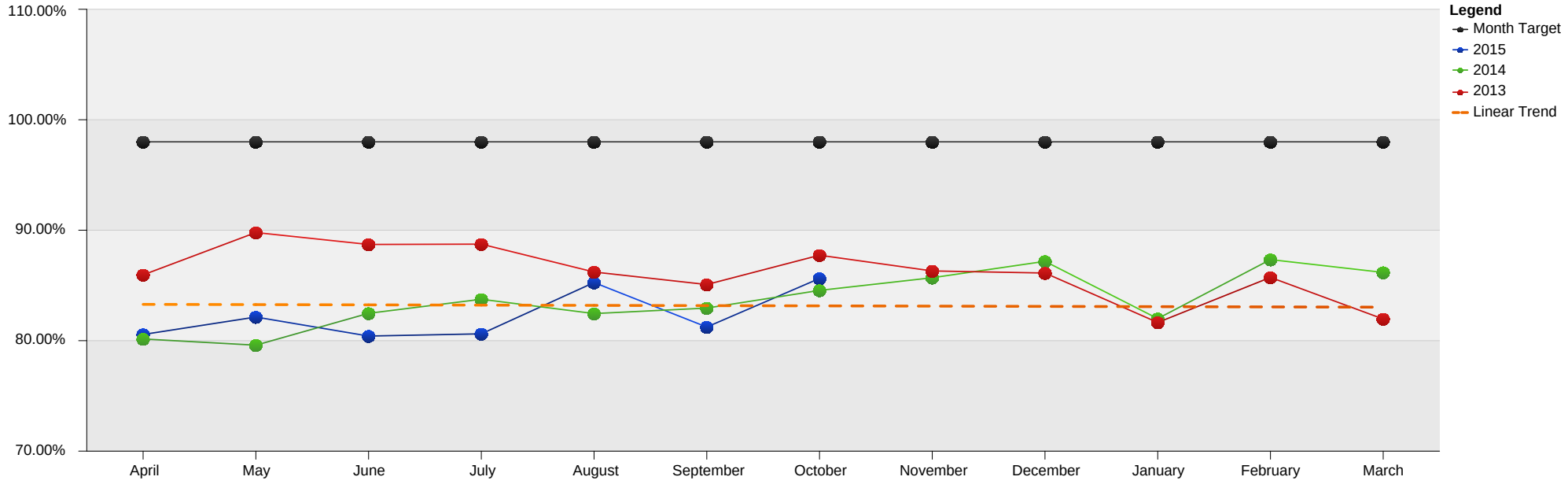
Trust Dashboard Summary for TRUST

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

	October 2015				April 2015 To October 2015			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00			0.00	0.00		0.00
23) Total number of External Referrals into the Trust Services	5,940.00	6,977.00			41,001.00	43,680.00		69,931.00
24) Delivery of our financial plan (I and E)	-428,300.00	-653,000.00			-4,600,300.00	-5,362,000.00		-4,784,000.00

Trust Dashboard Graphs for TRUST

1) Percentage of patients seen with 4 weeks for a first appointment (external referral)



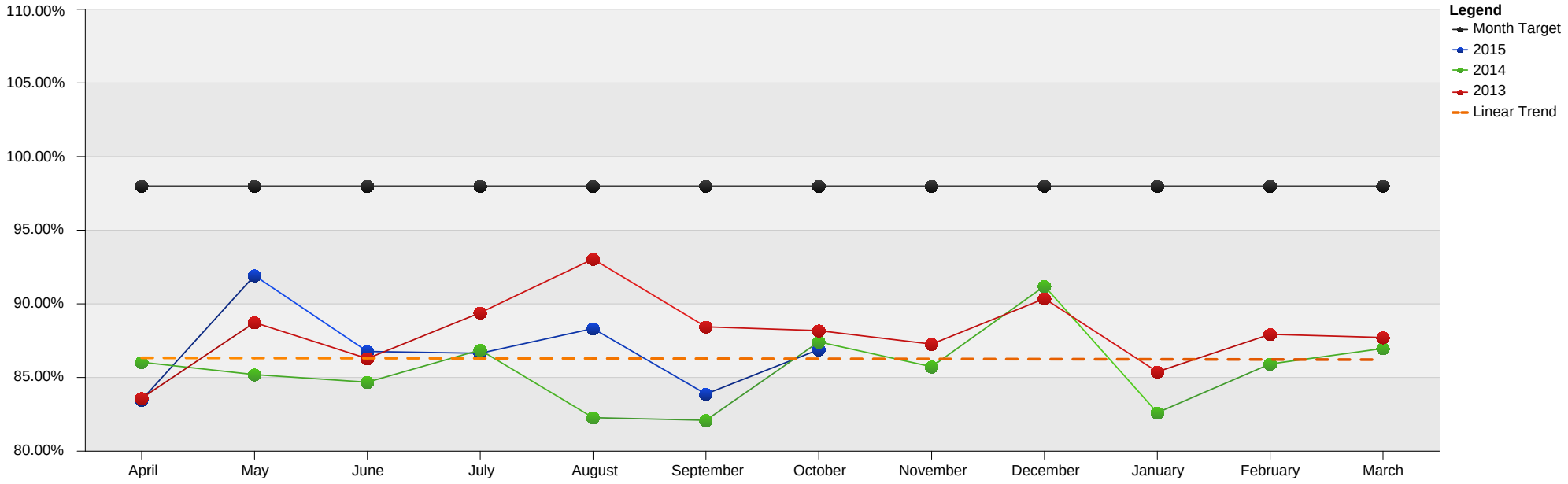
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	85.63%	82.20%	83.19%	78.11%	91.18%	89.05%	76.43%	74.59%	100.00%	99.87%

Narrative

The Trust position for October 2015 is 85.63%, which relates to 533 patients out of 3849 who had waited longer than 4 weeks for a first appointment. This is 12.37% below target, but an improvement on September 2015 performance. The Trust position for the financial year to date is 82.20%, which is 15.80% below target.The specific areas of concern are:• Durham & Darlington CYP at 56.34% (93 patients) and AMH at 82.04% (90 patients). Within CYP, resources are being aligned to achieve target but there are 2 vacancies and some on long term sickness. Although there has been an improvement in AMH there have been capacity issues; recruitment is underway to fill the vacancies. • Teesside CYP at 65.54% (92 patients). An increased number of assessment slots have been made available but it will take some time for the impact to be fully seen.• North Yorkshire CYP at 78.50% (23 patients), MHSOP at 65.29% (101 patients) and AMH at 82.54% (92 patients). The action plan within MHSOP remains delayed due to staff sickness. A request for dedicated locum support is under consideration and nurse support has been provided. Within AMH, teams have been impacted by staff sickness and vacancies.Whilst there has been an increasing trend during this year to date, there remains a significant risk that we will not achieve the annual target of 98%. The annual outturn for 2014/15 was 83.73%.

Trust Dashboard Graphs for TRUST

2) Percentage of patients seen with 4 weeks for a first appointment (internal referral)



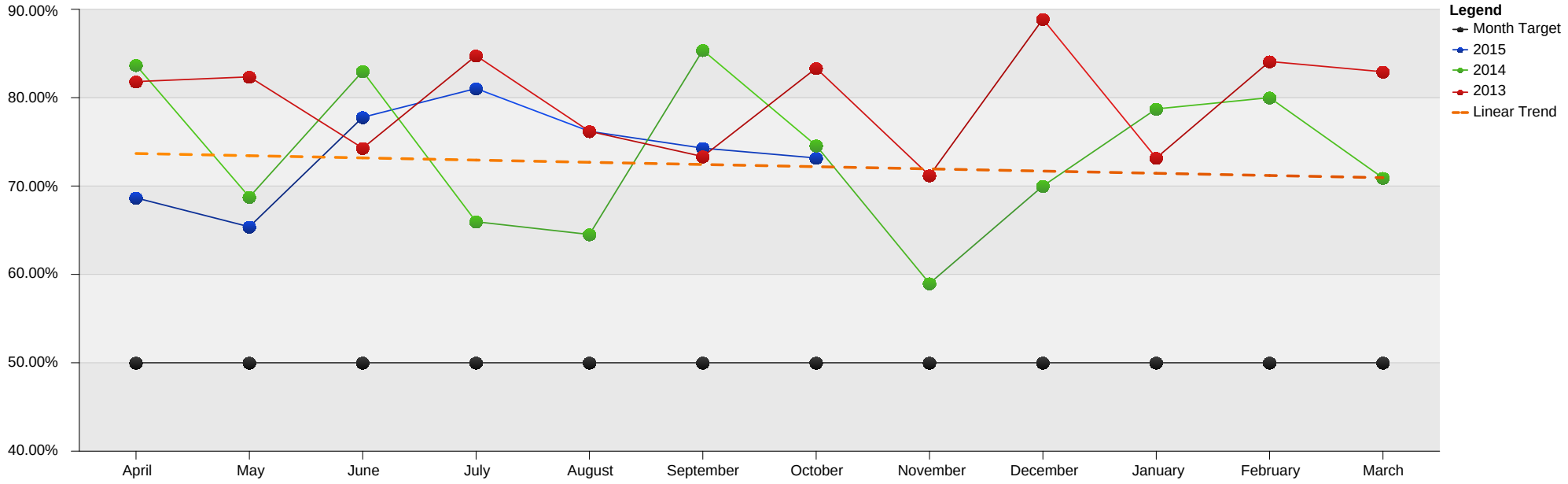
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	86.89%	87.18%	78.46%	82.64%	94.20%	92.04%	91.86%	89.86%	57.14%	50.53%

Narrative

The Trust position for October 2015 is 86.89%, which relates to 294 patients out of 2243 that were not seen within 4 weeks of an internal referral. This is 11.11% below target but an improvement on September performance. The Trust position for the financial year to date is 87.18%, which is 10.82% below target.The specific areas of concern are:• Durham & Darlington CYP at 62.82% (87 patients) and AMH at 82.73% (72 patients)• Teesside CYP at 83.66% (25 patients)• Forensic Learning Disability Services at 22.22% (14 patients), all of which are within Forensic Learning Disability autism services. High referral rates continue to impact on the capacity of the team to see patients within the 4 week target. The Directorate is investigating ways to improve the waiting times for this service.Whilst there has been an increasing trend during this year to date, there remains a significant risk that we will not achieve the annual target of 98%. The annual outturn for 2014/15 was 85.79%.

Trust Dashboard Graphs for TRUST

3) Percentage of people with first episode of psychosis treated with NICE care package in two weeks

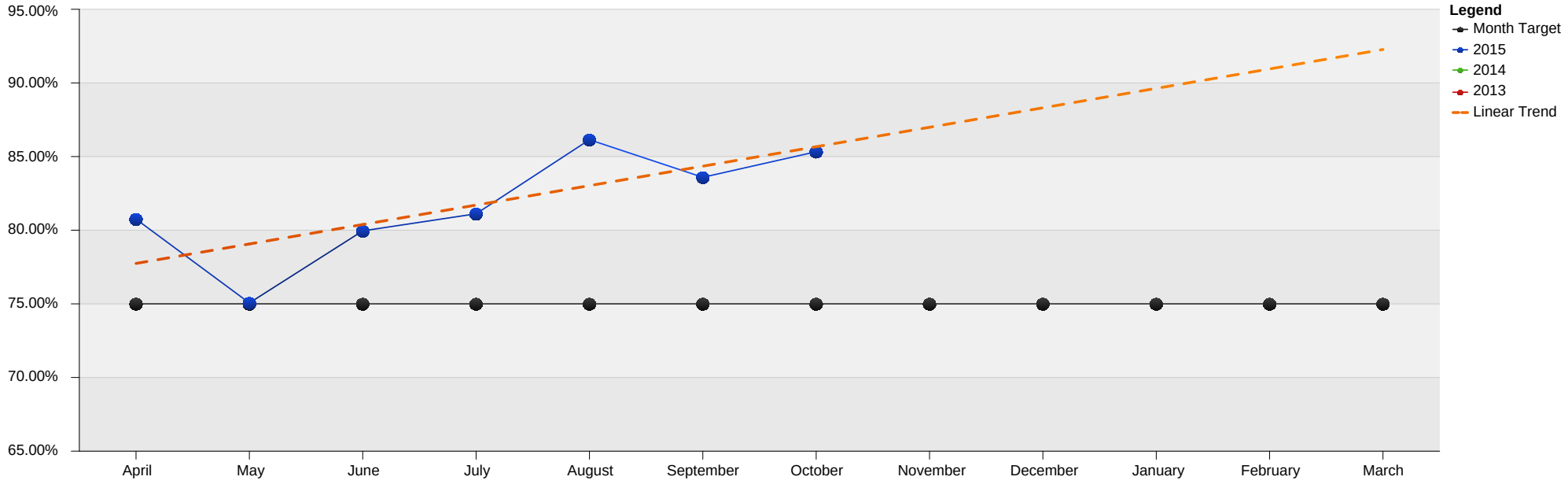


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	73.17%	73.64%	68.75%	62.12%	83.33%	81.29%	57.14%	79.03%	NA	NA

Narrative
The Trust position for October 2015 is 73.17%, which relates to 11 patients out of 41 that were not treated within 2 weeks of referral. This is 23.17% above target but a deterioration on September 2015 performance. All localities are achieving target. The Trust position for the financial year to date is 73.64%, which is 23.64% above target. It should be noted that the national definition for this indicator has not yet been published.Based on past performance and October's performance it is anticipated that we will achieve the annual target of 50%; however it should be notes that October reports the lowest position since June 2015. The annual outturn for 2014/15 was 74.22%.

Trust Dashboard Graphs for TRUST

4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.

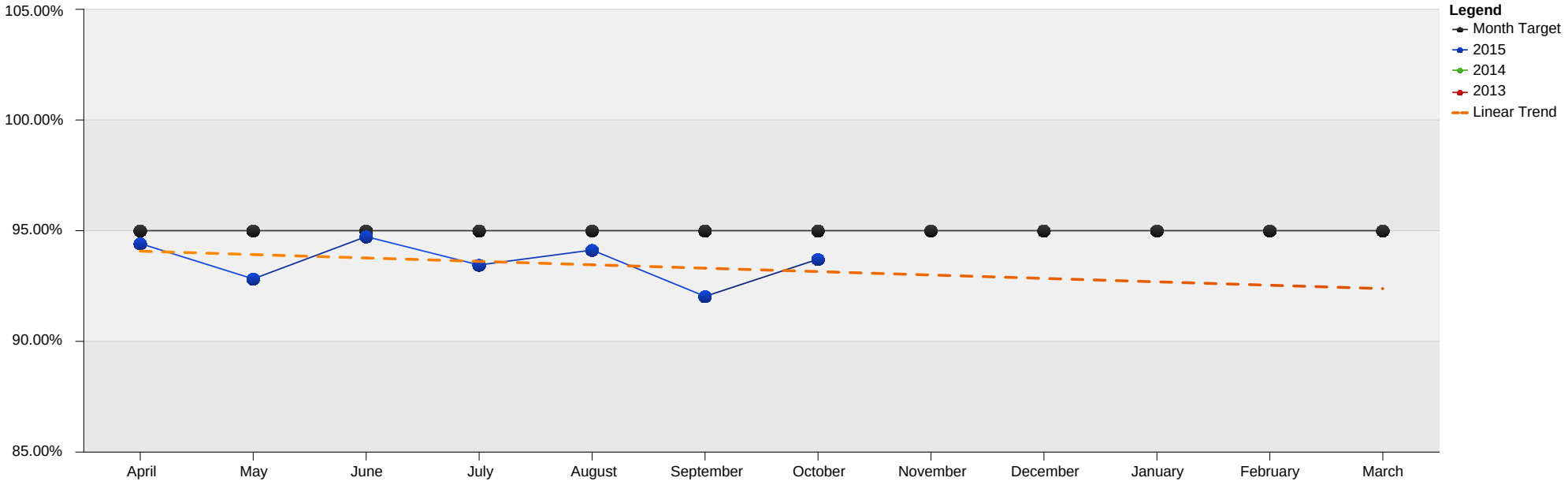


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	85.33%	81.63%	98.97%	98.50%	56.67%	58.99%	81.75%	68.11%	NA	NA

Narrative
The Trust position for October 2015 is 85.33%, which relates to 119 patients out of 811 that were not treated within 6 weeks of referral. This is 10.33% above target and an improvement on September 2015 performance. The Trust position for the financial year to date is 81.63%, which is 6.63% above target.Both Durham & Darlington and North Yorkshire are above target at 98.97% and 81.75% respectively. Teesside reports significantly below target at 56.67% but is showing an improvement on September performance. Referrals have now ceased to the service. Assessments for referrals received will be completed by mid-November, following which additional treatment slots will be made available to ensure that patients commence treatment as soon as possible. Based on past performance, and the improving trend in performance since May 2015, it is anticipated that we will achieve the annual target of 75%.Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

Trust Dashboard Graphs for TRUST

5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.

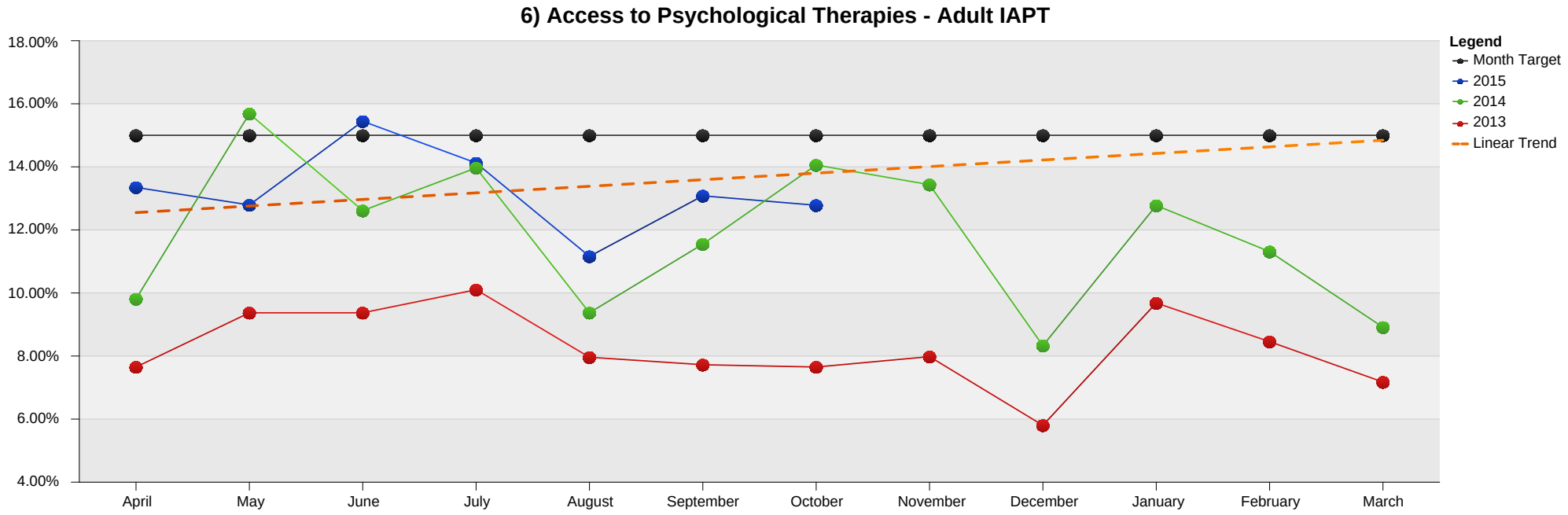


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	93.71%	93.62%	100.00%	99.83%	82.00%	79.54%	91.24%	91.77%	NA	NA

Narrative

The Trust position for October 2015 is 93.71%, which relates to 51 patients out of 811 that were not treated within 18 weeks of referral. This is 1.29% below target but an improvement on September 2015 performance. Only Durham & Darlington are achieving target, reporting 100% for October. The Trust position for the financial year to date is 93.62%, which is 1.38% below target.North Yorkshire reports 91.24% (24 patients). Whilst the position is improving, the action plan in place has been revised and implementation will commence in November.Teesside reports 82.00% (27 patients). Referrals have now ceased to the service. Assessments for referrals received will be completed by mid-November, following which additional treatment slots will be made available to ensure that patients commence treatment as soon as possible. Based on the slightly decreasing trend during this year to date, there is a risk that we will not achieve the annual target of 98%. Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

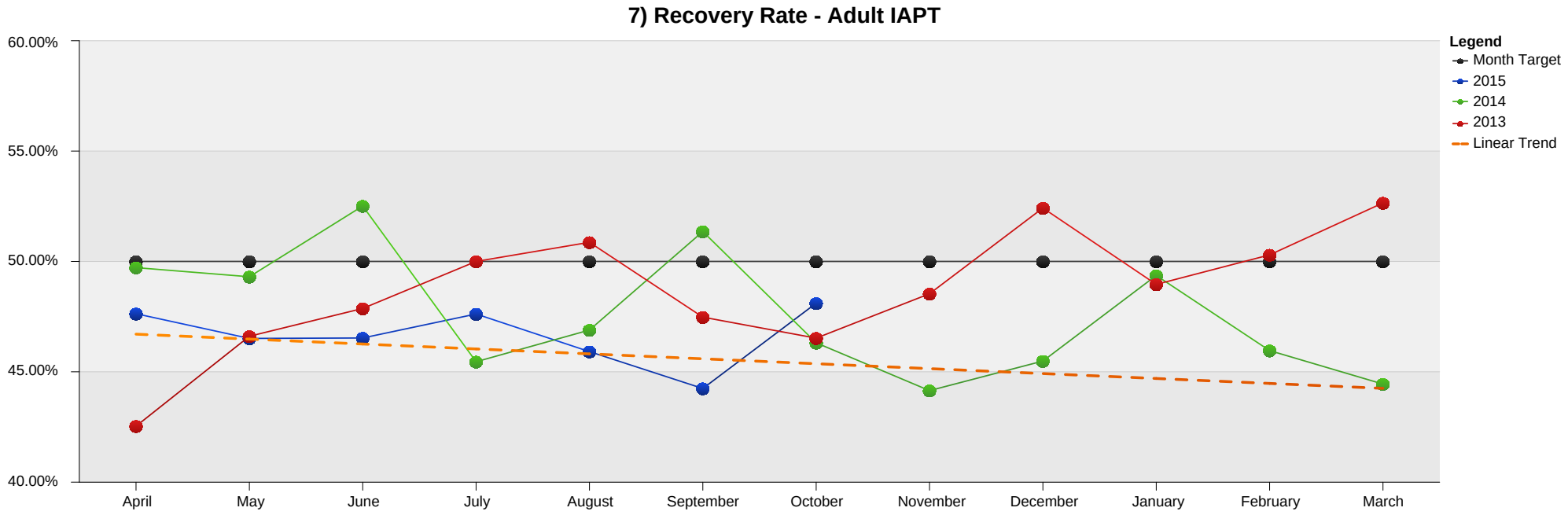
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	12.78%	13.25%	12.63%	12.72%	NA	NA	13.01%	14.06%	NA	NA

Narrative
The Trust position for October 2015 is 12.78% which equates to 1151 people entering treatment from 9005 of the general population. This is 2.22% below the target of 15% and a deterioration on September 2015 performance. The Trust position for the financial year to date is 13.25%, which is 1.75% below target. North Durham CCG (13.79%), DDES CCG (11.03%) and Darlington CCG (14.25%) are below target. There remains a high number of referrals for step 2a treatment and teams are working to allocate patients as soon as possible, whilst managing their waiting lists. 26 Therapy Support Workers are now in post and having completed inductions and screening training, are starting to pick up Step 2a interventions.Scarborough & Ryedale CCG (11.60%), Hambleton, Richmondshire & Whitby CCG (13.77%), Harrogate & Rural CCG (14.06%) and Vale of York CCG (7.14%) are below target. An action plan has been revised and implementation will commence in November. Harrogate has reported a 35% improvement in referrals since making contact with the GP practices.Based on the decreasing trend during this year to date, there is a risk that we will not achieve the annual target of 15%, unless further action is taken.The annual outturn for 2014/15 was 11.82%.

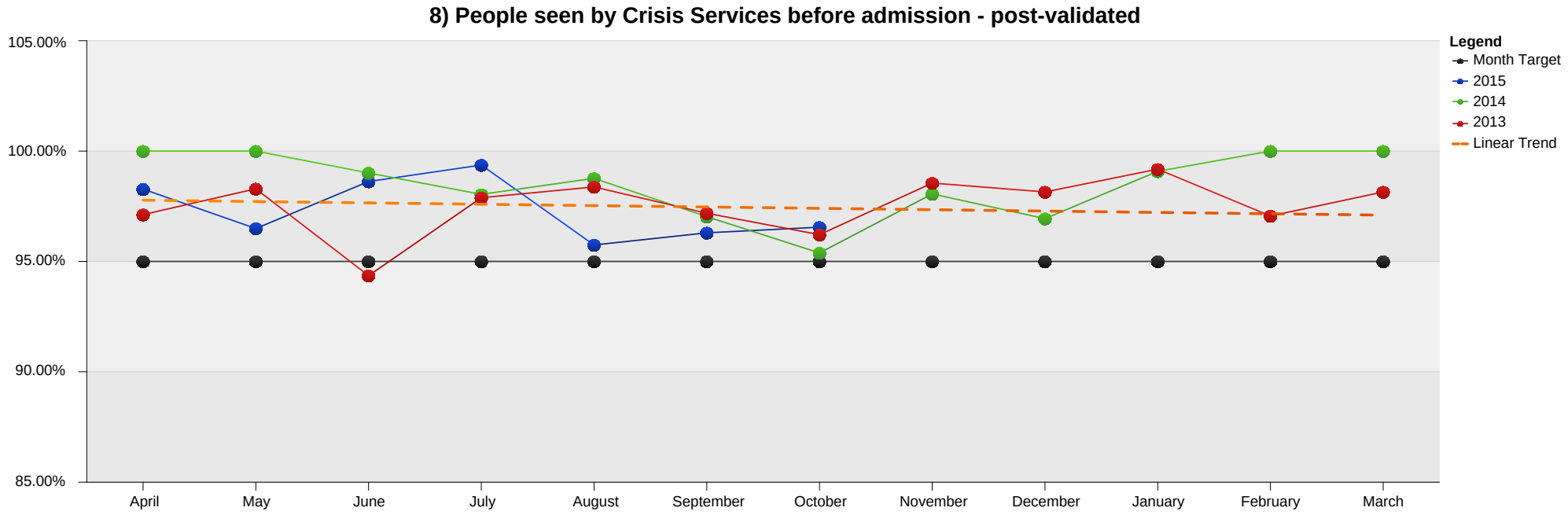
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	48.11%	46.66%	47.47%	45.21%	51.01%	46.71%	47.23%	48.94%	NA	NA

Narrative
The Trust position for October 2015 is 48.11%, with 384 people out of 740 not achieving recovery. This is 1.89% below the target of 50% but an improvement on September performance. Teesside is the only locality achieving target at 51.01%. The Trust position for the financial year to date is 46.66%, which is 3.34% below target.Darlington CCG (41.67%) and North Durham CCG (51.28%) have reported an improvement, whereas DDES CCG (45.71%) has reported a very slight deterioration. Focussed work is underway to ensure patients are screened as soon as possible. Analysis has not highlighted any patterns or trends in non-engagement; this will be repeated in the New Year in conjunction with work to ensure caseloads are being managed effectively and that patients move through the pathway efficiently. Hambleton, Richmondshire & Whitby CCG (54.88%) and Harrogate & Rural CCG (50.60%) have reported improvements, whereas Scarborough & Ryedale CCG (34.38%) and Vale of York CCG (33.33%) have reported deteriorations. Recruitment continues in Scarborough and analysis on the severity of illnesses at referral has been shared with commissioners.Based on past performance and performance during October, there is a risk that we will not achieve the annual target of 50%.The annual outturn for 2014/15 was 47.63%.

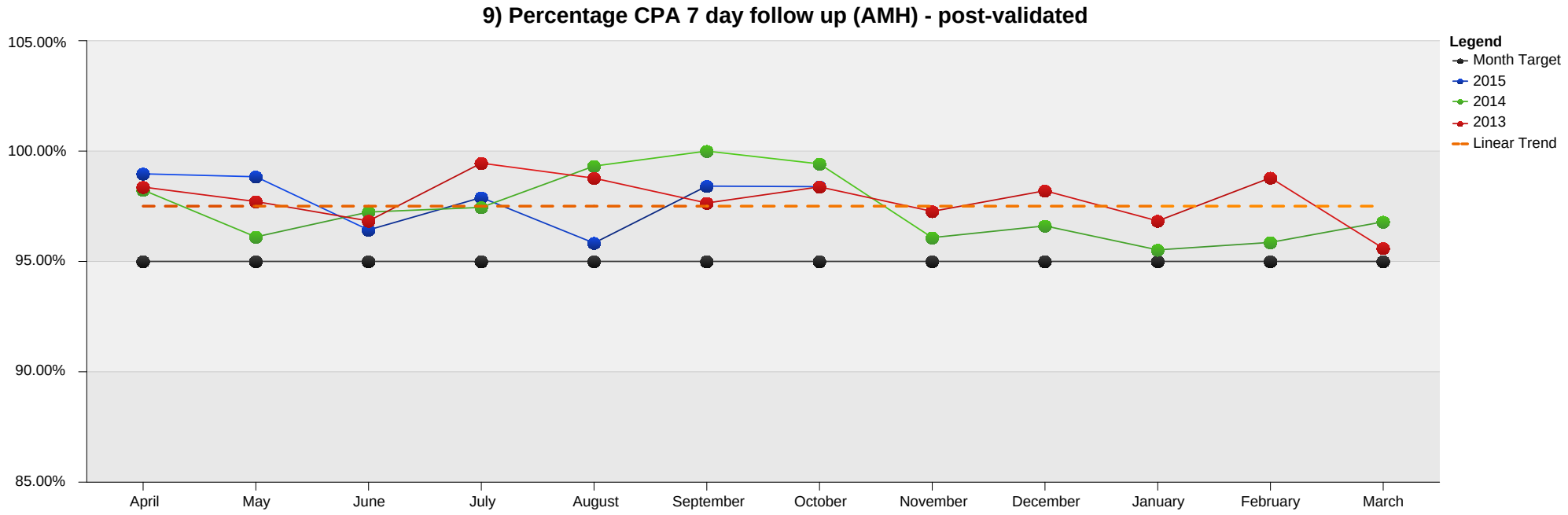
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	96.55%	97.38%	96.00%	96.81%	96.55%	97.43%	97.30%	97.95%	NA	NA

Narrative
The Trust post validated position for October 2015 is 96.55%, which relates to 5 patients out of 145 that were not seen by a Crisis Home Treatment Team prior to admission. This is 1.55% above the target and a slight improvement on September's performance. The Trust post validated position for the financial year to date is 97.38%, which is 2.38% above target.Whilst October has reported a slight improvement in performance, the financial year has seen a deteriorating trend. It is, however, anticipated that we will achieve the annual target of 95%.The annual outturn for 2014/15 was 98.42%.

Trust Dashboard Graphs for TRUST

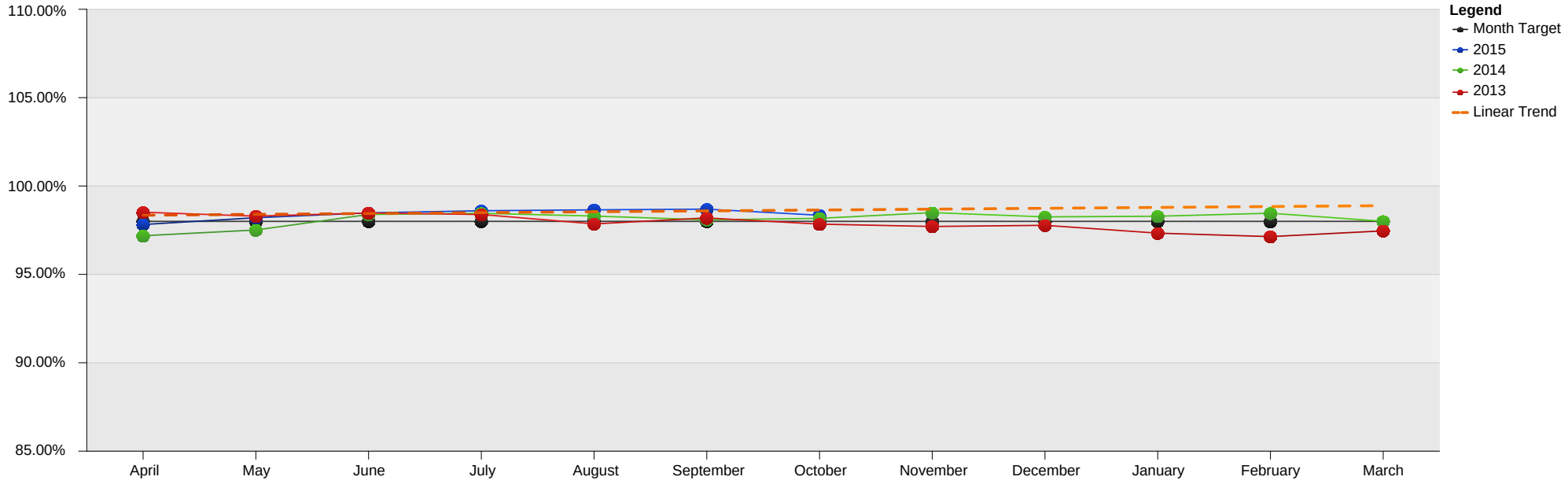


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) Percentage CPA 7 day follow up (AMH) - post-validated	98.39%	97.87%	98.68%	98.20%	98.70%	98.39%	96.97%	96.30%	NA	NA

Narrative
The Trust post validated position for October 2015 is 98.39% which relates to 3 patients out of 186 that were not followed up within 7 days of discharge. This is 3.39% above the target but a slight deterioration on September performance. The Trust post validated position for the financial year to date is 97.87%, which is 2.87% above target.Based on past performance and October's performance, it is anticipated that we will achieve the annual target of 95%.The annual outturn for 2014/15 was 97.42%.

Trust Dashboard Graphs for TRUST

10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)



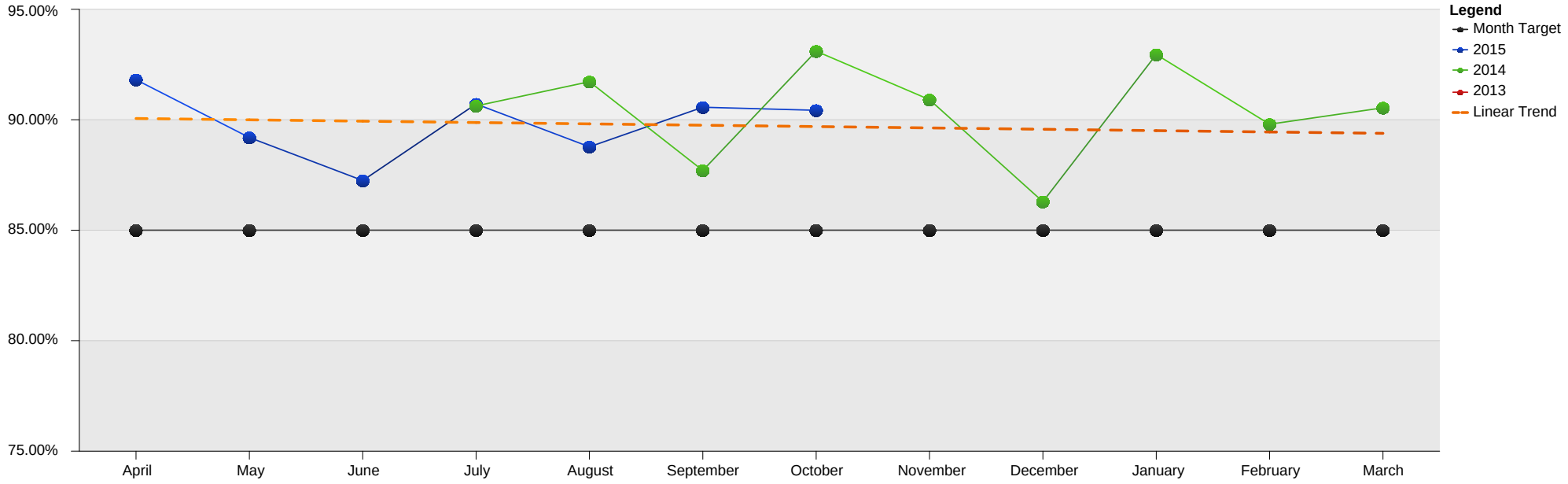
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.35%	98.35%	97.76%	97.76%	99.69%	99.69%	97.68%	97.68%		

Narrative

The Trust position for October 2015 is 98.35% which relates to 68 patients out of 4114 that had not had a formal review documented within 12 months. This is 3.35% above the Monitor target of 95% and 0.35% above the Trust target of 98%, but a very slight deterioration on September performance. Only Teesside are achieving target. Durham & Darlington and North Yorkshire are reporting 97.76% and 97.68% respectively. Durham & Darlington have experienced some staffing issues in respect of sickness and vacancies; however the importance of completion of reviews within the 12 month period is being reiterated to all staff. Within North Yorkshire, the service is monitoring activity and managers are identifying ways in which they can improve the position.Since May performance has consistently been above target and it is expected that we will achieve the annual target of 98%.The annual outturn for 2014/15 was 97.90%.

Trust Dashboard Graphs for TRUST

11) Community patients involved in the development of their care plan (month behind)

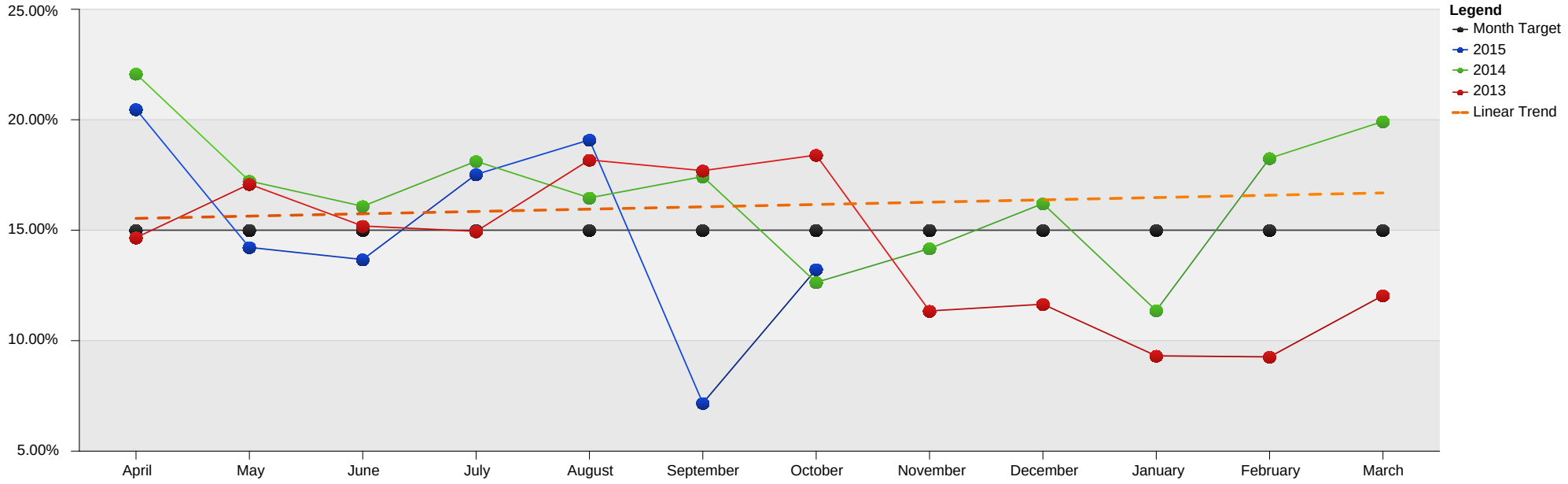


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	90.43%	89.83%	88.83%	89.62%	92.26%	90.44%	88.41%	88.82%	100.00%	95.45%

Narrative
The position reported in October 2015 relates to September performance. The Trust position for September 2015 is 90.43%, which relates to 65 patients out of 679 that state they have not been involved in the development of their care plan. This is 5.43% above the target of 85% but a slight deterioration on the performance reported for August. The Trust position for the financial year to date is 89.83%, which is 4.83% above target.Based on past performance and September's performance, it is anticipated that we will achieve the annual target of 85%.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).The annual outturn for 2014/15 was 90.58%

Trust Dashboard Graphs for TRUST

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

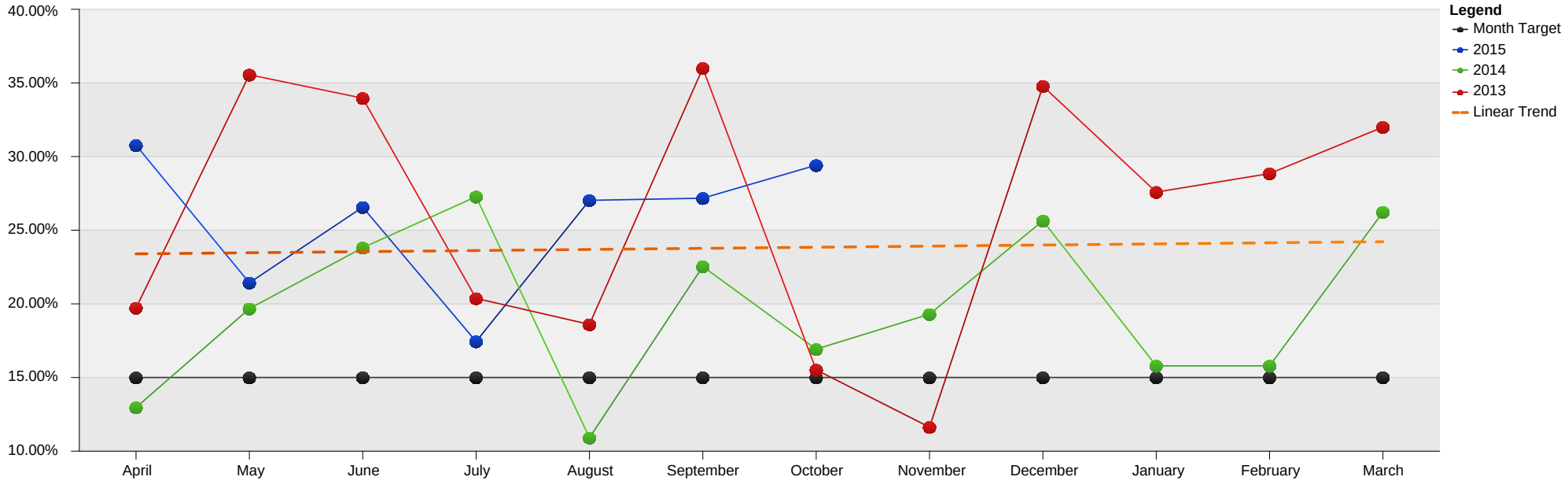


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	13.23%	15.10%	9.80%	15.26%	16.09%	8.50%	15.15%	23.99%	NA	NA

Narrative
The Trust position for October 2015 is 13.23%, which relates to 34 admissions out of 257 that were admitted to out of locality assessment and treatment wards. This is 1.77% below the target of 15% but a deterioration on the position reported in September. Only Durham & Darlington are below target . Teesside are reporting 16.09% and North Yorkshire 15.15%. The Trust position for the financial year to date is 15.10%, which is 0.10% above target. Of the 34 patients admitted to an 'out of locality' bed:• 33 were due to no beds being available at their local hospital(AMH 12, MHSOP 21)• 1 was due to Other - breaches. The localities continue to investigate ways in which they can improve OOL admissions. Whilst this financial year has reported an improving trend, there remains a risk that we will not achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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



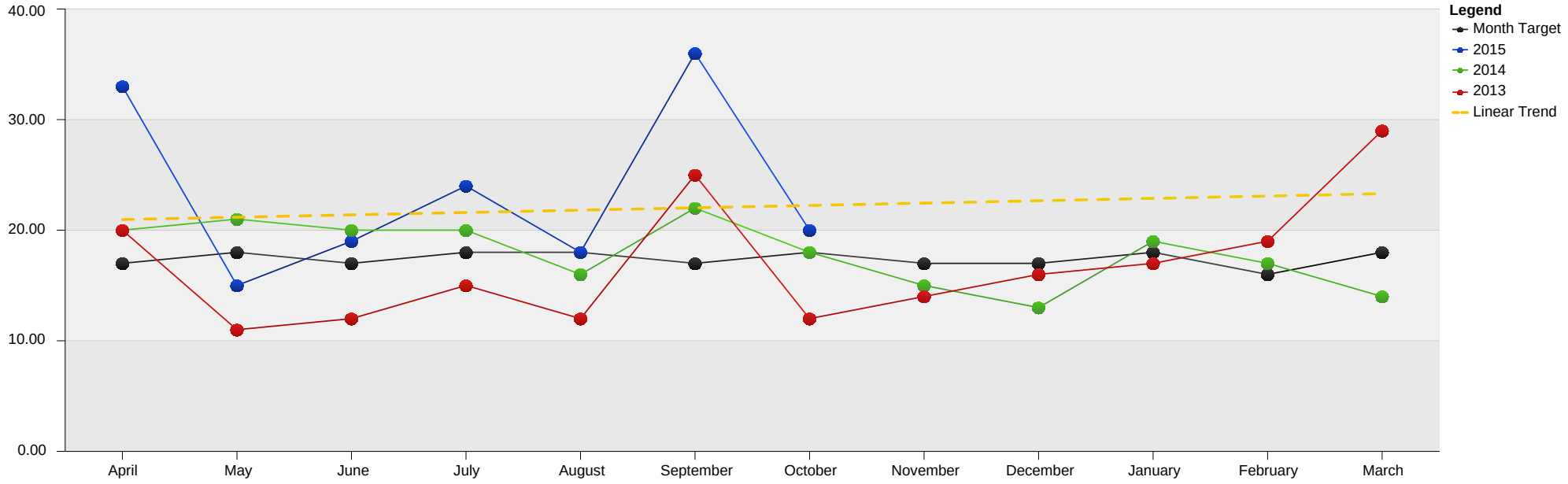
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	29.41%	25.68%	20.83%	22.84%	15.79%	21.92%	48.00%	32.73%	NA	NA

Narrative

The Trust position for October 2015 is 29.41%, which relates to 20 patients out of 68 that were readmitted within 30 days. This is 14.41% above the target of 15% and a deterioration on the position reported in September. The Trust position for the financial year to date is 25.68%, which is 10.68% above target.All of the 20 readmissions were within AMH Services:• 5 (25%) were within Durham & Darlington • 3 (15%) were within Teesside.• 12 (60%) were within North Yorkshire No particular patterns or trends in terms of wards or community teams have been identified; however these are being further reviewed by the services.October has reported the highest position since April and based on this and performance throughout the year to date, there is a significant risk we will not achieve the annual target of 15%.The annual outturn for 2014/15 was 19.89%.

Trust Dashboard Graphs for TRUST

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

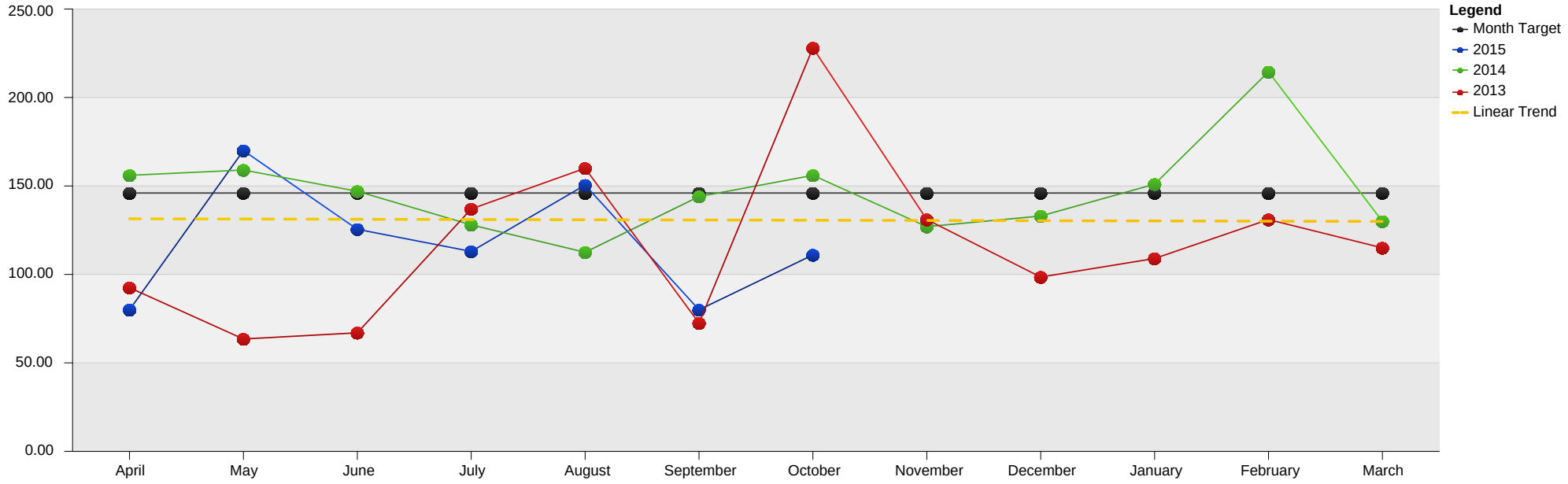


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	20.00	165.00	5.00	55.00	5.00	48.00	10.00	61.00	NA	NA

Narrative
The Trust position for October 2015 is 20, which is 2 above the target of 18 but a significant improvement on the position reported in September. Only North Yorkshire locality are below target. The Trust position for the financial year to date is 165, which is 42 above target.Of the 20 readmissions:• 5 (25.00%) were Durham & Darlington AMH patients.• 5 (25.00%) were Teesside patients - AMH 4, MHSOP 1.• 10 (50.00%) were North Yorkshire – AMH 9, MHSOP 1.Whilst performance peaked last month, based on past performance and performance in October, there remains a risk that we will not achieve the annual target of 209.The annual outturn for 2014/15 was 219.

Trust Dashboard Graphs for TRUST

15) Median number of days between admissions (AMH & MHSOP) - Monthly

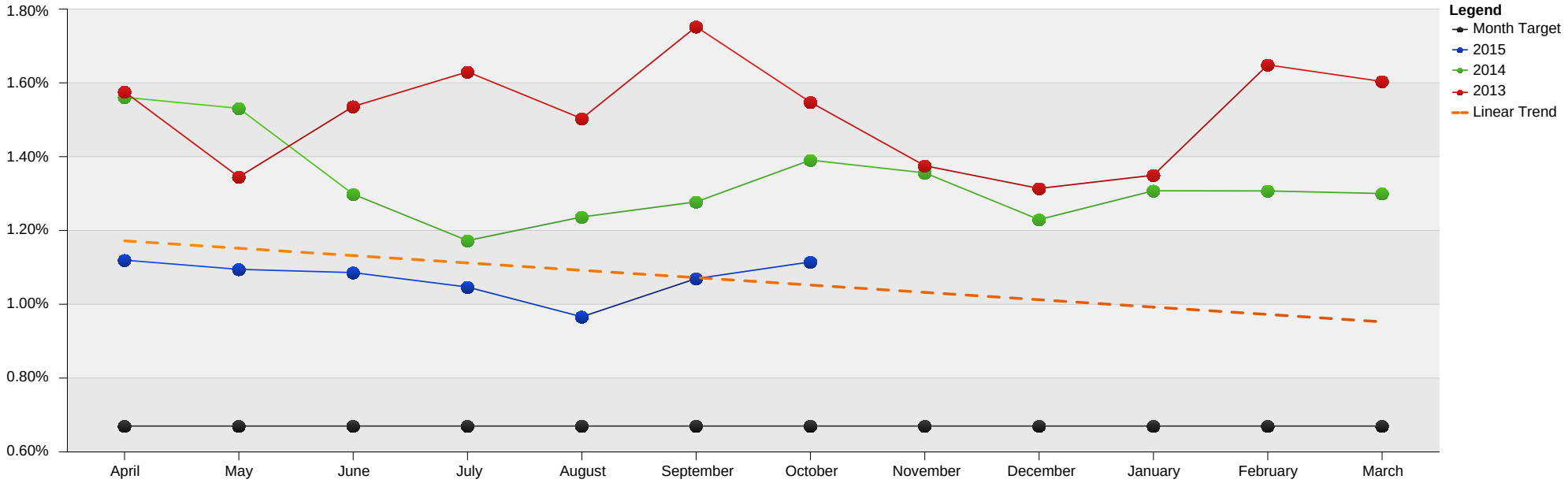


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	111.00	111.00	122.00	129.00	136.00	139.00	57.00	79.00	NA	NA

Narrative
The Trust position for October 2015 is 111, which is 35 below the target of 146 but a significant improvement on September performance. The Trust position for the financial year to date is 111, which is 35 below target.Based on past performance and October's performance, there is a risk that we will not achieve the annual target of 146.The annual outturn for 2014/15 was 139.

Trust Dashboard Graphs for TRUST

16) Percentage of appointments cancelled by the Trust



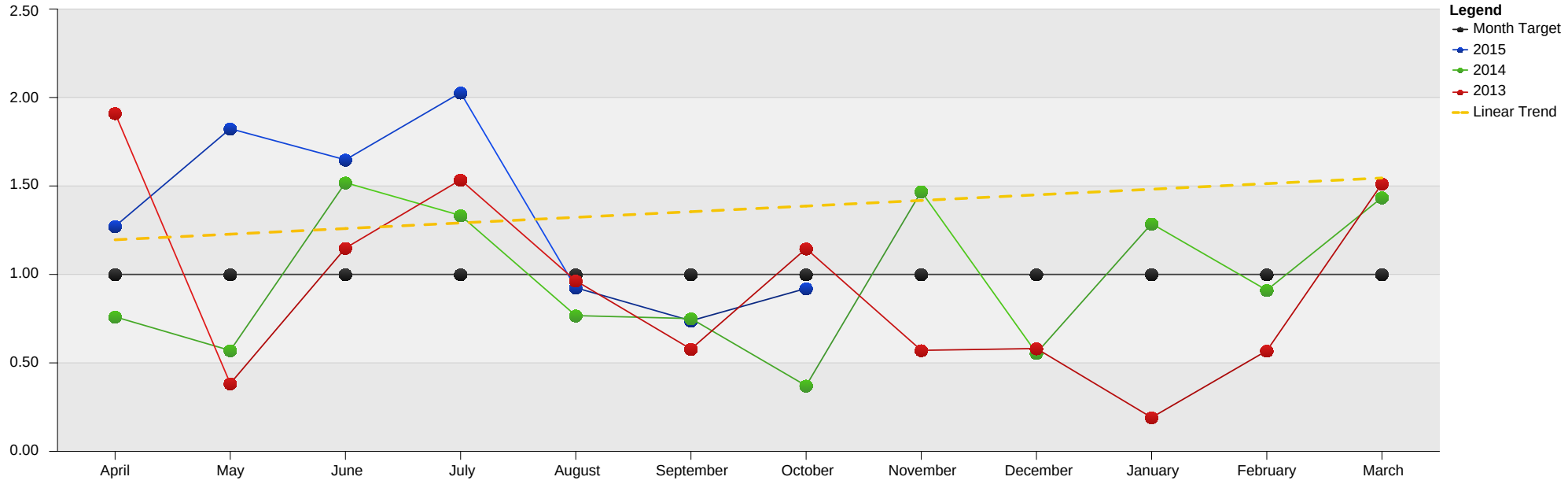
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of appointments cancelled by the Trust	1.11%	1.07%	1.10%	1.08%	1.19%	1.03%	1.18%	1.30%	0.16%	0.08%

Narrative

The Trust position for October 2015 is 1.11%, which relates to 860 appointments out of 77,148 that have been cancelled. This is 0.44% above the target of 0.67% and a slight deterioration compared to September performance. The Trust position for the financial year to date is 1.07%, which is 0.40% above target.All localities are failing to achieve target; however, it has been identified that some of these cancellations may be due to how clinics are managed and investigations into this continue. This work is being coordinated by the Data Quality Working Group who report progress to the Data Quality Group on a regular basis.Performance shows a deteriorating trend since August and based on this and past performance, there remains a risk that we will not achieve the annual target of 0.67% unless further action is taken.The annual outturn for 2014/15 was 1.33%.

Trust Dashboard Graphs for TRUST

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

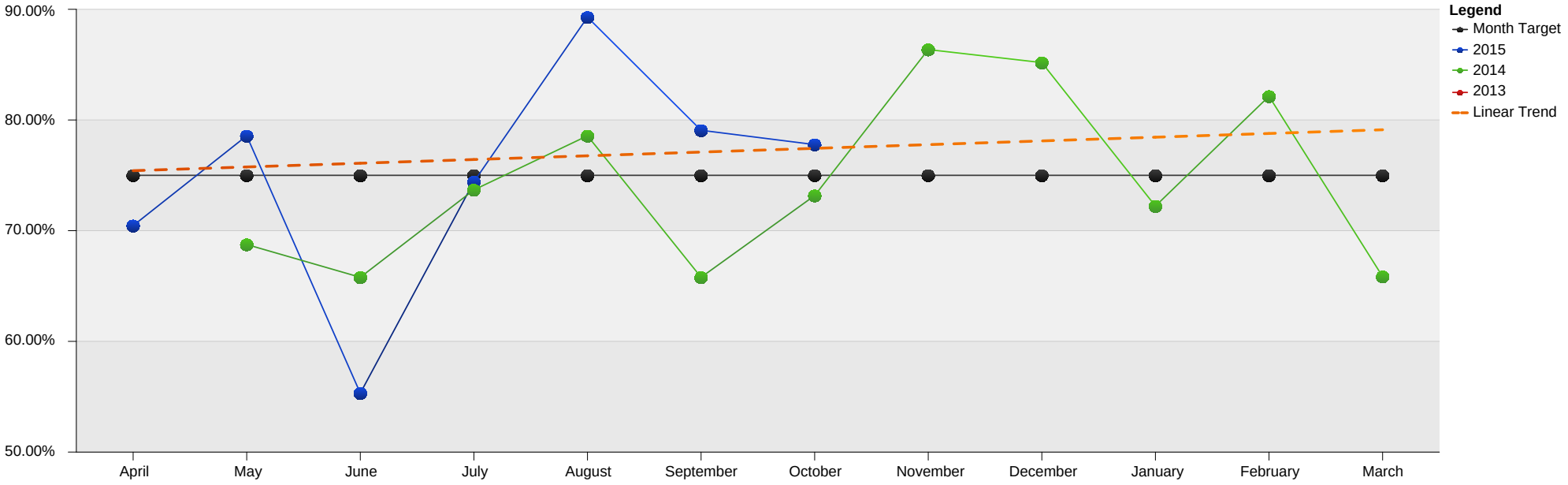


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.92	9.36	1.22	8.44	0.60	7.90	0.82	13.12	0.00	12.88

Narrative
The Trust position for October 2015 is 0.92, which is 0.08 below the target of 1.00 and a deterioration on September performance. This rate relates to 5 unexpected deaths reported in October; 3 in Durham & Darlington, 1 in North Yorkshire, 1 in Teesside. No patterns or trends have been identified. The Trust position for the financial year to date is 9.36, which is 2.36 above target.Performance has improved in the last 3 months but has primarily been higher than the equivalent months in 2014/15 and based on this there is a risk that we will not achieve the annual target of 12.00.The annual outturn for 2014/15 is 12.16; therefore we have not quite achieved the annual target of 12.00.

Trust Dashboard Graphs for TRUST

18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)



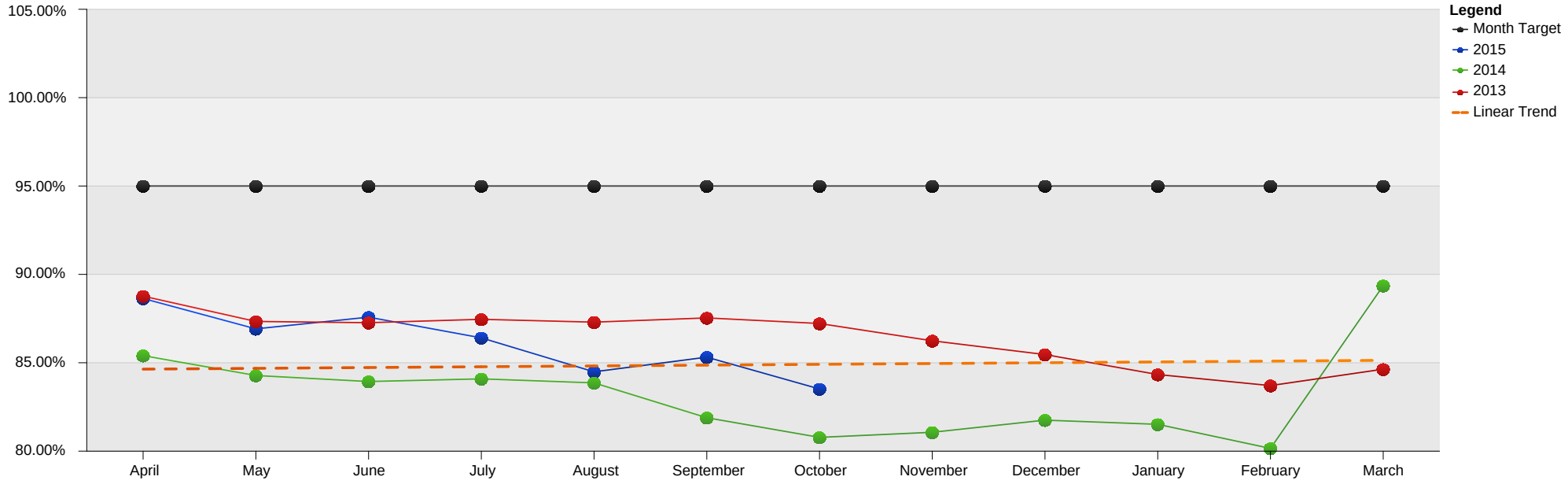
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	77.78%	73.61%	100.00%	86.42%	66.67%	85.71%	71.43%	72.00%	57.14%	37.93%

Narrative

The Trust position reported in October relates to September performance. The Trust position for September 2015 is 77.78% with 8 wards out of 36 surveyed in September not scoring higher than 80%. This is 2.78% above the target of 75.00% but a deterioration on August's position. Only Durham & Darlington are achieving target at 100%. The Trust position for the financial year to date is 73.61%, which is 1.39% below target.Teesside are reporting 66.67% (3 wards), North Yorkshire are reporting 71.43% (2 wards) and Forensics are reporting 57.14% (3 wards).The position within Forensics is largely attributable to the low numbers of surveys that are being returned by patients. Discussions continue within the service as to how this can be improved, as given the inherent nature of forensic patients being detained it is less likely that that they will be positive about the experience on the ward. Those within the localities are being investigated for any patterns of trends.Performance at Trust level has reported an improving trend since June (May's data) despite dipping over the last two months; should this continue there is a possibility that we will achieve the annual target of 75%.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).The annual outturn for 2014/15 was 73.17%.

Trust Dashboard Graphs for TRUST

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



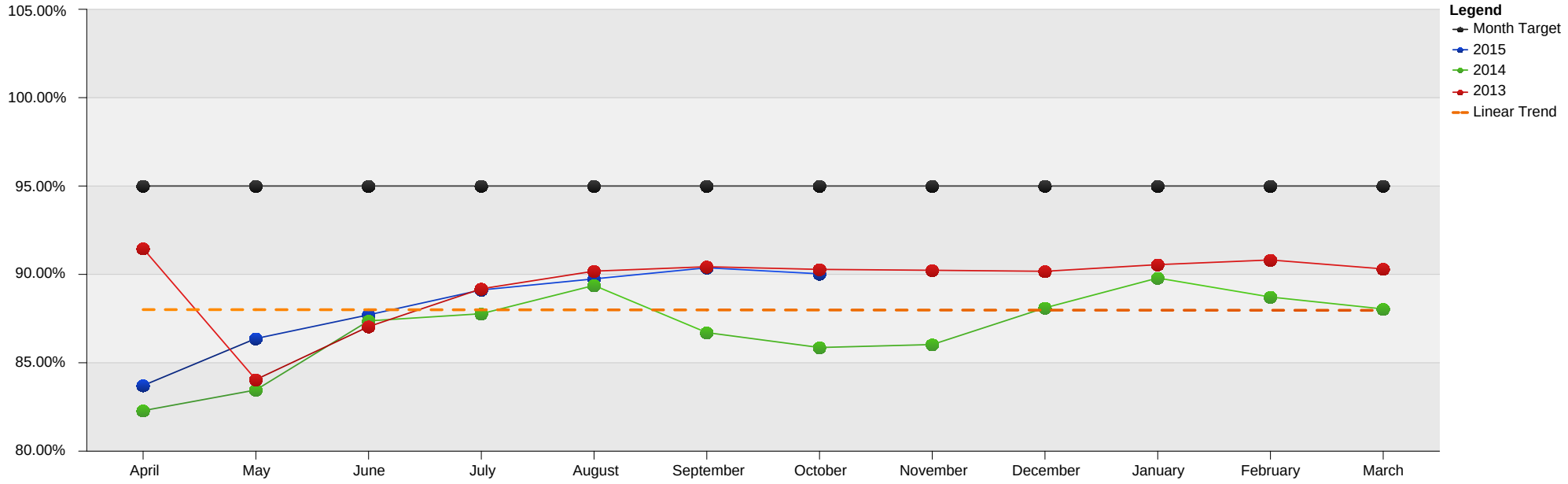
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	83.52%	83.52%	80.85%	80.85%	84.38%	84.38%	83.79%	83.79%	87.04%	87.04%

Narrative

The Trust position for October 2015 is 83.52% which relates to 854 members of staff out of 5181 that do not have a current appraisal. This is 11.48% below the target of 95% but a slight deterioration on September's position.Managers are able to access compliance reports through the IIC to monitor performance against the target of 95%. Monitoring of compliance against the target is picked up at the Performance Improvement Group where Directors of Operations provide details of actions being taken to improve compliance. 19 staff had their pay progression withheld at the end of October due to non-compliance of mandatory training and/or appraisal, this is lower than the figure of 24 reported in September Despite performance consistently reporting higher than that during 2014, based on the deteriorating trend and October's performance there remains a significant risk that we will not achieve the annual target of 95%, unless further action is taken.The annual outturn for 2014/15 was 85.41%.

Trust Dashboard Graphs for TRUST

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

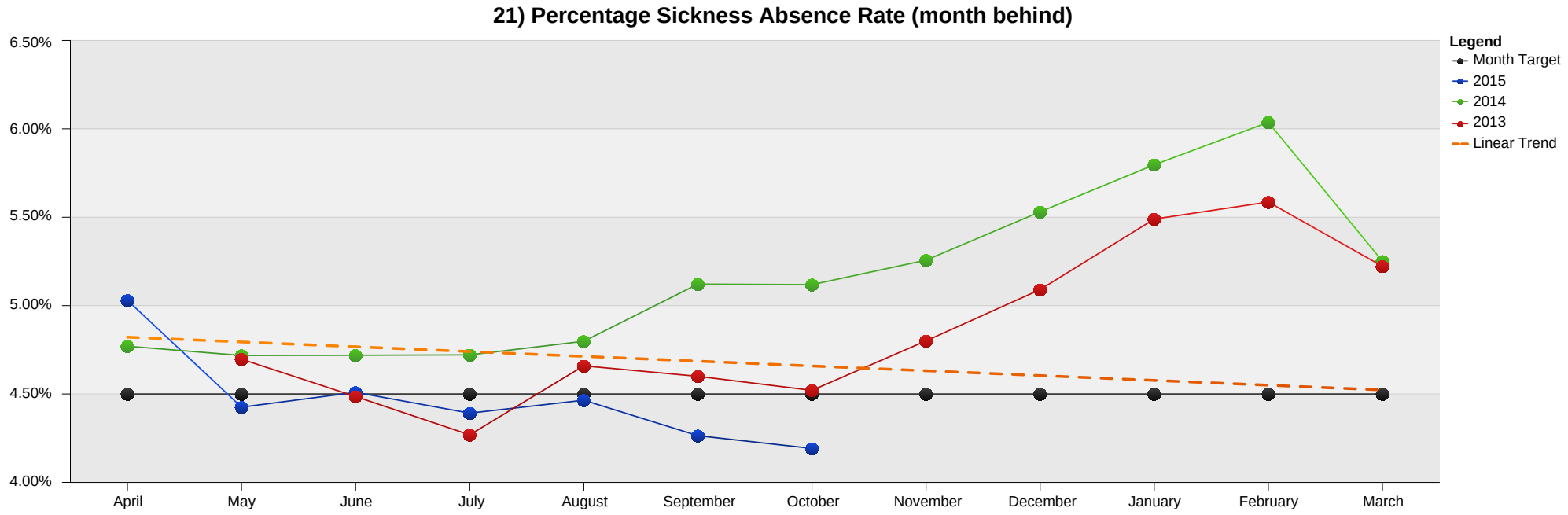


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Percentage compliance with mandatory and statutory training (snapshot)	90.03%	90.03%	88.37%	88.37%	90.58%	90.58%	86.79%	86.79%	91.41%	91.41%

Narrative

The position for October 2015 is 90.03%. This is 4.97% below the target of 95% and a slight deterioration on September 2015 performance.Regular monthly reports are produced for Heads of Service and line managers to monitor performance against the target of 95%. A meeting is scheduled this month to continue investigations into how the IIC can be further developed to support managers to manage their workforce compliance against key performance indicators.Whilst the improving trend since April 2015 continues, there is still a risk that we will not achieve the annual target of 95%, unless further action is taken.The annual outturn for 2014/15 was 82.29%.

Trust Dashboard Graphs for TRUST

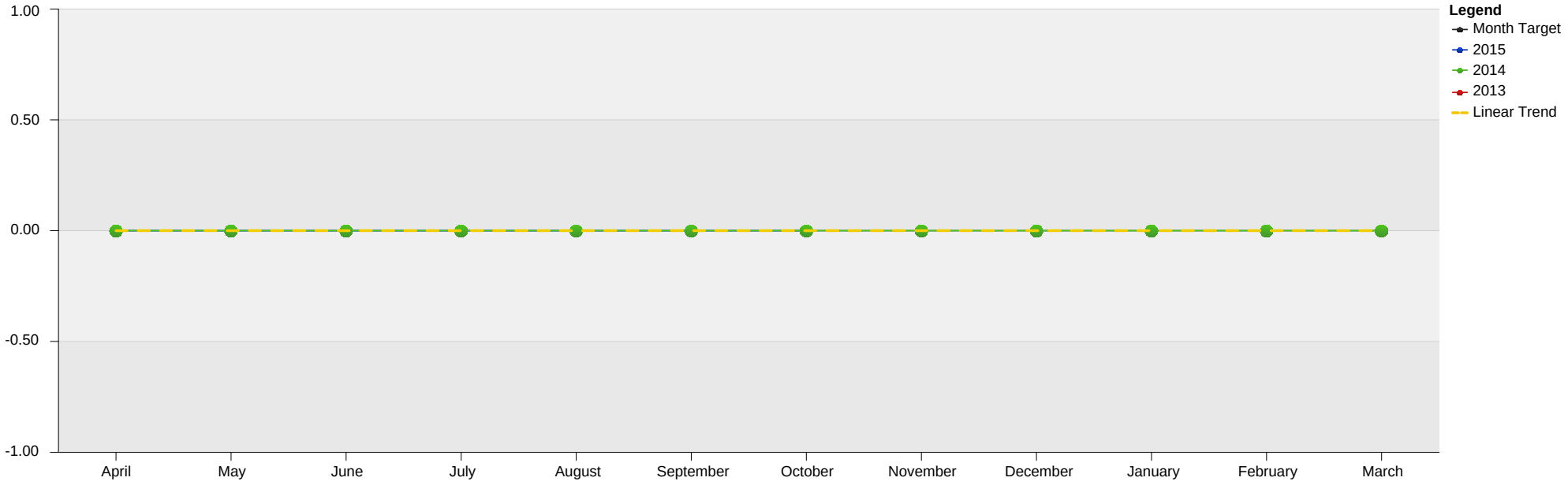


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Percentage Sickness Absence Rate (month behind)	4.19%	4.47%	4.05%	4.35%	4.75%	4.77%	3.88%	4.28%	5.52%	6.13%

Narrative
The Trust position reported in October relates to the September sickness level. The Trust position reported in September 2015 is 4.19%, which is 0.31% below the Trust target of 4.50% and an improvement on August 2015. The Trust position for the financial year to date is 4.47%.Whilst there has been a decreasing trend during this financial year with October reporting the lowest position to date, past performance indicates sickness increases in the latter half of the year. Should this occur, there is a risk that we will not achieve the annual target of 4.50%; however, a decreasing trend has been reported since February with October 2015 reporting the best position since July 2013. Should this improvement continue, the target could be achieved.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).The annual outturn for 2014/15 was 5.12%.

Trust Dashboard Graphs for TRUST

22) Number of reds on CQC action plans (including MHA action plans)

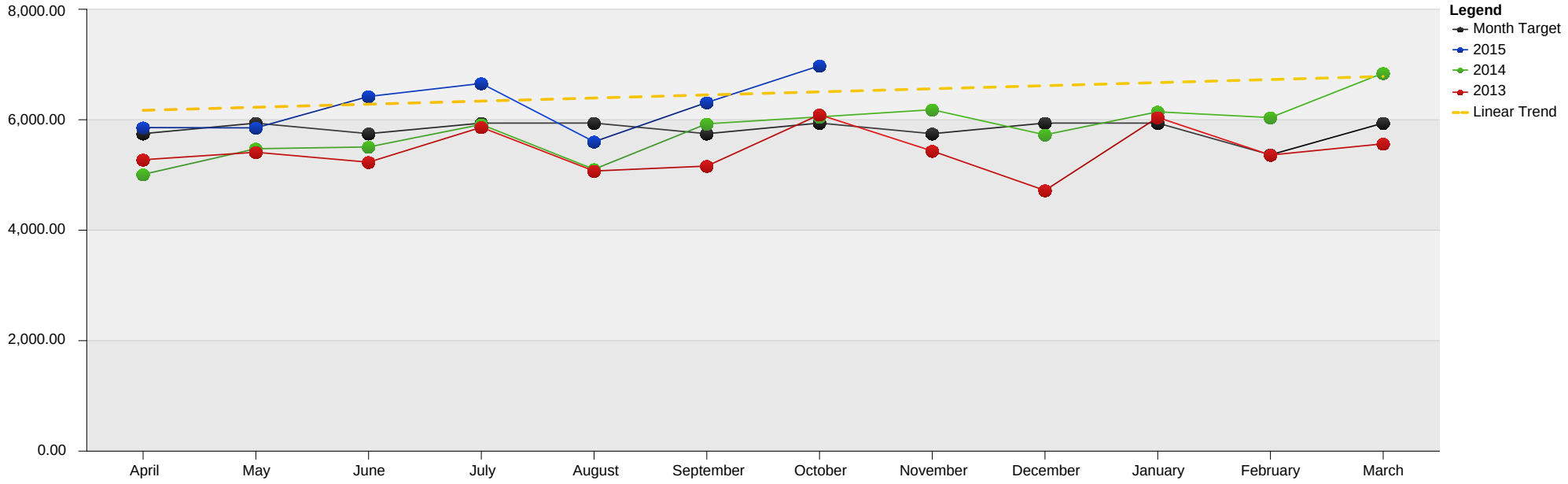


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative
The Trust position for October 2015 is zero, which is consistent with 2014/15 reporting.Based on past performance and October's performance, it is anticipated that we will achieve the annual target.The annual outturn for 2014/15 was 0.

Trust Dashboard Graphs for TRUST

23) Total number of External Referrals into the Trust Services

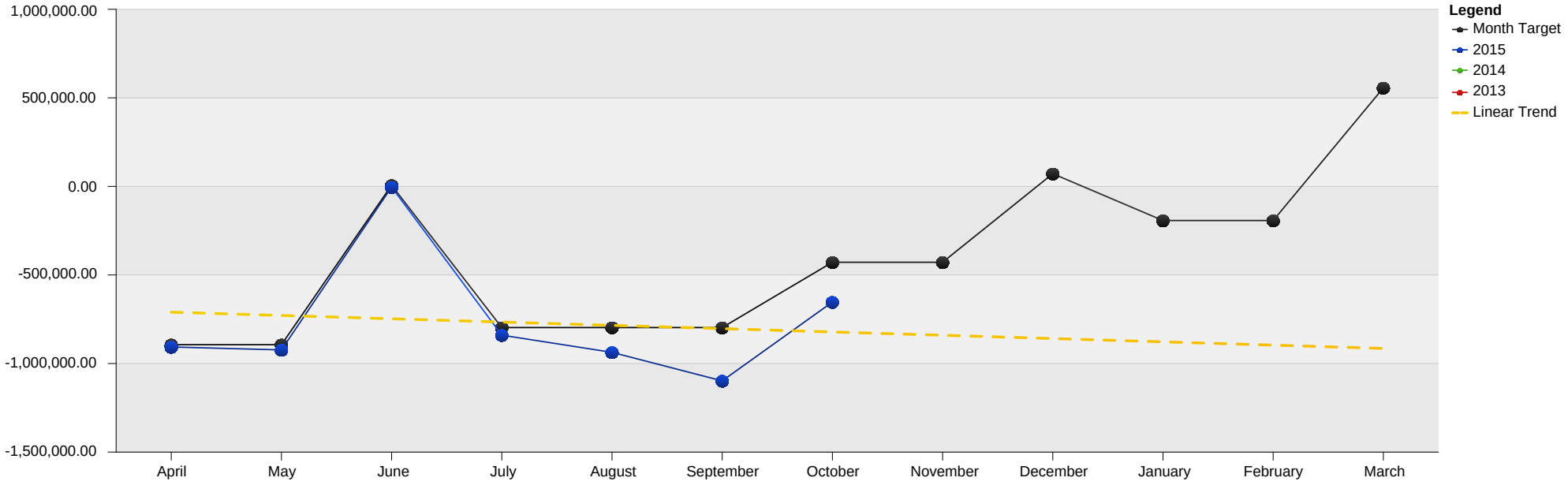


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
23) Total number of External Referrals into the Trust Services	6,977.00	43,680.00	2,055.00	13,290.00	2,103.00	14,127.00	2,049.00	12,905.00	763.00	3,307.00

Narrative
The Trust position for October 2015 is 6977, which is 1037 above the Trust target of 5,940 and an increase on the number received in September; the highest number received since April 2013. The Trust position for the financial year to date is 43,680, which is 2679 above target. This increase in referrals is in line with patterns in previous years and should this continue it can be expected that referrals will rise as the year progresses and we will receive more external referrals than the expected number of 69931.The annual outturn for 2014/15 was 69,920.

Trust Dashboard Graphs for TRUST

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



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
24) Delivery of our financial plan (I and E)	-653,000.00	-5,362,000.00	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The Trust position for October 2015 is a surplus of £653,000 which is £224,700 better that the expected surplus of £428,300. The Trust position for the financial year to date is a surplus of £5,362,000, which is £761,700 above target. Based on performance during this financial year to date, it is anticipated that we will achieve the annual target of a surplus of £4,784,000.Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 1: To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

	October 2015										April 2015 To October 2015									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	98.00%	85.63%	98.00%	83.19%	98.00%	91.18%	98.00%	76.43%	98.00%	100.00%	98.00%	82.20%	98.00%	78.11%	98.00%	89.05%	98.00%	74.59%	98.00%	99.87%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	86.89%	98.00%	78.46%	98.00%	94.20%	98.00%	91.86%	98.00%	57.14%	98.00%	87.18%	98.00%	82.64%	98.00%	92.04%	98.00%	89.86%	98.00%	50.53%
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	50.00%	73.17%	50.00%	68.75%	50.00%	83.33%	50.00%	57.14%	NA	NA	50.00%	73.64%	50.00%	62.12%	50.00%	81.29%	50.00%	79.03%	NA	NA
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	85.33%	75.00%	98.97%	75.00%	56.67%	75.00%	81.75%	NA	NA	75.00%	81.63%	75.00%	98.50%	75.00%	58.99%	75.00%	68.11%	NA	NA
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	93.71%	95.00%	100.00%	95.00%	82.00%	95.00%	91.24%	NA	NA	95.00%	93.62%	95.00%	99.83%	95.00%	79.54%	95.00%	91.77%	NA	NA
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	15.00%	12.78%	15.00%	12.63%	NA	NA	15.00%	13.01%	NA	NA	15.00%	13.25%	15.00%	12.72%	NA	NA	15.00%	14.06%	NA	NA
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	48.11%	50.00%	47.47%	50.00%	51.01%	50.00%	47.23%	NA	NA	50.00%	46.66%	50.00%	45.21%	50.00%	46.71%	50.00%	48.94%	NA	NA
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	95.00%	96.55%	95.00%	96.00%	95.00%	96.55%	95.00%	97.30%	NA	NA	95.00%	97.38%	95.00%	96.81%	95.00%	97.43%	95.00%	97.95%	NA	NA
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.39%	95.00%	98.68%	95.00%	98.70%	95.00%	96.97%	NA	NA	95.00%	97.87%	95.00%	98.20%	95.00%	98.39%	95.00%	96.30%	NA	NA
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.35%	98.00%	97.76%	98.00%	99.69%	98.00%	97.68%	98.00%		98.00%	98.35%	98.00%	97.76%	98.00%	99.69%	98.00%	97.68%	98.00%	
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	90.43%	85.00%	88.83%	85.00%	92.26%	85.00%	88.41%	85.00%	100.00%	85.00%	89.83%	85.00%	89.62%	85.00%	90.44%	85.00%	88.82%	85.00%	95.45%

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 2: To continuously improve the quality and value of our work

	October 2015										April 2015 To October 2015									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	13.23%	15.00%	9.80%	15.00%	16.09%	15.00%	15.15%	NA	NA	15.00%	15.10%	15.00%	15.26%	15.00%	8.50%	15.00%	23.99%	NA	NA
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	29.41%	15.00%	20.83%	15.00%	15.79%	15.00%	48.00%	NA	NA	15.00%	25.68%	15.00%	22.84%	15.00%	21.92%	15.00%	32.73%	NA	NA
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	18.00	20.00	5.00	5.00	5.00	5.00	6.00	10.00	NA	NA	123.00	165.00	38.00	55.00	38.00	48.00	46.00	61.00	NA	NA
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	146.00	111.00	146.00	122.00	146.00	136.00	146.00	57.00	NA	NA	146.00	111.00	146.00	129.00	146.00	139.00	146.00	79.00	NA	NA
16) Percentage of appointments cancelled by the Trust	0.67%	1.11%	0.67%	1.10%	0.67%	1.19%	0.67%	1.18%	0.67%	0.16%	0.67%	1.07%	0.67%	1.08%	0.67%	1.03%	0.67%	1.30%	0.67%	0.08%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.92	1.00	1.22	1.00	0.60	1.00	0.82	1.00	0.00	7.00	9.36	7.00	8.44	7.00	7.90	7.00	13.12	7.00	12.88
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	77.78%	75.00%	100.00%	75.00%	66.67%	75.00%	71.43%	75.00%	57.14%	75.00%	73.61%	75.00%	86.42%	75.00%	85.71%	75.00%	72.00%	75.00%	37.93%

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce

	October 2015										April 2015 To October 2015									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	83.52%	95.00%	80.85%	95.00%	84.38%	95.00%	83.79%	95.00%	87.04%	95.00%	83.52%	95.00%	80.85%	95.00%	84.38%	95.00%	83.79%	95.00%	87.04%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	90.03%	95.00%	88.37%	95.00%	90.58%	95.00%	86.79%	95.00%	91.41%	95.00%	90.03%	95.00%	88.37%	95.00%	90.58%	95.00%	86.79%	95.00%	91.41%
21) Percentage Sickness Absence Rate (month behind)	4.50%	4.19%	4.50%	4.05%	4.50%	4.75%	4.50%	3.88%	4.50%	5.52%	4.50%	4.47%	4.50%	4.35%	4.50%	4.77%	4.50%	4.28%	4.50%	6.13%

Trust Dashboard - Locality Breakdown for TRUST

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

	October 2015										April 2015 To October 2015									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
23) Total number of External Referrals into the Trust Services	5,940.00	6,977.00	1,939.00	2,055.00	1,985.00	2,103.00	1,826.00	2,049.00	189.00	763.00	41,001.00	43,680.00	13,386.00	13,290.00	13,704.00	14,127.00	12,605.00	12,905.00	1,306.00	3,307.00
24) Delivery of our financial plan (I and E)	-428,300.00	-653,000.00	NA	NA	NA	NA	NA	NA	NA	NA	-4,600,300.00	-5,362,000.00	NA	NA	NA	NA	NA	NA	NA	NA

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at June 2015	Percentage	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
1	Percentage of patients who have not waited longer than 4 weeks for a first appointment	5						4				5					14	93%	93%	
2	Percentage of patients who have not waited longer than 4 weeks following an internal referral	5						4				5					14	93%	93%	
3	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	5						4				5					14	87%	93%	The Trust has developed a local KPI pending publication of national construction. There is an issue identified with allocation of a care co-ordinator which was required for this indicator, which has been monitored through the Data Quality group, but has temporarily been removed from the logic. Work has been undertaken with the services to improve reliability, therefore the score for data reliability has increased from 3 to 4.
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral		4					4				5					13	87%	87%	
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral		4					4				5					13	87%	87%	
6	Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)		4					4				5					13	87%	87%	
7	Recovery Rate – Adult IAPT: The percentage of people who complete treatment who are moving to recovery		4					4				5					13	87%	87%	
8	Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only)		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.
9	Percentage CPA 7 day follow up (adult services only)		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 CPA Patients having a formal review documented within 12 months – snapshot (adult services only)	5						4				5					14	93%	93%	
11	Percentage of community patients who state they have been involved in the development of their care plan (month behind)					1		4				5					10	67%	67%	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.
12	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated		4					4				5					13	87%	87%	
13	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						4				5					14	93%	93%	

		Data Source					Data Reliability					KPI Construct/Definition								
		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	Total Score	Percentage as at June 2015	Percentage	Notes
14	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	5					5					5					15	100%	100%	
15	Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	5					5					5					15	100%	100%	
16	Percentage of appointments cancelled by the Trust	5									1	5					11	87%	73%	Whilst data reliability has been tested, a number of data quality issues identified by the Patient Experience Group and the localities have raised a significant concern; therefore the Data Quality Group has assessed reliability at 1. For example: • appointments being incorrectly recorded as cancelled • not all cancelled appointments being recorded • appointments not having outcomes recorded A working party is to be established to investigate the problem and produce longer term recommendations
17	Number of unexpected deaths classed as a serious incident per 10,000 open cases					1		4				5					10	67%	67%	Different sources in calculation - lower one used which is a manual process including a telephone call and data entered onto Datix (unexpected deaths)
18	Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)			3				4				5					12	80%	80%	Surveys for ward are via the hand held device. The devices are uploaded electronically (can sometimes be issues with the devices) direct to CRT. Patient Experience Team (PET) provided with ward based reports. PET open every ward report, identify the % and number completing, calculate the numerator manually then type this into the spreadsheet for each individual ward. Latter 2 processes open to human error.
19	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	93%	93%	
20	Percentage compliance with mandatory and statutory training – snapshot	5						4				5					14	93%	93%	
21	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.
22	Number of reds on CQC Action Plans (including MHA Action Plans)				2		5					5					12	73%	80%	Whilst static reports are emailed to the Trust, the information is maintained on an Excel spreadsheet. This is monitored and updated in conjunction with the services. Contingencies are now in place to ensure data is correctly reported and sourced on time and data is extracted from the spreadsheet onto the manual return for upload onto the IIC. Therefore, the score for data source has increased from 1 to 2.
23	Total number of External Referrals into the Trust Services	5					5					5					15	100%	100%	
24	Are we delivering our financial plan (I and E)		4				5					5					14	93%	93%	

Number of unexpected deaths and verdicts from the coroner April 2015 - October 2015

	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	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	
Accidental death	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Natural causes	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Hanging	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Suicides	6	1	3	0	0	0	0	0	0	0	0	0	0	1	0	0	**11**
Open	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Abuse of drugs	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
Drowning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Misadventure	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Awaiting verdict	8	4	7	0	0	0	0	0	2	1	3	0	1	4	1	1	**32**
Total	**18**	**7**	**12**	**0**	**0**	**0**	**0**	**0**	**2**	**1**	**3**	**0**	**1**	**5**	**1**	**1**	**51**

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	11	5	4	5					

This table has been included into this appendix for comparitive purposes only

Number of unexpected deaths and verdicts from the coroner 2014 / 2015

	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	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	
Accidental death	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Natural causes	1	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	**3**
Hanging	1	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	**4**
Suicides	14	8	3	1	0	0	0	1	0	0	0	0	1	3	2	0	**33**
Open	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Abuse of drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Drowning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Misadventure	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**2**
Awaiting verdict	6	1	3	0	1	1	0	0	1	0	0	0	3	1	0	0	**18**
Total	**22**	**11**	**8**	**1**	**1**	**1**	**0**	**1**	**2**	**0**	**0**	**0**	**7**	**4**	**3**	**0**	**61**

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	2	7	7	4	4	2	8	3	7	5	8

ITEM 16

BOARD OF DIRECTORS MEETING

Date of Meeting: 24th November 2015
Title: Proposed Trust Dashboard Key Performance Indicators 16/17
Lead Director: Sharon Pickering, Director of Planning, Performance and Communications
Report for: Decision

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose	✓	Assessing and monitoring quality of service provision	✓	Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS MEETING

Date of Meeting: **24th November 2015**

Title: **Proposed Trust Dashboard Key Performance Indicators 16/17**

1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to present to the Board of Directors the output from the Board Business Planning Event on Key Performance Indicators for the 2016/17 Trust Dashboard for discussion and agreement.

2. BACKGROUND INFORMATION

2.1 The consideration of an Operational Performance Dashboard by the Board is recommended good practice in the Board Governance Assurance Framework produced by the Department of Health and the Quality Governance Framework published by Monitor. Both of these frameworks were used to assess the Trust's governance arrangements in 2013 by Deloitte.

Board's should receive a fully integrated performance dashboard which enables the Board to consider the performance of the Trust against a range of metrics including quality, performance, activity and finance and enables links to be made (e.g. financial variances are linked to activity).
(Board Governance Assurance Framework for Aspirant Foundation Trusts, December 2011)

2.2 The Trust Dashboard provides a monthly high level overview of operational delivery throughout the financial year using a range of key performance indicators. These indicators are then measured from Ward/Team level through to Board level (where relevant).

2.3 In October 2015, as part of the Board Business Planning Event, members of the Board, EMT and Senior Clinical Directors discussed the Trust Dashboard for 16/17 as part of the planning process.

3. KEY ISSUES:

3.1 At the Board Business Planning Workshop and as part of the 16/17 development process, senior leaders were asked to identify 3-5 measures for each of the following domains that we proposed to use in a balanced scorecard:

- Activity
- Quality
- Workforce
- Money

The results from the Board Planning Event are detailed in Appendix A.

3.2 The Corporate Performance Team have taken the output from the event and have taken the following into consideration when making proposals for consideration for the 2016/17 Board Dashboard:

- The frequency each indicator was proposed
- The frequency the data is collected and therefore could be reported
- Whether the indicators were in the "right" domain e.g. there were a number of indicators suggested for activity that it was felt were more appropriate for quality
- Identified any gaps and suggested further indicators e.g. activity domain

3.3 Executive Management Team reviewed the proposals identified by the Corporate Performance Team on the 18th November 2015 and made some amendments. The final list of suggested indicators is detailed in Appendix B.

3.4 Once the final list of key performance indicators for 2016/17 have been agreed by the Board, work will commence on gaining specificity on the indicator construction and where necessary baselines and it is planned to bring proposed targets back to the Board of Directors at the end of February 2016.

4. IMPLICATIONS / RISKS:

4.1 Quality: Measures of quality are included in the proposed indicators for 16/7

4.2 Financial: Financial measures are included in the proposed indicators for 16/17.

4.3 Legal and Constitutional: There are no direct legal and constitutional implications arising from this report.

4.4 Equality and Diversity: There are no direct equality and diversity implications arising from this report

4.5 Other Risks: There are no further risks associated with this report.

5. CONCLUSION

5.1 As part of the planning process, senior leaders have discussed and suggested a range of indicators to be included in the 16/17 Trust Dashboard which the Corporate Performance Team and EMT have reviewed and progressed further (Appendix B).

6. RECOMMENDATIONS

6.1 The Board of Directors are asked to discuss the proposed indicators in Appendix B and agree the final list for inclusion in the 2016/17 Trust Dashboard.

Sarah Theobald
Head of Corporate Performance

Appendix A

Output from Board Planning Event

Activity	**Quality**
• % OoL • % of patients seen within 4 weeks from external referral √√√ • % of patients re-admitted to A&T wards • Instances of 3 or more admissions • Assessments carried out • Discharges √√* • Referrals √√* • Regulatory targets being achieved √ • Number of contacts • Length of Stay • Number of people on a pathway • Assessment to treatment waiting times *Active caseload?	• Number of Serious incidents/unexpected deaths √√√√ • Number of complaints • OoL √√√ • CPA Review in 12 months • Patient FFT/Patient Experience √ • Whistleblowing • Cancellations √ • Patient Cancellations/DNA • Days to discharge • Regulatory Targets √ • Outcome measures? • Waiting Times
Workforce	**Money**
• Sickness √√√√ • Appraisal √√√√ • Mandatory Training √√√√ • Fill rate to vacancy √√ • Turnover √ • Vacancy rates √ • Actual number of workforce in month (%) *from finance report* • Staff FFT	• Cash against plan √ • Expenditure against plan √ • CRES √√ • EBITDA • Income and Expenditure √√ • Monitor Risk Rating • Cost of staffing (additional) • Cost of sickness

√ denotes frequency proposed

Appendix B

Recommended KPIs for 16/17

Activity	**Quality**
1. Number of External Referrals into Trust Services* 2. Caseload turnover (links to productivity metric)** 3. Number of patients with a length of stay over 90 days (AMH and MHSOP A&T Wards) 4. Percentage Bed Occupancy 5. Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)* 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)*	1. Number of unexpected deaths classed as a serious incident per 10,000 open cases* 2. Percentage of patients seen within 4 weeks for a first appointment following an external referral* 3. Percentage of Out of Locality Admissions to assessment and treatment wards (AMH & MHSOP)* 4. Percentage of patients surveyed reporting their overall experience as excellent or good 5. Percentage of appointments cancellations by the Trust* 6. 100% Compliance with Monitor Targets *7.* Outcome measure - *to await for Monitor confirmation on payment mechanisms for Adult Mental Health and Mental health Services for Older people (possible 2 outcome measures)*
Workforce	**Money**
1. Percentage Sickness Absence* 2. Percentage of staff in post more than 12 months with a current appraisal* 3. Percentage compliance with mandatory and statutory training* *4.* Actual number of workforce in month (Establishment 90%-95%) *5.* Percentage of registered healthcare professional jobs that are advertised two or more times	1. Are we delivering our financial plan (Income and Expenditure)* 2. Delivery of CRES against plans 3. Cash against plan

*Existing Trust Dashboard 15/16 KPI
** Additional indicators proposed by the Corporate Performance Team

ITEM 17

BOARD OF DIRECTORS

Date of Meeting: 24th November 2015

Title: Strategic Direction Performance Report Quarter 2 2015/16

Lead Director: Sharon Pickering, Director of Planning & Performance & Communications

Report for: Assurance

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
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 our communities	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users		Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services		Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse		Cleanliness and infection control		Management of medicines	
Safety and suitability of premises		Safety, availability and suitability of equipment			
Suitability of staffing					
Requirements relating to workers		Staffing		Supporting workers	
Quality and management					
Statement of purpose		Assessing and monitoring quality of service provision		Complaints	
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records					
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					✓

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

Date of Meeting: **24th November 2015**

Title: **Strategic Direction Performance Report Quarter 2 2015/16**

1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to present to the Board of Directors the first Strategic Direction Performance Report as at quarter 2 2015/16.

2. BACKGROUND INFORMATION

2.1 Following feedback from the Board of Directors this report has been developed further not only to report progress against the Strategic Direction Scorecard but to include other forms of intelligence that demonstrates progress on delivering the 5 strategic goals, including progress of the agreed priorities in the Business Plan.

2.2 The 5 year targets for the scorecard for the Trust's Strategic Direction were agreed by the Board on the 18th August 2015. The Board also agreed some changes to the metrics that were reported previously.

3. KEY ISSUES

3.1 Trust Strategic Direction Scorecard

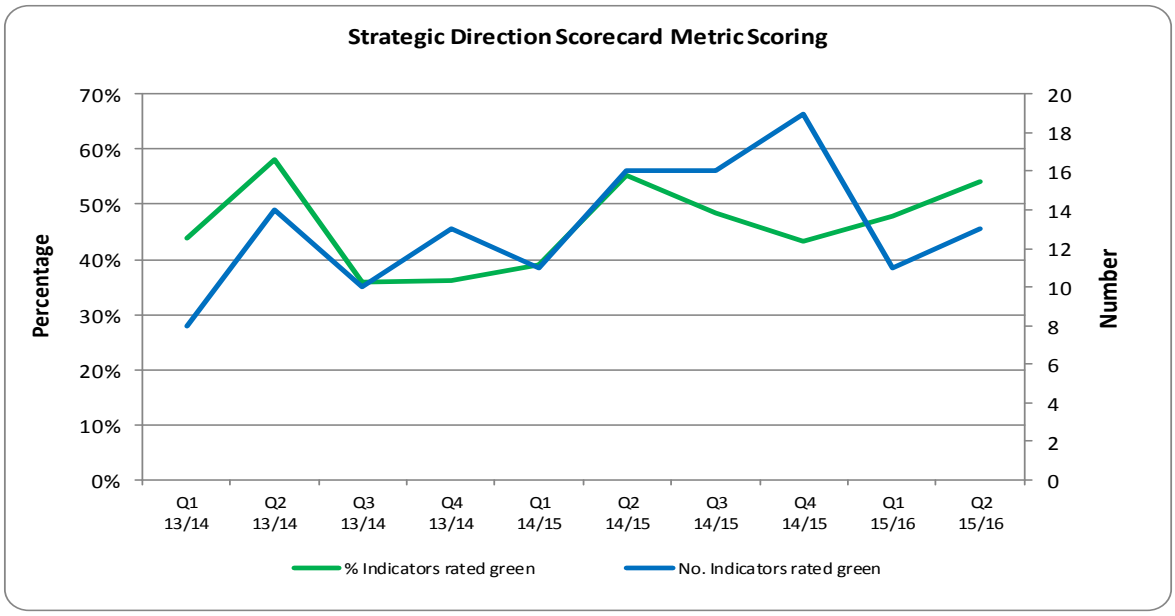
The Strategic Direction Scorecard is shown under each strategic goal with further narrative in section 3.2 to 3.6.

The following table and graph provide a summary of the RAG ratings at quarter 2 compared to the position in the previous quarter (Q1) and the previous financial years 2014/15 and 2013/14:

	2013/14 Actual		2014/15 Actual		Q1 2015/16		Q2 2015/16		2015/16 Actual YTD	
	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	11	31%	18	42%	11	48%	13	54%	13	54%
Indicators rated red	25	69%	25	58%	12	52%	11	46%	11	46%
Indicators with no target	5		2		1		1		1	
Indicators currently under development/being finaliased	1		1		2		2		2	
Indicators where data is not yet available	5		0		12		11		11	

* The percentage is based on the number of indicators that can be RAG rated (24 for quarter 2)

Note – for quarter 1 there were 11 indicators rated as red due to one indicator being finalised. The indicator relating to "excess cost of employing medical agency versus substantive" is now being reported and quarter 1 position has been included.



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 7 as at quarter 2, and the overall change is more positive than quarter 1 with 3 indicators improving.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16									
	Indicator	Q2 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	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	>90.14%	89.96%	92.32%	↑	>90.14%	91.24%	>14/15 out-turn	>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%	83.94%	83.78%	↓	98.00%	83.86%	98.00%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	78.05%	80.34%	↑	85.00%	79.19%	85.00%	tbc
4	Number of community teams who have implemented the model line way of working	3	2	3	↑	5	5	11	tbc
5	The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)	Surveys: Top 20% of MH Trusts	Results due in Q3	Results due in Q3	n/a	n/a	Results due in Q3	Surveys: Top 20% of MH Trusts	Surveys: Top 20% of MH Trusts
6	The Trust ranks in the top 10th percentile of all mental health Trusts for the NHS Staff Survey (annual)	n/a	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	Surveys: Top 10% of MH Trusts	Surveys: Top 10% of MH Trusts
7	Percentage of service users with a recovery focussed action plan (Adult Mental Health)	95.00%	93.53%	92.88%	↓	95.00%	92.88%	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 2 is 83.78% against a target of 98% which is a small reduction on the quarter 1 position.

All localities are reporting below target with Durham and Darlington the lowest at 76.52% and North Yorkshire slightly above at 80.46%.

Within Durham and Darlington locality, the main areas of under-performance are in relation to Adult Mental Health services (AMH) and Children and Young People's Services (CYP). In AMH staff vacancies are being addressed within the Access teams with recruitment being progressed. For CYP initial work concentrated on reducing the waiting times to ensure the 9 week contract target time was achieved; however work is now ongoing to achieve the internal 4 week targets.

Within North Yorkshire locality all services are under-performing. The main issues relate to the levels of sickness, vacancies and maternity leave with the teams. Recruitment is ongoing although some staff are yet to commence employment. An update on the action plan developed to improve the performance against the waiting times target will be considered by the Board at its November meeting.

- **KPI 7 - Percentage of service users with a recovery focussed action plan (Adult Mental Health)** – the Trust position for quarter 2 is 92.88% against a target of 95%.

  All localities are under reporting with Teesside reporting the highest performance at 94.23% and Durham and Darlington the lowest at 91.47%. There are two concerns to note in relation to the achievement of this indicator:

  - All services have access to IIC to monitor the Recovery Star tool for patients on the assertive outreach and psychosis team's caseloads. For both Tees and Durham and Darlington localities the target of 95% could be achievable for assertive outreach teams due to a more static caseload. However for the psychosis teams caseloads it is not clinically appropriate to complete a Recovery Star tool immediately after referral. Discussions about recovery with the patient usually take place around 12 weeks, dependent on the patient.

  - An additional impact on the achievement of this indicator relates to significant staffing issues experienced in some teams within Durham and Darlington locality which are being addressed and expect this to improve in the forthcoming months. Within North Yorkshire, additional Recovery Star training has recently been completed and therefore expects to see an improvement in the near future.

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green (85.3%) which was an improvement on Q1 (71.1%). However 11.6% of the priorities / service developments in the Business Plan are at high risk of failure to deliver on-time or within budget which is a deterioration on the Q1 position (9%).

The 11.6% represents 19 priorities / service developments. Of these:

- 2 are recommended for removal from the Plan for which Board approval is needed
- 1 requires a change in completion date to 16/17 for which Board approval is needed but this does not significantly impact on overall achievement of this Strategic Goal
- 1 required agreement to incorporate into other projects which was agreed by EMT
- 15 required "in-year" timescale changes which have been agreed by EMT.

There are also 5 actions which are grey as they cannot now be delivered due to reasons external to the Trust. The Board are required to approve these being removed. There is a further 1 'grey' action for a change in completion date to 16/17 for which Board approval is needed.

Where a Board decision is required to change or remove an action, this is contained in Appendix 1 for approval.

3.2.3 Other Qualitative Intelligence

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

- **Positive Practice Mental Health Awards –** TEWV has been shortlisted in two categories of the Positive Practice Mental Health Awards:
  - The Children and Adolescent Mental Health Crisis and Liaison team in Durham and Darlington has been shortlisted in the "Innovation in Child, Adolescent and Young People's Mental Health" category. The team was **announced as the winners on 14th October 2015.**
  - Talking Changes in Durham and Darlington has reached the final in the "Partnership Working" category. The team was **announced as the winners on 14th October 2015.**

- **Royal College of Psychiatrists – TEWV has been shortlisted in four categories:**
  - Team of the Year award – Ward 15, The Friarage, Northallerton
  - Specialist and Associate Specialist (SAS) Doctor of the Year award – Dr Sagrika Nag, MHSOP at Roseberry Park
  - Carer Contributor of the Year award – Pam Elliott has reached the final of the category.
  - Psychiatric Trainer of the Year award – Dr Mani Krishnan, MHSOP in North Tees.

  Winners of the above awards will be announced in November 2015.

- **Recovery Scorecard –** The Trust is progressing well against the Recovery Strategy with 13 out of 14 (92.9%) metrics rated green as at Q2. The only metric showing red is not a concern as actions are in place to improve the position.

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 and is improving with the exception of waiting times. Work is continuing in terms of improving access to services and a separate paper is being considered by the Board of Directors on this at its November meeting.

3.3 **Strategic Goal 2** - ***To continuously improve the quality and value of what we do***

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of 8 as at quarter 2, and the overall change is more positive than quarter 1 with 4 indicators showing an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16									
	Indicator	Q2 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 2 (To continuously improve the quality and value of what we do)									
8	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	4	7	↓	0	7	0	0
9	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	8	1	↑	0	1	0	0
10	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?"	>89.75%	86.55%	88.07%	↑	>89.75%	87.37%	>89.75%	> previous year out-turn
11	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	22.22%	75.00%	↑	50.00%	52.38%	50.00%	>=75%
12	Percentage of staff reporting that they can 'contribute towards improvements at work'*	n/a	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	> 2014/15 and in top 20%ile for MH/LD Trusts	> 2018/19 and in top 20%ile for MH/LD Trusts
13	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"	>77.85%	82.87%	82.47%	↓	>77.85%	82.69%	>77.85%	> previous year out-turn
14	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%	Assessment due in Q2	80.00%	↑	80%	80.00%	80%	80%
15	Hospitality Assured Accreditation score*	n/a	Assessment due in Q4	Assessment due in Q4	n/a	n/a	Assessment due in Q4	82.00%	86.00%

Indicators of concern are:

- **KPI 8 - 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** – the Trust position for quarter 2 is 7 action points outstanding against a target of zero. These relate to:

  - 3 outstanding action points from 1 Serious Incident action plan are addressed by AMH services in North Yorkshire. The details are as follows:
    - One action relates to Ripon and Harrogate Community Mental Health (CMH) Services to address urgent referrals received by both teams. Following a Rapid Process Improvement Workshop (RPIW) in July 2015 all referrals to both CMH teams are now triaged daily and all patients are contacted by telephone within 24 hours of receipt of referral to offer them an appointment within 28 days (a letter is sent if not contactable via telephone). For any urgent referrals, there is an "urgent" slot allocated every day which meets the need identified in the RPIW to support meeting the urgent assessments within 72 hours. This process was put in place early September 2015; therefore this action is now complete. The delay was due to the service not providing confirmation the action had been completed to the Patient Safety team prior to quarter end.
    - One further action relating to Ripon and Harrogate Community Mental Health teams to ensure all staff are aware patients can access multiple services when appropriate. The Harrogate CMH team manager addressed this concern at both Ripon and Harrogate team meetings in August 2015 to reiterate that patients can receive services from both the CMH teams and Improving Access to Psychological Therapy (IAPT) teams simultaneously. There is also ongoing dialogue between the IAPT team manager and the CMH team managers to ensure this continues. Therefore this action has been completed. The delay was due to the service not providing confirmation the action had been completed to the Patient Safety team prior to quarter end.
    - One action relates to IAPT services in North Yorkshire. This action was confirmed as completed by the team manager on 24th September 2015 but there was a delay in updating the database used to monitor all action plans prior to reporting the quarter 2 position.

  - 1 action point from 1 Serious Incident action plan was aligned to Nursing & Governance Directorate. This action relates to the requirement of an audit to demonstrate associated actions are implemented. A target completion date of 31st August 2015 was originally applied but this was incorrect and has since been updated to 31st October 2015. The audit was completed on 8th October within the revised timeframe.

  - 2 actions from 1 Serious Incident action plan were aligned to Tees AMH services for Redcar and Cleveland Affective Team. The team was required to ensure other services who are involved in their patients care are included in the care and treatment and are also invited to formulation meetings.
    Both these actions were completed on 6th October and evidenced through team meeting minutes. The delay in completing these two action points was due to

miscommunication between the responsible service and the Patient Safety team. Once these outstanding action points were brought to the attention of the relevant "action owner", this was rectified at the earliest opportunity.

- 1 action point from 1 Adult Safeguarding Review action plan (*jointly with the local authority*). The action required is to "audit of uptake of the Mental Capacity Act (MCA) training with regular refreshers" which should have been completed by March 2015 on staff within the Hartlepool area.

  To address this, the locality manager for Hartlepool in (AMH) services will undertake an audit of the uptake of MCA training by Hartlepool staff from data collated by the training department. This is not mandatory training so an agreement will need to be reached to identify those staff who should undertake this level of training in order to ensure the staff are skilled to carry out their role. A plan with timeframe to ensure relevant staff are trained in MCA will be developed and agreed. A meeting is being arranged to agree the plan and time scales and the target date will then be revised once known. Please note this was not reported as outstanding at quarter 1, so the indicator on the scorecard above has been updated to reflect the action outstanding at June 2015 and September 2015.

All outstanding actions over 1 month are escalated to the EMT on a monthly basis and monitored by the relevant QuAGs and Locality Management Group Boards (LMGBs).

- **KPI 9 - 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 2 is 1 against a target of zero in relation to Clinical Audit:

  This relates to an action on the clinical audit relating to "Prescribing antipsychotics for children and adolescents – POMH topic 10c". The action relates to implementing the new Trust physical health monitoring tool to Children and Young Peoples Services in community teams. This has been outstanding for 92 days as at 30th September. Work has progressed to develop a physical health monitoring tool which is in draft form which is currently out to services for consultation until 15th October 2015. The action owners will review feedback and then schedule implementation after that.

3.3.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 2 were rated green (100%), however there is 1 priority / service development in the Business Plan at high risk of failure to deliver on-time or within budget. This priority requires a change in actions and final completion date to Q2 of 16/17 for which Board approval is needed but this does not significantly impact on overall achievement of this Strategic Goal.

3.3.3 Other Qualitative Intelligence

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

- Within the Forensic Services we have had 2 positive NHS England Quality visits to Mandarin Ward on 15th September 2015 and Robin and Heron wards on 22nd September 2015.

- Accreditation for Inpatient Mental Health Services (AIMS) - accreditation was achieved for the Ayckbourn Unit within North Yorkshire AMH services (Danby and Esk wards) with a rating of "excellent" being awarded for the 4th consecutive cycle.

- Accreditation for Inpatient Mental Health Services (AIMS) - accreditation was achieved for Willow Ward within Durham and Darlington AMH services with a rating of "excellent" being awarded.

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 is positive. However further work is needed in terms of ensuring the completion of action points for Level 5 SUIs and action points for safeguarding serious case reviews and domestic homicide reviews in a timely manner.

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 3 indicators rated red out of 12 as at quarter 2, with only two indicators showing an improvement on the quarter 1 position.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16									
	Indicator	Q2 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 3 (To recruit, develop and retain a skillled, compassionate and motivated workforce)									
16	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"	>66.57%	71.04%	70.46%	↓	>66.57%	70.77%	>66.57%	> previous year out-turn
17	Percentage of medical students and junior doctors reporting satisfaction with their placement	87.00%	91.03%	90.44%	↓	87.00%	90.44%	87.00%	90.00%
18	Percentage of positive nursing placement evaluations received	95.00%	96.86%	91.50%	↓	95.00%	95.93%	95.00%	95.00%
19	Excess cost of employing medical agency versus substantive	£0	£251.9K	£240.2K	↑	£0	£492.1K	tbc	tbc
20	NHS Employers Assessment of Wellbeing	n/a	due in Q3	due in Q3	n/a	n/a	due in Q3	100%	100%
21	Percentage of Culture Metrics showing improvement at year end*	n/a	due in Q4	due in Q4	n/a	n/a	due in Q4	100%	100%
22	Percentage of positive staff responses for training/development evaluations received	n/a	72.04%	no data for Q2	n/a	n/a	72.04%	Collect Baseline	tbc
23	Percentage of staff reporting that they have had a 'well-structured appraisal in last 12 months'*	n/a	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	>= 2014/15 & in top 20%	>= 2018/19 & in top 20%
24	Percentage of medical staff successfully revalidated	100%	100.00%	90.91%	↓	100%	96.77%	100%	100%
25	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*	n/a	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	70% points or less	50% points or less
26	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	40%	21.74%	50.00%	↑	40.00%	38.60%	40.00%	80.00%
27	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	n/a	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	< previous year out-turn: <38%	< previous year out-turn

Indicators of concern are:

- **KPI 18 - Percentage of positive nursing placement evaluations received –** the Trust position for quarter 2 is 91.50% which is 3.5% below the target of 95%. The responses to 3 questions are monitored within this indicator, 2 of which are below target. Of significance is the response for "sufficiency of learning opportunity" where 8 nurses out of 51 did not respond positively. This relates to students who are allocated short placements who therefore tend to rate this question lower than those students allocated a longer placement. This could link to the level of student confidence and orientation to the placement. However this is not entirely consistent so this will be monitored to assess whether this is an emerging issue. If this is identified as an issue this will then be addressed when writing the next curriculum.

- **KPI 19 – Excess cost of employing medical agency versus substantive** – the Trust position for quarter 2 is £240.2k against a target of zero value but an improvement on the quarter 1 position. The incurred costs are as a result of covering sickness leave and vacancies whilst recruitment is ongoing. As at quarter 2, there were 2 vacancies within Teesside (1 for AMH and 1 for MHSOP); 3 in North Yorkshire (2 for AMH and 1 for MHSOP) and 1 in Durham (AMH).

  The target proposed for this metric is zero which the Trust Board are asked to approve.

- **KPI 22 – Percentage of positive staff responses for training/development evaluations received** – this is a new indicator that was agreed in quarter 1. Quarter 2 is being reported as "no data to report" because the courses that were selected for evaluation have not been provided during quarter 2.

  There are four main types of work stream the training department are evaluating: CPD, Training Portfolio, OD and Vocational. The courses selected for evaluation within each work stream will differ each quarter. Some courses are yearly or are intensive over a few days and would normally be evaluated certain months throughout the year, such as at initial training, at 3 months and again after a 3-6 month period.

- **KPI 24 - Percentage of medical staff successfully revalidated** – the Trust position for quarter 2 is 90.91% against target of 100% and relates to 10 medics re-validated out of 11. One doctor could not be revalidated as a result of not participating in the appraisal process. The doctor was therefore submitted for 'Non-engagement' to the GMC and the Trust is awaiting the outcome of the investigation.

3.4.2 Trust Business Plan

The majority of business plan actions are rated green (85.7%) as at quarter 2 which is a significant improvement on quarter 1 (40.0%). There is 1 priority / service development in the Business Plan that is at high risk of not being delivered. This requires "in-year" timescale changes which have been agreed by EMT

3.4.3 Other Qualitative Intelligence

- **Health Education North East - General Medical Council –** TEWV has topped the regional rankings for health education in the North East following the publication of the General Medical Council's National Trainee Survey. Health Education North East compared all of the responses from doctor's on placement in each of the North East Trust's and provided a regional ranking of the 11 Trusts against 14 different categories. TEWV rated first in 9 of the 14 categories including induction, access to educational resources, feedback, supportive environment and overall satisfaction.

- **Medical Student satisfaction 2015** – the Tees Essential Junior Rotation (EJR) programme in 2015 received an overall satisfaction score of 93.9% in comparison to the score of 85.3% in 2014. The highest scoring areas are:

  - "Formal teaching took place as planned" – 100%
  - "Assessments were helpful" – 100%
  - "I received formal feedback" – 99%

- **HSJ Awards 2015 –** TEWV has been shortlist for the category of "Staff Engagement", the winner will be announced in November 2015.

- **HSJ and Nursing Times –** TEWV has been named by Health Service Journal and Nursing Times as one of the best places to work in the NHS. They recognised 100 providers and we were one of 31 mental health trusts on the list.

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 nursing placement evaluations needs to be closely monitored as described.

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 5 as at quarter 2, although the rating remains the same as quarter 1, the overall change is less positive with 2 indicators showing a reduction on the quarter 1 position.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16									
	Indicator	Q2 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	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)									
28	Attendance rate at H&WB Boards	90%	83.33%	57.14%	↓	90%	69.23%	90%	90%
29	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	100.00%	↔	98%	100.00%	98%	98%
30	Proportion of student nursing placements provided as a % of placements requested	90%	100.00%	99.48%	↓	90.00%	99.74%	90.00%	90.00%
31	Research and Development Outcomes (to be developed)	tbc	KPI under development	KPI under development	n/a	tbc	KPI under development	tbc	tbc
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 and Green	Signed and Green	↔	Signed & Green	Signed and Green	Signed & Green	Signed & Green

Indicators of concern are:

- **KPI 28 - Attendance rate at H&WB Boards** – the Trust position for quarter 2 is 57.14% which is 40.86% below the target of 98%.

  The Trust was represented at 4 out of 7 Health and Well Being Boards.
  The following Health and Well Being Boards were planned but apologies were given by the Trust as a suitable deputy was not available:

- Durham H&WB – July 2015
- Darlington H&WB – July 2015
- Stockton H&WB – September 2015

3.5.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 2 were rated green (87.5%); however this is a deterioration compared to the quarter 1 position (100.0%). There is 1 priority / service development in the Business Plan that is at high risk of not being delivered. This requires "in-year" timescale changes which has been agreed by EMT.

3.5.3 Other Qualitative Intelligence

- **DDES CCG investment into new practice based service models.**

  Further progress has been made in terms of implementing this as follows:

  - A draft service spec and MOU have been drafted, and are being refined.
  - Funding allocations have been confirmed for Dales, South Durham Health and Intrahealth. We are agreeing with the Federations how the money will flow from the CCG.
  - It has been agreed that there will be no KPIs for the first 6 months of operation. Instead we will use this time to gather some baseline data and understand better the kind of people the new service is seeing, what work is adding the most value and what is/isn't realistic within the available resource. We also agreed that TEWV would do some work to map if there is any impact on our existing services.
  - Mobilisation plans will be agreed with the CCG in the middle of November.
  - Intrahealth is going to work with South Durham CIC on this so we can have geographic-based provision.

- **Partnerships –** Our Darlington and Teasdale mental health team for older people was part of a multidisciplinary team that won the Best Integration Project of the Year award in the North East and Cumbria commissioning awards. Darlington Clinical commissioning Group (CCG) received the award on behalf of partner organisations. The award recognises the way partner organisations work together to plan and achieve integrated care for vulnerable older people, and demonstrate an understanding and awareness of the needs of patients and service users, to improve quality and safety. The partner organisations are the CCG, TEWV, Darlington Borough Council, County Durham and Darlington NHS Foundation Trust, Primary Healthcare Darlington, community and voluntary groups, and Healthwatch Darlington.

- **North Yorkshire Dementia Services - Quality Award in Harrogate –** The Trust, together with NHS Harrogate and Rural District Clinical Commissioning Group

(CCG), has been awarded Yorkshire and Humber Dementia Quality Award. The award recognised how the two organisations worked with local GP practices to streamline the way patients with Alzheimer's disease and dementia receive their routine reviews. Instead of having duplicate appointments at the memory clinic and GP practice twice a year, care is now shared and patients are seen alternately by their GP and memory clinic every six months.

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 is positive but we need to ensure we have people attending the Health and Wellbeing Boards.

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 6 as at quarter 2, although this same indicator has shown an improvement on the quarter 1 position.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16									
	Indicator	Q2 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	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)	56.25%	81.25%	75.00%	↑	56.25%	75.00%	<=56.25%	<=6.25%
34	Percentage of Information Strategy outcomes achieved that are reported on Information Strategy Metrics Scorecard	n/a	due in Q3	due in Q3	n/a	n/a	due in Q3	Collect Baseline	tbc
35	Percentage change in income for Trust contracted services compared to previous year	-1.30%	-0.01%	-0.25%	↓	-1.30%	-0.13%	-1.30%	Better than deflator
36	Productivity Metric (to be developed)	tbc	KPI under development	KPI under development	n/a	tbc	KPI under development	tbc	tbc
37	EBITDA **	7.90%	8.41%	8.18%	↓	8.15%	8.30%	7.01%	8.00%
38	Good Corporate Citizenship audit scores*	n/a	due in Q4	due in Q4	n/a	n/a	due in Q4	60.00%	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 2 is 75% which is 18.75% above the target of 56.25%.

  The Data Quality Scorecard is monitored by the Data Quality Group and actions are derived from the discussions at this meeting. This includes focussed work to be completed by the Information Service Managers (ISM) directly with services and by

ISMs highlighting issues at Performance Improvement Group. The improving position reflects this focused work.

3.6.2 Trust Business Plan

This strategic goal has a small number of actions and whilst only 63.6% are rated green as at quarter 2, this is an improvement compared to the quarter 1 position (40.0%). There are 3 priorities/service developments in the in the Business Plan that are at high risk of failure to deliver on-time or within budget which is a deterioration on the quarter 1 position.

Of the 3 priorities/service developments:

- 1 is recommended for approval from the Plan for which Board approval is needed
- 2 required "in-year" timescale changes which have been agreed by EMT

3.6.3 Other Qualitative Intelligence

- **Q2 Contract Round -** information on the current position with 15/16 contracts for provision of services is as follows:
  - North Yorkshire CCGs – the North Yorkshire contract has now been signed.
  - The Vale of York CCG 5 year contract was signed on 30th September and the service commenced on 1st October 2015.
  - Durham and Darlington IAPT – contract discussions still are ongoing and we await a revised offer from the CCGs.
- **Health Service Journal Awards 2015 –** TEWV has been shortlisted by HSJ for the category of "Board Leadership", the winner will be announced in November 2015.

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 is positive.

4.0 IMPLICATIONS & RISKS

4.1 **Quality**: The report highlights that three of the Quality metrics are below target**.**

4.2 **Financial:** The report highlights that one of the Sustainability metrics is below target.

4.3 **Legal and Constitutional:** There are no direct legal or constitutional implications from this paper.

4.4 **Equality and Diversity:** There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled'.

4.5 **Other Risks:** None.

5. CONCLUSIONS

5.1 Whilst this is the second Strategic Direction Performance Report which reports progress against the Strategic Direction Scorecard and the Trust Business Plan whilst also considering other forms of qualitative intelligence.

The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics; however there is an overall improved position compared to quarter 1. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

6. RECOMMENDATIONS

6.1 The Board is asked to:

- Comment on the format of this report
- Approve changes in the Trust Business Plan in Appendix 1
- Approve the proposed target referenced in section 3.4.1

Sharon Pickering
Director of Planning & Performance & Communications

Appendix 1

Changes to the Business Plan that require Board approval

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Due Q2 status	Future Risk Status	Comment and requests for decisions
5.3	Understand demand patterns and develop a capacity versus demand model and trigger points to inform dynamic deployment of resource	COO	All	Develop capacity versus demand model and produce roll out programme	Capacity versus Demand model, and roll out programme agreed by EMT	15/16 Q2	Brent Kilmurray			Priority is intrinsically linked to Community Productivity (BP 5.2) and it is proposed to take forward this priority as part of the Community Productivity priority. **Req: removal.**
1.5.105	Develop and implement plans to deliver significant service changes/ developments required for each service - **Develop and implement Medical Training Packages**	Medical	NA	Complete paper and submit to EMT for approval setting out possibility of using our expertise in medical education to develop and sell educational training to other providers and individuals	Paper presented to EMT	~~15/16 Q1~~ 15/16 Q3	Dr Jim Boylan / Bryan O'Leary	**N/A**		Due to the integration of the York and Selby Locality, achievement of quality improvement targets for Local Education and Training Board's and the faculty restructure in Spring we are unable to complete this action at present. The department aims to review this in the future however does not have the capacity at the moment. **Req: removal.**
1.5.126	Develop and implement plans to deliver significant service changes/ developments required for each service - **Development of Forensic LD Step Down Services**	Teesside	LD	Development of new services - **Forensic Step Down**	Scope the potential for development of LD Forensic Step Down facilities	15/16 Q3	Kirsty Passmore / Paul Ellis	**N/A**		The Transformation agenda and Fast Track are now specifying the developmental agenda for LD services. As such this will not be progressed. **Req: removal.**
1.5.131	Develop and implement plans to deliver significant service changes/ developments required for each service - **Review Assessment & Treatment Services for LD**	Teesside	LD	Review provision of A&T services to identify if patient needs are resulting in the need for inpatient provision exceeding A&T specification	Review of inpatient services to identify what is being carried out differently and the impact	15/16 Q2	Alastair Jeeves			The Transformation agenda and Fast Track are now specifying the developmental agenda for LD services. As such bed configuration will focus on commissioner requirements. **Req: removal.**

Appendix 1

Changes to the Business Plan that require Board approval

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Due Q2 status	Future Risk Status	Comment and requests for decisions
1.5.134	Develop and implement plans to deliver significant service changes/developments required for each service - **Assessment of the impact of changes to specialist commissioning arrangements on LD Service**	Teesside	LD	Assessment of the impact of changes to specialist commissioning arrangements on LD Services	Submission of paper to commissioners	15/16 Q2	Kirsty Passmore / Paul Ellis			Work has been completed with Forensic services however the Transformation agenda and Fast Track will specify future requirements. **Req: removal.**
1.5.147	Develop and implement plans to deliver significant service changes/ developments required for each service - **Improving productivity**	Teesside	LD	Improve productivity linked to achievement of outcomes and PBR (if tool available)	Confirmation of outcome tool from national work	15/16 Q1	Kirsty Passmore			Still no information nationally however outcome measures are an ongoing theme for the Transformation agenda. **Req: removal.**
					Required staff trained in use of the identified outcome tool	15/16 Q2	Kirsty Passmore			
1.5.155	Develop and implement plans to deliver significant service changes/ developments required for each service - **Further development of C&YP services**	Teesside	CYP Tier 2 and 3	Secure 'Year 3' funding to enable full implementation of service specification	Should bid prove successful, commence implementation	15/16 Q2	Chris Davis			Discussions to be had with commissioners however we believe that the Future in Mind funding and subsequent transformation plans have superseded this bid. **Req: removal.**
1.4	Undertake a review of patient preferences regarding how they access community services (including when and where) and identify how services can change to meet those preferences	COO	All	Produce scoping document and develop review methodology	Scoping Document agreed by EMT	~~15/16 Q1~~ 15/16 Q2	Brent Kilmurray			This needs to link in with the NHS E-referral Service (previously known as Choose and Book) aspect of Paris (V6). We are awaiting roadmap from Civica to better understand timescales associated with this. **Req: Q4 16/17.**

Appendix 1

Changes to the Business Plan that require Board approval

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Due Q2 status	Future Risk Status	Comment and requests for decisions
2.5	Introduce a revised risk assessment and management process that incorporates best practice of co-produced risk information with service users and positive risk management to improve the person's health, wellbeing and quality of life to facilitate their recovery	Nursing & Governance	NA	Develop an implementation and briefing plan and baseline audit	Implementation plan in place and baseline audit completed	15/16 Q1	Christine McCann			Revised actions and metrics have been developed following on from EMTs approval to remove priority 2.2 in Q1. **Req: remove actions, replace with those below.**
		Nursing & Governance	NA	Develop the training plan	Training plan developed	~~15/16 Q2~~ 15/16 Q3	Christine McCann	**N/A**		
		Nursing & Governance	NA	Implement training and supervision	New training and supervision strategy implemented	15/16 Q4	Christine McCann	**N/A**		
2.5	Introduce a revised risk assessment and management process that incorporates best practice of co-produced risk information with service users and positive risk management to improve the person's health, wellbeing and quality of life to facilitate their recovery	Nursing & Governance	NA	Develop a project plan	PM3 agreed by EMT	15/16 Q3	Christine McCann	**N/A**	**N/A**	Further to the request above, **req: replace with these actions.**
		Nursing & Governance	NA	Review current training provision regarding harm minimisation & suicide prevention	Key recommendations & training options identified	15/16 Q4	Christine McCann	**N/A**	**N/A**	
		Nursing & Governance	NA	Develop training and training plan	Training plan/framework completed	16/17 Q1	Christine McCann	**N/A**	**N/A**	
		Nursing & Governance	NA	Scope & appraise a regional strategic approach to harm minimisation	Regional strategic approach developed	16/17 Q2	Christine McCann	**N/A**	**N/A**	
		Nursing & Governance	NA	Review Current Practice across Trust including policies/procedures	Harm Minimisation Policy & Engagement Policy including framework for supervision developed	16/17 Q1	Christine McCann	**N/A**	**N/A**	

Appendix 1

Changes to the Business Plan that require Board approval

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Due Q2 status	Future Risk Status	Comment and requests for decisions
1.5.097	Develop and implement plans to deliver significant service changes/ developments required for each service - **Develop and implement a management system which prioritises, evaluates and governs standard work to embed it across the organisation**	KPO	N/A	Agree the concept of initiation and management of prioritised standard work in both clinical and corporate services	3P event held. Concept developed and evaluated	15/16 Q1	Maureen Raine			3P event has not been held. Discussions were held with the COO, Head of KPO and Senior Planning and Business Development Manager to agree a revised set of actions and timescales to take forward the priority. Draft guidance has been developed for staff if standard processes/work conflicts with current Trust policy/ procedure advising on next steps. Operational services are being actively encouraged to store standard processes/work on the T:\drive and have improved arrangements for version control. KMS will further support this. **Req: removal.**

ITEM 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **24th November 2015**

Title: **Policies and Procedures Ratified by the Executive Management Team**

Lead Director: **Martin Barkley, Chief Executive**

Report for: **Information**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of our communities	
To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users	✓	Consent to care and treatment	✓		
Personalised care, treatment and support					
Care and welfare of people who use services		Meeting nutritional needs		Co-operating with other providers	
Safeguarding and safety					
Safeguarding people who use services from abuse	✓	Cleanliness and infection control	✓	Management of medicines	✓
Safety and suitability of premises	✓	Safety, availability and suitability of equipment	✓		
Suitability of staffing					
Requirements relating to workers	✓	Staffing		Supporting workers	✓
Quality and management					
Statement of purpose	✓	Assessing and monitoring quality of service provision	✓	Complaints	✓
Notification of death of a person who uses services		Notification of death or AWOL of person detained under MHA		Notification of other incidents	
Records	✓				
Suitability of Management (only relevant to changes in CQC registration)					
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

BOARD OF DIRECTORS

Date of Meeting: **24th November 2015**

Title: **Policies and Procedures Ratified by the Executive Management Team**

1. INTRODUCTION & PURPOSE

1.1 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

2.1 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.

2.2 Each policy and procedure ratified by the Executive Management Team will have gone through the Trust's consultation process.

3. KEY ISSUES:

3.1 The following had undergone significant review and required ratification

CORP-0021-v7 Patient and carer information policy

The supporting procedure was approved alongside the policy at Senior Managers Team meeting on 24 August 2015.

CLIN-0008-v4 Medical devices policy

This policy has been to full Trust review and undergone significant change in terms of both new formatting and content.

CLIN-0012-v6 Admission, transfer and discharge of service users within hospital and residential settings

This policy has been to full Trust review and undergone significant change in terms of both new formatting and content. The resulting policy framework is derived from a multi-agency working group and Trustwide consultation.
At COO's request, this has been brought directly to EMT for approval and ratification.

MHA-0004-v8 Associate Hospital Managers Policy

CORP-0010-v9 Confidentiality and Sharing Information Policy

Revised following comments made at EMT 5 August 2015.

3.2 The following policies have undergone minor amendment and required re-ratification:

CORP-0006-v6 Information Governance Policy
Update governance structure and incorporate new procedure for Requests for Information.

HR-0012-v6(2) Staff development policy
Contains minor revisions to staff declaration and nurse revalidation.

IT-0010-v4 Information Security and Risk Policy
Detail added around safe haven principles and NHSmail encryption feature.

3.3 The following documents required their review date to be extended:

HR-0024-v3 Dress code policy
Extension requested to 31 December 2015

CORP-0001-v3(1) Policy for developing policies and procedures
CORP-0002-v4 Smoke Free policy
Extension requested to 31 January 2016

CLIN-0065-v3 Policy and Procedural Guidelines for use in cases of unexpected death, suspected suicide and near misses to fatality
CORP-0031-v7(1) Minimum standards for clinical record keeping
Extension requested to 29 February 2016

HR-0018-v5(1) Organisational Change Policy
HR-0020-v2 Standard of business conduct for NHS staff
HR-0037-v3 Staff Rostering Policy
STRAT-0016-v2 Leadership and management development plan
STRAT-0019-v1 E-learning plan
STRAT-0020-v2 Health and wellbeing plan
STRAT-0027-v1 Volunteering strategy
Extension requested to 31 March 2015

3.4 The following document was to be removed from the policy portfolio.

CORP-0025-v6 Safe Haven Policy
The Trust's safe haven principles and standards are now contained within the CORP-0010-v9 Confidentiality and Sharing Information Policy, IT-0010-v4 Information Security and Risk policy and procedural elements of the safe haven policy are now published in CORP-0010-003-v1 Safe Haven Procedure ratified by ISGG.

4. IMPLICATIONS / RISKS:

4.1 **Quality:**
Sound policy development improves patient experience and enhances patient safety and clinical effectiveness

4.2 **Financial:**
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:**
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 Risks:**
None Identified

5. CONCLUSIONS

The decisions detailed above made at the EMT meeting on 4 November 2015 have been presented for ratification.

6. RECOMMENDATIONS

6.1 The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

Martin Barkley
Chief Executive