AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 29TH SEPTEMBER 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 meetings of the Board of Directors held on **23rd July** and **18th August 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 consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 8	To consider the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**

Performance (10.15 am)

Item 9	To consider the summary Finance Report as at 31st August 2015.	**CM**	**Attached**
Item 10	To consider the Trust Performance Dashboard as at 31st August 2015.	**SP**	**Attached**
Item 11	To consider the Strategic Direction Scorecard as at Quarter 1, 2015/16.	**SP**	**Attached**

Governance (10.35 am)

Item 12	To receive and note the Register of Interests of the Board of Directors.	**PB**	**Attached**
Item 13	To review the terms of reference of the Board's Committees.	**PB**	**Attached**
Item 14	To approve the Board Business Cycle October 2015 to December 2016.	**PB**	**Attached**

Items for Information (10.50 am)

Item 15	To receive and note a report on the use of the Trust's seal.	**MB**	**Attached**
Item 16	Policies and Procedures ratified by the Executive Management Team.	**MB**	**Attached**

Item 17 To note that the next meeting of the Board of Directors will be held on **Tuesday 27th October 2015** in Lake House, 20 Manor Court, Scarborough Business Park, Eastfield, Scarborough YO11 3TU at 9.30 am.

Confidential Motion (10.55 am)

Item 18 **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 a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

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

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

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

Refreshment break

Mrs. Lesley Bessant
Chairman
23rd September 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 23RD JULY 2015 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM.

Present:
Mrs. L. Bessant, Chairman
Mr. M. Barkley, Chief Executive
Mr. J. Tucker, Deputy Chairman
Mr. J. Robinson, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. M. Hawthorn, 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
Mrs. C. Stanbury, 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. E. Moody, Director of Nursing and Governance (Designate)
Mrs. B. Gibson, Public Governor for Durham
Mr. J. Robinson, Quintiles
Mr. D. Brown, Director of Operations for Teesside (minute 15/198)
Mr. P. Bellas, Trust Secretary
Mr. D. Kendall, Associate Director of Finance
Mrs. J. Jones, Head of Communications

Mr. F. Porritt, Ms. S. Price and Ms. E. Rodriguez, student nurses

15/192 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. C. Martin, Director of Finance and Deputy Chief Executive.

15/193 MINUTES

Agreed *– that the public minutes of the last meeting held on 23rd June 2015 be approved as a correct record and signed by the Chairman.*

15/194 PUBLIC BOARD ACTION LOG

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

Mr. Barkley reported that, with regard to the action under minute 15/65 (24/3/15), Mrs. Stanbury was due to meet Mrs. J. Wilkes, Head of Inspections (Mental Health) at the Care Quality Commission, later in the day, to discuss the regulator's approach to restrictive practices and its interpretation of the Mental Health Code of Practice.

The Board noted that the background to this action was that, based on inspection reports for other organisations, the Trust believed that CQC inspectors locally had different interpretations of these matters to their counterparts elsewhere in the country.

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

Action: Mr. Bellas

15/195 DECLARATIONS OF INTEREST

There were no declarations of interest.

15/196 CHAIRMAN'S REPORT

Mrs. Bessant:

(1) Drew the Board's attention to her report to the meeting of the Council of Governors held on 7th July 2015.

(2) Reported that she had visited the Goodall Centre in Bishop Auckland on 21st July 2015 to present a "Living the Values" award to the South Durham Psychosis Team.

The Board noted that:

(a) During the visit, the Chairman had had an opportunity to witness the Team's "huddle" and had received positive feedback on the benefits of this way of working for both patients and staff.

(b) The Team was also looking forward to implementing the model lines.

15/197 GOVERNOR ISSUES

No issues were raised.

15/198 LOCALITY BRIEFING – TEESSIDE

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

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

Arising from the presentation the Board discussed:

(1) The development of services for 0 to 4 year olds.

In response to questions Mr. Brown reported that:

(a) A very successful 3P event involving the Trust and Stockton Borough Council had been held. This had identified ways of providing greater support to parents and had also highlighted the benefits which could be achieved from staff in both organisations working more closely together.

(b) The development of the services was not confined to supporting people with mental ill-health but would also seek to address the issue of the significant proportion of children in Teesside who were not reaching normal levels of development.

(c) Work on this matter was being undertaken with the other local authorities in Teesside but through different approaches.

(d) The local authorities were responsible for the provision of services to young people with autism; however, the Trust contributed to the diagnosis of this condition and, where appropriate, provided support to the local authorities.

(2) The impact of spending reductions by local authorities on the Trust and, in particular, the implications of Government departments having to plan to make further savings of 25% or 40% by 2019/20 as recently announced by the Chancellor of the Exchequer.

Mr. Brown reported that the impact of spending reductions by the local authorities had been managed, to date, and there had been no significant impact on the Trust's ability to deliver services. However, risks to the sustainability of nursing home provision might create pressure on the Trust's inpatient beds in the future.

Looking forward he advised that it was difficult to imagine the impact of funding reductions, on the scale described by the Chancellor of the Exchequer, on the communities served by the Locality and considered that this matter should be discussed during the refresh of the Business Plan.

(3) The Trust's relationships with its local authority partners in the Locality particularly with Middlesbrough Council.

In response Mr. Brown advised that:

(a) Although there had been some changes, he was optimistic about the Trust's relationships with the local authorities.

(b) There were no concerns about the Trust's relationship with Middlesbrough Council and those with the other local authorities had improved.

(4) The action to be taken in response to staff not being interested in taking up management positions.

Mrs. Stanbury advised that work was being undertaken to clarify the roles of team and ward managers with a pilot scheme (i.e. ward manager role) being held in learning disabilities services in Durham. Part of this work was to seek to reduce the unattractive bureaucratic elements of those roles.

(5) The training of community nurses.

The Board noted that nurse training was now more focussed on community services, including placements and training on the theory of interventions, and this provided students with greater choice in their future careers.

At the conclusion of the debate, the Chairman thanked Mr. Brown for his presentation and asked him to pass on the Board's appreciation to staff in the Locality for their hard work.

15/199 QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of its meeting held on 4th June 2015 (Appendix 1 to the report).
(2) The key issues discussed by the Committee at its meeting held on 2nd July 2015.
(3) The Patient Safety and Patient Experience Data Report for May 2015 (Appendix 2 to the report).

Mrs. Stanbury:

(1) Apologised for the formatting of the report.
(2) Provided an update on the Datix Project which had been mentioned in the Patient Safety Group's report to the Committee.

The Board noted that, in recognition of the benefits of undertaking further testing, the system was now due to "go live" in September 2015.

Arising from the report:

(1) Dr. Griffiths, who had chaired the meeting of the Committee held on 2nd July 2015, reported that concerns about data quality had been highlighted in the report of the North Yorkshire Locality Management and Governance Board.

He advised that assurances had been provided to the meeting that improvements to data quality were being made and these would be further supported by the implementation of version 6 of the Paris system.

(2) Mr. Robinson drew attention to the request received from the mother of a patient for CCTV footage of her son, whom she believed to have been assaulted.

It was noted that this was the first time such a request had been received and the footage provided assurance that the child had not been assaulted.

Mrs. Stanbury reported that:

(a) The request had been managed within the scope of the Trust's Data Protection Act registration.
(b) Software, to enable images of third parties in footage to be pixelated, was being procured to support the Trust respond to any similar requests received in the future.

(3) The Non-Executive Directors questioned whether the statement in the report, with regard to the long term viability of services in North Yorkshire in their current model/structure, highlighted general or specific issues and sought clarity on how these were being addressed.

Mr. Kilmurray responded that:

(a) The Board had previously discussed the resilience of services in North Yorkshire in the context of contract discussions and the ability of the Locality to generate CRES. If further efficiency savings were required it would create risks particularly in CAMH services. These risks were not

current but were possible, looking forward, and changes might be needed to the provision of services if they materialised.

(b) A significant amount of work was being undertaken by CAMH services in the Locality following a 3P event. This had focussed on the transformation of services and the reinforcement of standard ways of working.

(c) Further consideration would be given to addressing the key risks to the sustainability of services in the Locality during the refresh of the business plan.

(4) The Chairman sought clarity on the reasons why only the confirmed minutes of meetings of the Committee were presented to the Board.

It was noted that this issue had been discussed previously and the present arrangements took into account that the Committee's reports were considered in public and the short timescale, between meetings and the publication of the Board reports, for draft minutes to go through the approvals process.

The Chairman indicated that this issue might need further discussion.

15/200 ANNUAL NURSE STAFFING REPORT

The Board received and noted the report on the annual review (1st June 2014 to 31st May 2015) on issues, trends and quality indicators in relation to nurse staffing 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").

In introducing the report, Mrs. Stanbury advised that:

(1) The actual staffing establishment, in post, had been compared with the budgeted establishments drawn from the Healthroster.

(2) Staffing data had been triangulated against level 4 and 5 incidents, complaints and information on the use of control and restraint. This analysis had not identified any trends or themes with regard to patient safety.

(3) The analysis of the staffing data had also not highlighted significant variations in the staffing establishment. Changes to services, for example as a result of additional investment, were being tracked.

(4) There appeared to be no correlation between occupancy rates and staffing levels.

(5) The key factors influencing variations in the workforce were cited as being sickness and vacancies.

During the discussions a number of points were raised about the activities being undertaken by registered and unregistered nursing staff, particularly with regard to direct and indirect care provided by them.

In response to questions on this matter Mrs. Stanbury:

(1) Drew attention to the breakdown of activities representing direct and indirect care provided in Appendix 8 to the report.

(2) Advised that differentiating between direct care and indirect care, based on the added value of activities from a service user's perspective, provided scope for capitalising on the skills of registered nurses.

(3) Reported that the data, which showed that registered nurses spent significantly more time on administration than unregistered staff, mirrored the national picture. This position was, in part, due to the erroneous assumption that only registered nurses could undertake certain administrative tasks e.g completing ward orders. The challenge was to determine those activities registered nurses were required to undertake, based on patient need, and those tasks which other staff could perform following training. The model lines project was important in supporting this work.

The Chairman considered that this was a very important issue which the Board might need to discuss further. In doing so, further information would be required as the data on contact time, provided in Appendix 8 to the report, was based on a small sample.

In addition Board Members:

(1) Sought clarity on the following matters:

(a) The reasons for the staffing changes in the Durham and Darlington Locality.

On this matter:

- It was noted that the staffing changes were linked to the reconfiguration of MHSOP inpatient services in the Locality.
- Mrs. Stanbury offered to provide a narrative on the above changes.

Action: Mrs. Moody

(b) The reasons for the variations in the banding of staff in the section 136 suites in North Yorkshire.

In response it was noted that the lower banding of certain staff in the Harrogate section 136 suite was linked to the skill mix of the CHRT in the Locality.

(c) The position in Forensic Services as it had been understood that a number of new staff had been appointed but this was not reflected in the data.

Mr. Kilmurray advised that the new appointments were not included in the funded establishment on which the data in the report was based.

(d) The mental health framework which had been devised to support the establishment of appropriate staffing levels.

It was noted that the framework was intended to provide a basis to review the skill mix of teams based on dependency levels, linked to cluster groups, and the types of interventions required.

(2) Highlighted the following issues:

(a) The data which showed that actual staffing levels were consistently higher than those planned.

The Board noted that consideration was being given to whether this situation indicated that the services required more resources than those provided at present.

(b) The availability of bank staff, as the number of unfilled sessions had increased, and how the shortfall was being addressed.

Mr. Levy reported that the fill rate for bank staff where at least 48 hours' notice was provided was good; however, it was less so where bank staff were required at short notice. In response to this situation it had been suggested that a piece of work should be undertaken in the County Durham and Darlington Locality based on assessing the benefits of providing a floating nurse on the hospital site to provide cover.

(c) The extent to which enhanced observations were being used to accumulate more resources on wards as it was understood that this was a greater problem than suggested in the report.

It was noted that, hypothetically, services could use the reason of enhanced observations to boost resources; however, it was expected that better utilisation of e-rostering would reduce demand for bank staff.

At the conclusion of the discussions the Board:

(1) Asked Mrs. Stanbury to pass on its appreciation to Mr. Scorer and Ms. Haimes for their work in preparing the report.

(2) Considered that, based on the assurances provided in the report, staffing levels in the Trust's inpatient services were being maintained at safe levels.

15/201 PROGRESS REPORT ON THE FRANCIS 2 ACTION PLANS

Further to minute 15/8 (27/1/15) the Board received and noted the progress report on the action plans developed in response to the recommendations of the Public Inquiry into Mid Staffordshire NHS Foundation Trust ("The Francis 2 report").

15/202 FIFTH MALCOLM RAE ACTION PLAN

Further to minute 15/96 (28/4/15) the Board received and noted a progress report on the action plan developed in response to the overview (fifth) report provided by Mr. Malcolm Rae (external reviewer) into the deaths of four patients in Derwentside in February 2013.

The Board noted that all the actions included in the action plan had been completed with the exception of:

(1) Item 7, "To review and update supervision policy to reflect peer review to be used in in-patient areas".

Mrs. Stanbury reported that this issue was being taken forward as part of a Trustwide piece of work. It was, therefore, proposed that, in future, it should be treated as a separate workstream in its own right.

(2) Items 1b, "To implement the new model of CRAM", and 4, "To design a training syllabus, competency assessment and implementation plan for clinical risk assessment and management".

It was noted that these actions were on track for completion through the clinical risk workstream. A framework for Clinical Risk and Harm Minimisation had been approved by the Clinical Leaders Board and ratified by EMT. An implementation project had also been scoped which included suicide prevention training and the development of formulation based approaches. This project, which was proposed to be at level 1, was due to be presented to the EMT in the near future.

In view of the above matters it was:

Agreed –

(1) that updates on the workstreams for Clinical Supervision and Clinical Risk and Harm Minimisation be provided to the Board on a quarterly basis; and

(2) that, subject to (1) above, the action plan in response to the overview report provided by Mr. Rae be signed off as complete.

Action: Mrs. Moody

15/203 SMOKING CESSATION AND NICOTINE MANAGEMENT PROJECT

Further to minute 15/171 (23/6/15) the Board received and noted the business case (PM3 form) for the Smoking Cessation and Nicotine Management Project.

Dr. Land reported that:

(1) The aims of the Project were supported by senior clinical staff in the Trust.
(2) The EMT had considered and supported the business case.
(3) The introduction of smoking cessation was complicated and the Project was generating lively discussions with both patients and staff.
(4) Significant progress was being made on implementing the Project including training for staff having commenced and consideration being given to the effects of smoking on medication.
(5) The key areas for further discussion were listed in the report. These included the approach to be taken if staff insisted on continuing to smoke; how to support staff challenge patients and colleagues who smoked on Trust premises; and finding a constructive approach to stopping people smoking.
(6) It remained the Trust's intention to introduce the ban on smoking on national no smoking day on 9th March 2016.

In response to questions Dr. Land advised that:

(1) The Trust was continuing to learn from the approaches to smoking cessation taken by other organisations; however, a wide range of issues remained to be resolved during the Project.

(2) The types of e-cigarettes to be used in the Trust, if permitted, would need to be standardised.

The Board noted that Dr. Land was in favour of allowing the use of these devices; however, he recognised that the Trust's approach needed to be managed carefully as they presented a risk in certain services.

(3) A range of routine communications was planned for people entering the Trust's inpatient services so that they understood the Trust's policy on smoking cessation and the impact of smoking on some medications. It was also hoped that relatives would support patients in their efforts to stop smoking.

He added that he had been genuinely shocked by the impact of smoking on patients including the implications for their mental health.

(4) It was intended that Trust staff would provide advice on smoking cessation in inpatient services but community staff would signpost service users to those services provided by public health.

(5) The Trust was continuing to work with and learn from the approach being taken to smoking cessation by Northumberland, Tyne and Wear NHS Foundation; however, there was no need for the two organisations to progress at the same pace.

(6) It was recognised that there were risks to staff attending patients who smoked in their homes. In these circumstances patients would be asked not to smoke and staff would be advised that they did not need to remain in an environment where people were smoking. However, the risks to patients arising from this approach were understood.

(7) The Trust's policy would be that staff would not be allowed to smoke whilst being paid by the Trust. This would include smoking in their cars during those times.

(8) Whilst the benefits of smoking cessation were well documented, smoking breaks had some positive aspects, including providing contact time between staff and patients on wards, and it was important that these were not lost.

15/204 REVIEW OF THE STRATEGIC GOALS "THIS MEANS THAT STATEMENTS"

Consideration was given to the proposed revisions to the Trust's "This Means That Statements."

The Chairman and Non-Executive Directors questioned:

(1) The inclusion of the word "dynamic" in the third statement under Strategic Goal 5.

Mr. Barkley considered that the word should be deleted as the statement also included reference to having a business and financial planning process which was flexible and responsive to the environment.

(2) The use of the word "productivity" in the fourth statement under Strategic Goal 5.

Mrs. Pickering responded that:

(a) The use of the term supported conversations on the issue which were starting in the Trust.

(b) It was recognised that embedding the term into the common parlance of the Trust would be challenging; however, work was also being undertaken to develop a strategic narrative to aid understanding.

Board Members considered that improving staff understanding of the concept was necessary and supported the approach described by Mrs. Pickering.

(3) The use of terminology to describe people who use the Trust's services and their carers which appeared inconsistent.

Mrs. Pickering explained that the use of the terminology had been carefully chosen e.g:

(a) The word "people" in the third statement under Strategic Goal 1 acknowledged that carers, as well as service users, could have their own care plan.

(b) The word "customer" in the fifth statement under Strategic Goal 2 recognised that the Trust did not only seek to actively respond to and learn from service users but also from CCGs, GPs etc.

However, Mrs. Pickering took on board the comments that the statements, where applicable, should refer to "families" as some service users did not have carers.

Agreed *– that the revised set of the "This Means That" statements, as amended, be approved.*

Action: Mrs. Pickering

15/205 SUMMARY FINANCE REPORT AS AT 30TH JUNE 2015

Consideration was given to the summary Finance Report as at 30th June 2015 including the "Continuity of Service" Declaration for Quarter 1, 2015/16 as required under Monitor's Risk Assessment Framework.

Agreed *–*

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

(2) that the following declaration for Quarter 1, 2015/16, be signed off: "The Board anticipates that the Trust will continue to maintain a continuity of service risk rating of at least 3 over the next 12 months."

Action: Mr. Kendall

15/206 PERFORMANCE DASHBOARD AS AT 30TH JUNE 2015

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

Mrs. Pickering advised that waiting times for C&YP services were highlighted in the report as a key concern across all three Localities. As the access indicators were based on the number of patients seen within four weeks they did not reflect the significant improvement on the number of patients waiting more than four weeks from 756 in March 2015 to 198 at present. However, there was expected to be some delay

before the work being undertaken on this matter became apparent in the performance dashboard reports.

Board Members raised the following matters:

(1) That, at the Quality Account Stakeholder meeting held on 21st July 2015, a number of CCG representatives had highlighted that, although the Trust was not achieving its four week waiting times targets, these were self-imposed and the requirements of the contracts were being met.

(2) Whether there were risks that actions being taken to address underperformance on waiting times would impact on quality.

Mr. Kilmurray responded that:

(a) As previously discussed an action plan to address waiting times was being delivered (minute 15/132 – 26/5/15 refers).
(b) Capacity had been increased either through additional staffing or the use of overtime.
(c) The Trust might need to review its offering, taking into account NICE guidelines, if demand proved unsustainable in the longer term.

(3) Whether there were any particular reasons for the downward trends on unexpected deaths and inpatient satisfaction levels.

On these matters:

(a) Mrs. Stanbury advised that:
- Whilst no trends on unexpected deaths had been identified, there appeared to be an increase in the number of incidents involving patients on leave and those in MHSOP.
- The number of unexpected deaths was increasing nationally.

(b) It was noted that the reasons for the trend on inpatient satisfaction levels continued to be investigated. In general Forensic Services tended to have both lower satisfaction rates, due to the nature of those services, and response rates to surveys. The results were also skewed by environmental issues in Harrogate and Northallerton.

(4) The benefits of presenting data on unexpected deaths using rolling averages.

In response it was noted that:

(a) The purpose of the performance dashboard report was to highlight significant issues e.g. spikes in the data.
(b) It had been agreed to use rolling averages in reports to the Patient Safety Group and the Quality Assurance Committee to enable them to identify and consider any trends in detail.

At the conclusion of the debate the Chairman highlighted that the number of “red” rated indicators was reducing and that the inclusion of trend arrows was providing assurance that performance, overall, was heading in the right direction.

15/207 WORKFORCE REPORT

The Board received and noted the Workforce Report including:

(1) Key workforce information for the period April to June 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 results for Quarter 1, 2015/16 (Appendix 3 to the report).

15/208 RISK ASSESSMENT FRAMEWORK REPORT

Further to minutes 15/205 and 15/206 above, consideration was given to the Risk Assessment Framework Report including:

(1) The proposed submission to Monitor for Quarter 1, 2015/16.

In response to a question it was noted that the declaration on the number of subsidiaries only related to those consolidated in the financial return for the relevant Quarter.

(2) The proposed changes to the Risk Assessment Framework summarised in Annex 3 to the report.

At the request of Board Members, Mr. Kendall undertook to provide information on the year to date position on the proposed Sustainability and Performance Risk Rating.

Action: Mr. Kendall

Agreed –

(1) that the Quarter 1, 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 1, 2015/16 Risk Assessment Framework return be submitted to Monitor by 31st July 2015.

Action: Mr. Kendall and Mr. Bellas

15/209 GOVERNANCE ACTION PLANS

Further to minute 15/102 (28/4/15) the Board received and noted the progress report on the Governance action plans (Annex 1 to the covering report).

Mr. Barkley drew attention to the change to the planned date for the completion of the DATIX project, to December 2015, to enable further testing and for more support to be provided to staff during an extended roll-out period to improve uptake and effective use of the system's additional functionality.

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

Action: Mr. Barkley

15/210 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

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

15/211 DATE AND TIME OF NEXT MEETING

It was noted that a special meeting of the Board, in conjunction with a Board Seminar, would be held, in public, at 9.30 am on Tuesday 18th August 2015 in the Board Room, West Park Hospital, Darlington.

15/212 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 terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

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

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

Following the transaction of the confidential business the meeting concluded at 12.30 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees Locality Board Presentation
23rd July 2015

David Brown

Director of Operations

making a difference together

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

- Last time
  - CYP waiting times, MHSOP OOA, Middlesbrough adult admissions
  - Winterbourne Review
- Now
  - Patient experience, SWEMWEBs, HoNOS
  - CQC Feedback
  - Crisis Assessment Centre, CYP Crisis Team, 0-4 services including perinatal care,

To continuously improve the quality and value of our work.

- Last time
  - QIS
  - Productivity
- Now
  - QIS
  - Productivity

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

- Last time
  - Recruitment Issues -medical staff, band 7s, CYP
  - Retention Issues -medical staff to Australia
  - Skill, compassion and motivation - nursing professional leadership
- Now
  - A lot of internal circulation to staff new developments
  - Talent management
  - Locality Head of Nursing post appointed full time

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

- Local
  - Four Local Authorities
  - Two CCGs
  - Two Acute Trusts
  - Four HWBBs
- National
  - No formal links nationally
- International
  - Asklepios

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

- Financial Issues
  - Then, medical locums- reduced, AQP tariff – no change, enhanced observations – still a pressure
  - Now also individual packages in LD, delayed CRES
  - But - investment in new services and money for pressures
- LMGB
  - CQC experience was positive
  - QAGs managing broad range of issues

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 18TH AUGUST 2015 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. M. Barkley, Chief Executive
Mr. J. Tucker, Deputy Chairman
Mr. J. Robinson, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. M. Hawthorn, 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
Mr. C. Martin, Director of Finance and Deputy Chief Executive
Mrs. E. Moody, Director of Nursing and Governance

In Attendance:
Mrs. M. Booth, Public Governor for Middlesbrough
Mrs. B. Gibson, Public Governor for Durham
Mr. C. Wilkie, Public Governor for Hambleton and Richmondshire
Mr. S. Hughes, Staff Governor for Teesside
Mr. J. Robinson, Quintiles
Mr. N. Ayre, York Mind
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Miss. S. Theobald, Head of Corporate Performance

The Chairman welcomed Mrs. Moody to her first Board meeting.

15/225 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr. N. Land, Medical Director, Mr. D. Levy, Director of HR and Organisational Development and Mrs. S. Pickering, Director of Planning, Performance and Communications.

15/226 DECLARATIONS OF INTEREST

There were no declarations of interest.

15/227 CHAIRMAN'S REPORT

Mrs. Bessant reported that her activities since the last meeting had been curtailed due to leave; however, she had had an opportunity to visit the County Durham Crisis and Recovery House.

The Chairman advised that:
(1) The lack of Wi-Fi availability in the premises, an issue raised by a service user during the visit, was being addressed.
(2) The service was achieving high occupancy rates.

15/228 GOVERNOR ISSUES

No issues were raised.

15/229 NURSE STAFFING REPORT

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

It was noted that the report had been circulated late due to the meeting being held earlier in the month than usual. In view of this Mrs. Moody provided an overview of the key issues as follows:

(1) The total number of inpatient rosters, 65, remained the same as in previous months; however, there had been changes to the wards in forensic services.
(2) 25 wards in June and 30 wards in July had fill rates of less than 89.9% for registered nurses; a slight deterioration on previous months. Whilst the main reason for the position on these wards related to registered nurse fill rates for daytime shifts, it was difficult to draw any conclusions from the data.
(3) The risks arising from temporary staffing were recognised and these were being mitigated by the use of regular bank and agency staff who had experience of the services.
(4) The percentage of hours worked by bank staff, by ward, was provided in Appendices 4 and 9 to the report. For both months bank usage was approximately 22%.
(5) The use of agency staff was mainly in the North Yorkshire Locality.
(6) Triangulation of staffing and quality data had not identified any direct risks or implications to patient safety or experience within the reporting period.
(7) Further work was being undertaken to seek to understand the context for those wards with low fill rates or high bank staff usage.

Mrs. Moody also sought the Board's views on how data on safe staffing should be presented in future reports.

Whilst recognising that reporting arrangements had improved over the past year and that the data provided was useful, Board Members considered that it would be helpful if future reports:

(1) Included an executive summary drawing attention to key issues/themes.
(2) Highlighted key areas of concern e.g. those wards with the lowest fill rates.
(3) Provided information on fill rates over time so that those wards not achieving target could be tracked.
(4) Included the financial implications of achieving safe staffing levels.

Mrs. Moody advised that certain of these matters might be more appropriate for inclusion in the six monthly safe staffing reports.

The Chairman considered that the key purpose of the report was to provide assurance to the Board that staffing levels were safe. In this context the information contained in Appendix 1 to the report was important but it might be more appropriate for the other information to be provided to Board Members separately.

It was noted that Mrs. Bessant was due to discuss this approach, with a view to reducing the length and improving the focus of Board reports, with the Trust Secretary.

Action: Mrs. Bessant and Mr. Bellas

For clarity Mrs. Moody confirmed that, based on the data provided, there were no patient safety or patient experience issues arising from the report.

15/230 STRATEGIC DIRECTION SCORECARD INDICATORS AND TARGETS - 2015/16-2019/20

Consideration was given to the proposed indicators and targets to feature in the Strategic Direction Scorecard for 2015/16 – 2019/20 as set out in Appendix 1 to the covering report.

The Board noted:

(1) That the proposals had been agreed by the Executive Management Team.

(2) The suggestion to remove the following four indicators which featured in the present Scorecard:
   (a) *"Investors in People Accreditation achieved at year end"*.
   (b) *"Percentage of 'excellent' or 'very good' responses to the question 'overall how would you rate services' in the Trust's GP Survey"* due to the frequency of survey (every 2 years) and the inclusion of information on this matter in the Business Development Scorecard.
   (c) *"Number of formal partnership agreements with Local Authorities"* as the metric was not considered to be meaningful.
   (d) "*Rating of Governors responding that they 'agree' with statements 'they are effectively holding the Non-Executive Directors to account for the performance of the Board' and 'they are effective in representing the members of the corporation and the public' in their evaluation"* as there were other evaluation mechanisms for these matters and the results of the survey were reported to the Council of Governors

(3) The rationale for each of the changes to the indicators and targets as set out in the report.

(4) That further consideration needed to be given to the indicators relating to outcome measures (metrics 3 and 4), which were due to be discussed at the Board Seminar later in the day; research and development outcomes (metric 35); and productivity (metric 40).

Arising from the report:

(1) Board Members supported the removal of the metrics listed in (2) above.

(2) In response to questions, Miss Theobald provided clarity on the targets for the following indicators:
   (a) The targets for metric 18 were based on four of the five categories assessed by PLACE visits being better than the national average (80%).
   (b) The targets for metric 25 were based on the results of all six culture metrics improving year on year.
   (c) The satisfaction of medical students and junior doctors with their placement (metric 21) was measured by the universities against a five point scale.

(3) The Chairman highlighted previous discussions on the importance of having clarity on the various scorecards produced by the Trust, and the indicators included in each of them, and an understanding of how they fitted together.

Miss. Theobald responded that work on these matters had commenced but was proving more challenging than initially thought.

Agreed *– that, noting the further discussions to be held on metrics 3, 4, 35 and 40, the indicators and targets for the Strategic Direction Scorecard for 2015/16 – 2019/20, as set out in Appendix 1 to the covering report, be approved.*

Action: Mrs. Pickering

15/231 APPOINTMENT OF THE SENIOR INDEPENDENT DIRECTOR

On the nomination of the Chairman and following consultation with the Non-Executive Directors and the Nomination and Remuneration Committee of the Council of Governors, it was:

Agreed *– that, subject to no objections being raised by the Council of Governors, Mr. Marcus Hawthorn be appointed as the Trust's Senior Independent Director with effect from 1st October 2015.*

15/232 APPOINTMENT OF THE NON-EXECUTIVE DIRECTOR CHAIRMEN AND MEMBERS OF THE BOARD'S COMMITTEES

Consideration was given to a report on the appointment of the Non-Executive Director Chairmen and Members of the Board's Committees.

Agreed *–*

(1) that, for the period 1st September 2015 to 31st August 2016, the appointment of the Chairmen and Non-Executive Director members of the Board's Committees be as set out in Annex 1 to these minutes; and

(2) that the terms of reference of the Quality Assurance Committee be amended, with effect from 1st September 2015, to increase the number of Non-Executive Director Members, including the Chairman of the Committee, from 3 to 5.

Action: Mr. Bellas

15/233 AMENDMENTS TO THE TRUST'S CONSTITUTION

Consideration was given to proposed changes to the Constitution in response to the expansion of the Trust into York and Selby.

The Board noted that:

(1) The proposed changes to Annexes 1 ("The Public Constituencies"), 2 ("The Staff Constituency") and 4 ("The Composition of the Council of Governors") were consistent with the approach taken in the Trust's other Localities.

(2) Any amendments to the Constitution required the approval of both the Board and the Council of Governors.

Agreed –

(1) that the changes to Annexes 1, 2 and 4 of the Constitution, as set out in the above report, be approved; and

(2) that the proposed changes to the Constitution be recommended to the Council of Governors for approval.

Action: Mr. Bellas

15/234 DATE AND TIME OF NEXT MEETING

It was noted that the next ordinary meeting of the Board of Directors would be held, in public, at 9.30 am on Tuesday 29th September 2015 in the Board Room, West Park Hospital, Darlington.

15/235 MR. JOHN ROBINSON

This being his last meeting, the Chairman led the Board in paying tribute to Mr. Robinson for his work and support for the Trust since his appointment as a Non-Executive Director in 2006.

15/236 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 terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 11.15 am.

Annex 1

Non-Executive Director Committee and SUI Panel Membership - 1st September 2015 to 31st August 2016

	Audit Committee	Investment Committee	Mental Health Legislation Committee	Quality Assurance Committee	Commercial Oversight Committee	SUI Panel
Number of Non-Executive Director seats (inc. the Chair of the Committee)	*4*	*3*	*2*	*5*	*3*	*3*
Lesley Bessant		**Ex Officio Member**	**Ex Officio Member**	**Ex Officio Member**	**Chair**	✓
Dr. Hugh Griffiths	✓		✓	**Chair**		
Marcus Hawthorn	**Chair**	✓			**Ex Officio Member**	
David Jennings	✓			✓		
Barbara Matthews		✓		✓		✓
Richard Simpson	✓		**Chair**	✓		✓
Jim Tucker		**Chair**		✓	**Ex Officio Member**	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **29th September 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	2015	
30/09/2015	14/284	A briefing to be provided to a Board Seminar on Equality and Diversity	MB/DL	Dec-15	
25/11/2014	14/358	Proposals to be developed for addressing concerns about the provision of temporary staffing at short notice due to sickness absence	BK	Sep-15	This action is being taken forward by the Director of Operations for County Durham and Darlington as agreed with the Joint Consultative Committee
27/01/2015	15/16	The information contained in the Equality Data Document to be used in future business planning	SP	Oct-15	
24/02/2015	15/42	Business case on the completion of the organic bed project in County Durham and Darlington to be developed	BK	Sep-15	See private agenda item 6
24/03/2015	15/68	Provision of a report on the updated culture metrics	DL	24/11/2015	
26/05/2015	15/131	Consideration to be given to alternative approaches to responding to the continuing low fill rate for registered nurses at Springwood e.g. compensating staff for travelling	DL	Oct-15	Outcome of the review to be included in the Workforce Report to the QuAC to be held on 1/10/15

Date	Minute No.	Action	Owner(s)	Timescale	Status
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	
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	
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	
26/05/2015	15/137	The Annual Report and Accounts of the Charitable Trust Funds 2014/15 (as approved) to be submitted to the Charities Commission	CM	Jan-16	Completed
26/05/2015	15/141	The contents of and language used in the quarterly Information Strategy and Governance Assurance Reports to be less technical	CM	From ~~Sept~~ Oct 2015	
23/06/2015	15/167	The transposition of column headings in Appendix 1 to the nurse staffing report to be addressed	EM	Sep-15	See agenda item 7
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	
23/07/2015	15/200	A narrative on the nurse staffing changes in the County Durham and Darlington Locality to be provided to Board Members	EM	Sep-15	
23/07/2015	15/202	Updates on the Clinical Supervision and Clincial Risk and Harm Minimisation Workstreams to be provided to the Board on a quarterly basis	EM	To commence 27/10/2015	
23/07/2015	15/204	Approval of the revised "This means that statements"	SP	-	Approved
23/07/2015	15/205 &15/208	Quarter 1, 2015/16 Risk Assessment Framework information to be submitted to Monitor	DK/PB	-	Completed

Date	Minute No.	Action	Owner(s)	Timescale	Status
23/07/2015	15/208	Information on the Trust's year to date position on the Sustainability and Performance Risk Rating (to be included in the revised Risk Assessment Framework) to be provided to Board Members	DK	-	See agenda item 9
23/07/2015	15/209	Progress on the Governance Action Plans to be reported to Monitor	MB	-	Completed
18/08/2015	15/229	Discussions to be held on the future approach to Board reporting	Chairman/PB	-	Completed
18/08/2015	15/230	Approval of the metrics and targets to feature in the Strategic Direction Scorecard subject to further discussions on metrics 3, 4, 35 and 40	SP	-	Approved
18/08/2015	15/231	The Council of Governors to be consulted on the appointment of Mr. Hawthorn as the Trust's Senior Independent Director	PB	-	Completed
18/08/2015	15/232	The terms of reference of the QuAC to be amended to increase the number of seats for Non-Executive Directors	PB	-	Completed
18/08/2015	15/233	Approval to be sought from the Council of Governors to change the Constitution to incorporate York and Selby	PB	-	Completed

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 29 September 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

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 29 September 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 03 September 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 North Yorkshire localities.

3.1 **Forensic Services LMGB** – where key issues raised were:

- NHS England and the LD transformation programme, with the intention to reduce LD beds by 50% within 3-5 years. Discussions and planning are ongoing with regard to this matter involving key staff, commissioners and NHS England, as there are concerns around clinical quality and business risks.
- Staffing pressures and the levels of qualified nursing cover between June – August 2015 in Forensic Learning Disability services as well as similar pressures in Forensic Mental Health. There were 8 shifts between June – August 2015 when a ward did not have registered members of staff to cover each clinical area. Ward Managers had stayed late to cover medication rounds and other qualified nursing staff had provided cross cover. The Committee was given assurance that mitigating actions were in place on the wards in the event of staffing issues.
- Following a CQC visit to FLD in March 2014 there would be a return visit regarding restrictive interventions. This may be unannounced.
- The lack of seclusion suites available when clinical activity is very high, should an FLD patient require access to seclusion.
- Recruitment to HMP Northumberland continued to be challenging and Commissioners had asked the Trust to consider recruitment premia as an incentive.

3.2 **North Yorkshire LMGB** – where key issues raised were:

- The new Orchards rehabilitation facility in Ripon was now fully operational following registration by the CQC.
- Plans and work had been agreed about work required on ward 15 to address issues around privacy and dignity standards, following the CQC visit at The Friarage Hospital.
- A business case had been developed at the request of North Yorkshire Police to create a NY wide Mental Health Triage Service.

- There had been a significant increase in very complex cases presenting to Children's services and all agencies were involved in discussions around these children to ensure appropriate delivery of care. Work was underway with foster placements to try and prevent admission to Trust beds.
- West Lane (phase 3 building) was on schedule; however the building work had caused some challenges with health and safety.

4. **Quality Strategy Scorecard, Quality Account & Stakeholder Event**

The Committee had received updates on the Quality Strategy Scorecard for Quarter 1 2015/16 and the outcome of a Quality Account Stakeholder Event held in July 2015.

- There would be a workshop held in October 2015 with Department Heads to look at the Quality metrics and scorecard, together with the targets. The outcome of this would be brought back to QuAC in December 2015.

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

- An MHSOP Falls audit had been compliance rated red. The report has been fully reviewed by the speciality but the root cause of the red compliance remains unclear; it is felt to be either due to recording issues or non-compliance with the Falls Pathway.
- CEG received the re-audit of POHM Topic 10c: use of anti-psychotic medication in C&YPS. The group noted the improved rating from red compliance at baseline to amber at re-audit but emphasised work is still required to further improve practice standards.

5.2 Patient Safety Group - The Key issue raised was around the number of outstanding Datix, however this would improve with the implementation of the central Datix team from September 2015.

5.3 Patient Experience Group/Carer Support Strategy Scorecard

- The response around Friends and Family had continued to improve, demonstrating good practice.
- There had been a 5% increase in PALs over the last Quarter with 268, compared to 256 in Quarter 4.
- There had been 54 complaints received between April to June 2015, which had all been investigated and responded to. 35 of those complaints had been received in AMH.
- A proposed strategy around Carer Support was discussed by the Committee and would require further work to identify the current status and how to monitor progress.

5.4 Infection Prevention and Control Committee Assurance Report/Procedures around the Management of Patients with MRSA/Accidental Innoculation/Outbreak of Infection

Key issues for consideration were:

- Audits would be undertaken in Quarter 2 to address wards and areas with less than 85% returns on monitoring data.
- Returns of 100% were also being investigated.
- Further analysis would be undertaken to look at the outbreak of D&V on Springwood to see if there was any correlation between the lack of returns of data for 2 months when the outbreak had occurred.

- The QuAC had agreed that clinical procedures should go through the Infection Prevention and Control Committee and then be formally approved at EMT, since it was not defined in the QuAC terms of reference to approve Trust Procedures.

5.5 Safeguarding Children and Adults - Verbal Updates.

- There were 3 child review cases in Redcar around sexual exploitation and 2 in Durham, one which was almost complete involving the crisis team and a young baby. There had been some lessons to learn from this incident around lack of communication with the midwife involved in the case. The Durham incident would be a serious case review and the Trust had been asked to provide a report.
- The incident in Hartlepool involving 2 young girls and a vulnerable adult had been delayed due to social media in February 2015 and would now take place in either Leeds or Newcastle. This was a case involving a service user well known to the Trust and whilst this case would not go to adult review there had been some learning points for services.
- It was pleasing to note that level 3 safeguarding children training had increased to 72% for all areas across the Trust, which was an improvement from 63%.

6. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

6.1 Compliance with CQC Registration Requirements, including Mental Health Act visit feedback summary report 1 April 2015 – 30 June 2015.

The Committee had considered the position of compliance with Care Quality Commission registration requirements and it was noted that:

- Applications to register locations in respect of the transfer of the Vale of York have been sent to the CQC and an action plan has been drawn up to identify any outstanding compliance issues at Bootham Park Hospital
- MHA reports had been received in connection with 6 inspections and actions were being taken to address the findings.
- There had been a delay in the opening and moving of patients from Abdale House to Orchards at Ripon due to the process of registering the property with the CQC and their requirement to visit as part of the registration process.
- Concerns were expressed over the environment at Bootham Park and how this may affect CQC compliance.
- Future reports would include an action plan with exception reporting and assurances following any MHA visits.
- To avoid duplication there would be further discussion around what information feeds through to the Mental Health Legislation Committee and to QuAC.

6.2 Quarterly Clinical Audit & Effectiveness – an update was heard by the Committee on the current position with clinical audits, which revealed that 12.4% of current audits were complete by the end of Quarter 1 with 3 audits around pharmacy behind schedule.

6.3 Patient Safety Annual Report - The key issues raised were around:

- An increase of 7 SUIs in 2014/15, compared to 2013/14.
- 2 homicides, (1 as a victim and the other as a perpetrator) and no increase in the number of physical assaults in 2014/15, compared to 2013/14.
- The total number of incidents reported overall by the Trust in the last year had increased by over 100.
- It was noted however that reporting incidents varied between wards, due to capacity issues.
- The new centralised approval team, effective from 1 October 2015, would provide a more vigorous sensor check on incidents.

6.4 Patient Safety & Patient Experience Report – is at Appendix 2

No key risks or trends were identified. It was agreed that this report should be presented to QuAC on a quarterly basis, rather than monthly.

6.5 **Information Strategy & Governance Assurance Report –** This report was withdrawn from the agenda in order for a discussion to agree on the appropriate information and assurances required in future for the QuAC, in accordance with the Committee's terms of reference.

6.6 **Drug & Therapeutics Report –** The Committee was informed about the delays in the project to integrate blood results onto Paris and the risks associated with prescribing when access to blood results was limited.

- Primary care colleagues had been unable to access the approved TEWV guidelines on the Trust website, due to the ongoing Trust website developments. Guidelines were being shared as attachments.
- There would be discussion at the next Drug and Therapeutics Committee around the potential move towards prescribing of E. Cigarettes and the financial impact this would have on the Trust.

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 2 July 2015, (appendix 1).

Hugh Griffiths, Non-Executive Director

Appendix 1 Confirmed minutes of meeting held on 2 July 2015

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 2 JULY 2015, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 11AM

Present:
Dr Hugh Griffiths, Non-Executive Director, (Acting Chairman)
Mrs Lesley Bessant, Chairman of the Trust
Mr Martin Barkley, Chief Executive
Mr Brent Kilmurray, Chief Operating Officer
Mrs Chris Stanbury, Director of Nursing & Governance
Mr Jim Tucker, Non-Executive Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing and Governance, (for minutes 15/121 & 15/122)
Mr Levi Buckley, Director of Operations, Forensic Services
Mrs Adele Coulthard, Director of Operations, North Yorkshire
Mrs Jennifer Illingworth, Director of Quality Governance
Dr Ahmed Khouja, Deputy Medical Director & Senior Clinical Director, Forensic Services
Mr David Levy, Director of Human Resources, (for minutes15/125 & 15/126)
Mrs Elizabeth Moody, Director of Nursing & Governance (Designate)
Dr Neil Mayfield, Deputy Medical Director, North Yorkshire
Mr Stephen Scorer, Deputy Director of Nursing
Mrs Donna Oliver, Deputy Trust Secretary
Mr Chris Williams, Chief Pharmacist, (for minute 15/127)

15/112 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Mr John Robinson, Chairman (Chairman of the Committee), Mr David Jennings, Non-Executive Director, Dr Nick Land, Medical Director, Dr Ingrid Whitton, Deputy Medical Director and Ms Christine McCann, Associate Director of Nursing.

It was noted that the Directors of Operations for County Durham and Darlington and Teesside and the Deputy Medical Director for Teesside were not required to attend the meeting.

15/113 MINUTES OF PREVIOUS MEETING

Agreed *- that the minutes of the meeting held on 4 June 2015 be approved, (subject to the amendments set out in Annex A attached to these minutes), as the correct record and signed by the Chairman.*

Resolved *- that the minutes of the meeting held on 7 May 2015, approved and signed by the Chairman, at the meeting on 4 June 2015 be amended in the following respect to correct inaccuracies subsequently discovered:*

Minute 15/73: *Mrs Stanbury commented that the 6 month staffing report, which was due in June, should be deferred to July to enable all the CRES data to be included. Action: Mr D Levy*, which should have read **Action: Mrs C Stanbury.**
Also, Mrs S Pickering was not in attendance.

15/114 ACTION LOG

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

The following updates were noted:

15/11 "*Suicide prevention progress report to come back to QuAC".*

This action had been referred to in the 4 June 2015 QuAC meeting, as the work had integrated with the proposed clinical risk and harm minimisation project and should therefore be marked as completed and removed.

15/73 (5) *"Seek external experts to review our physical environment at Ridgeway given the ongoing concerns the service has regarding its fixtures and fittings, building quality etc…"*

The Trust Security Manager was now leading on this and contact had been made with Rampton to see if this work could be undertaken.

15/74 *"An exception quality scorecard should be attached to all locality reports, as currently the format for the NY LMGB report".*

Mr Buckley confirmed under minute 15/115 that he would aim to include the quality scorecard for his next report, due in September 2105 and include a narrative around indicators which would show a negative score.

15/104 *"Discussion on the back of the press release about 'Mr S' with NHS England lead contacts (Karen Conway and Richard Barker) about minimising potential stigma from press conferences".*

It was noted that the person in connection with this incident was named 'Mr F'. Mrs Illingworth had spoken to Karen Conway at a recent conference and it had been concluded that under its new policy, NHS England would discuss any press releases before being released to the public, with the Trust involved, which was hoped to be a proactive measure.

15/15 (g) "*Further update on the Trust's Electronic Prescribing Project/PARIS workstream 2 to be provided by the Chief Pharmacist".*

This matter was dealt with under minute 15/127.

15/101 "*Patient Safety Group Assurance Report – Dr Land agreed to have "off the record" discussions with other providers to see if the Trust stood as an outlier…".*

Since Dr Land was not present at the meeting this would come back to the next QuAC meeting.

Action: Dr N Land

15/115 FORENSIC SERVICES LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Forensic Services Governance report.

Mr Buckley highlighted the following key messages:

(1) Forensic Mental Health (FMH)

(a) Recruitment was currently one of the top concerns across both FMH and FLD services, with around 43 unfilled vacancies at the end of May 2015. (14 of these were in FLD).

It was anticipated that these posts would be filled by the end of July 2015, however recruitment and retention was an ongoing concern across the localities.

(b) A recent NHSE Commissioners visit to Lark Ward on 6 June 2015 had received positive feedback.

The issue of drain smells on the ward had been picked up by Mr R Cowell in Estates.

(c) The specific needs of Forensic Service patients would be incorporated into the Trust MOVA training model.

(d) QuAG had supported discontinuing the smoking break pilot as it could not be rolled out safely across all FMH medium secure wards.
This could cause an issue for the Trust around blanket restrictive practices.

(2) Forensic Learning Disabilities (FLD)

(a) There was continued scrutiny from external agencies, which was causing pressure on the service and disruption to the delivery of care and treatment.

It was recognised that there was a lack of investment in community services, with no service specification for outreach services.

(b) There had been an increase in male and female referrals into LD which was believed to be due to the increased national closure of LD beds.

(c) Concerns around patient and staff safety had been discussed with consultants around CRES plans to reduce staffing on nights.

On this matter it was noted that:

- The CRES plans had been considered as part of the business planning process and reconfiguration work in FLD and the service model had changed following a review of the establishment. This would be discussed further at EMT Away Day on 13 July 2015.
- With imminent amendments to the Mental Health Code of Practice there would be some changes around staffing requirements during seclusion and these had not yet been costed.

(3) Offender Health & Quality Assurance Group (OH & QuAG)

(a) There were still difficulties recruiting to the services in Northumberland prisons and future recruitment drives would need to be more creative.

(b) There were risks to staff from patients taken the “legal high” (SPICE), and the side effects, which lasted 48 hours and led to severe aggressive behaviour.

On this matter it was noted that:

(i) There were still issues with patients returning to services and bringing in legal highs and prescription drugs, which were being distributed on wards to other patients. Wards affected by this were predominantly Kirkdale and Newtondale.

It was noted however, that the Trust canine would shortly add SPICE detection as part of his drug hunting repertoire. It was not Trust policy to search visitors.

(ii) Dealing with disruptions on wards and minimising the unstable environment could be dealt with in various ways, including increased security with restrictions, seclusion or segregation. Staffing could be increased on a 1 to 1 basis, on a separate part of the ward.
There were risks of a domino effect when difficult behaviours present and this could be a particular issue on the female wards.

Mrs Bessant suggested that it would be helpful for future reports to include the top 3 concerns for the services.

Mr Buckley responded that at present, these were:

1. Recruitment and retention, particularly in FLD, with a lack of stability in the teams, which could impact on the continuity of care.

2. The national agenda for learning disabilities and the potential for reduction in bed numbers. There were concerns that the national leads for these services were not thoroughly briefed on local issues.

   An investigation into the current patient pathway was required, as nationally the northern region had twice as many people in forensic beds as the south, probably due to local demographic factors.

3. New Mental Health Act Code of Practice – which included 2 registered nurses to be present for observations on patients who were on seclusion.

   There would be further debate around this as this would cause issues at night time when there would only be 1 registered nurse present. This could present a significant compliance issue.

Agreed: that future reports include the balanced scorecard as well as the top 3 concerns within the services and assurances around these areas.

Action: Mr L Buckley/All Locality Leads

15/116 NORTH YORKSHIRE LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the North Yorkshire Locality Governance Report.

(Mrs C Stanbury left the meeting).

Mrs Coulthard highlighted the following from the various services:

(1) Adult Mental Health (AMH)
- (a) Additional funding had been received for Early Intervention in Psychosis.
- (b) The CCG and North Yorkshire Police had confirmed funding for the Scarborough Street Triage service, until the end of 2015/16.
- (c) The Harrogate S136 Place of Safety had become operational on 16 June 2015 and was working well.
- (d) An open day had been arranged for the new Orchards facility in Ripon on 9 July 2015.
- (e) Work around single sex accommodation was underway on Ward 15 at The Friarage, however there were some issues in relation to the quality of some of the estate.

(2) Children & Young People's Services (CYPS Tier 3)
- (a) Staffing continued to be a problem, with Consultant long term sickness.
- (b) There were currently 5 difficult complex cases being dealt with in the Northallerton team, including a child that had returned to T4 services from the area, after their care package had broken down.
- (c) The service support plan was in place and being implemented.

(3) Children & Young People's Services (CYPS Tier 4)
- (a) Medical staffing continued to be an issue with reconfiguration of posts underway.
- (b) The phase 3 building work at West Lane continued on schedule.
- (c) The level of referrals for Newberry remained high due to the impact of NHS England contract and demand from out of the area referrals.
- (d) NHS Wales had confirmed that TEWV would be a preferred provider, however there had been no referrals received to date.

(4) Learning Disabilities Services (LD)
- (a) The Service Support plan was in place and being implemented

(5) MHSOP

(a) An agreed set of capital works would now be taken forward to address compliance with the mixed sex accommodation issues on Ward 14 at The Friarage.

In response to questions it was noted that:

(i) The additional investment of £125k in EIP services would need to be deployed across 3 teams to address issues around care coordination, psychology access and meeting NICE guidance and new access targets.
(ii) Data quality continued to be an issue. There would be however, opportunity for reviewing data with version 6 of PARIS and clinicians would be involved in the process to resolve problems.
(iii) There continued to be a drive for productivity and skilling up the workforce.
(iv) The CCG had commissioned a private provider in Hull to help reduce the backlog of referrals for diagnosis of autism, as the Durham and Tees services were over-subscribed. A specific Autism Diagnosis Service was currently out to tender, however the Trust would not be putting in a bid for this.

Mrs Coulthard advised that the top 3 challenges for the localities were:

1. Commissioning of a new model of CAMHS.
2. Recruitment of staff, particularly in the Harrogate, Malton and Scarborough areas.
3. The long term viability of services in North Yorkshire in the current model/structure.

Mrs Coulthard also raised concerns that the localities were not receiving information on the outcome of clinical audits.

Agreed – that clinical audit results would be provided to the Directors of Operations.

Action: Mrs J Illingworth

15/117 CLINICAL EFFECTIVENESS GROUP ASSURANCE REPORT

The Committee received and noted the Assurance Report of the Clinical Effectiveness Group.

Arising from the report it was highlighted that:

(1) It was recognised that Improvements were required detailing the outcome of clinical audits.

(2) The NICE guidance on the management of violence and aggression would have a significant effect on forensic services, if implemented:

(a) It would prohibit the use of mechanical restraint.
(b) There would be a requirement for an external review involving a service user from a 'service user monitoring unit' within 72 hours, after each restrictive intervention.

Dr Khouja had calculated that between March to May 2015 there had been over 300 incidents of violence and aggression, which would potentially mean around 5 reviews per working day.

Mrs Bessant highlighted the need for future reports to focus on providing further assurances as well as information.

Agreed that:

I. Future Clinical Effectiveness reports should give more detail around assurances, as well as information on activity.
II. A further debate would take place around compliance with the NICE guidance on violence and aggression in the Force Reduction Project

Action: Dr N Land

15/118 HEALTH, SAFETY, SECURITY AND FIRE WORKING GROUP ASSURANCE REPORT

The Committee received and considered the Health Safety, Security and Fire Group report.

Mr Kilmurray pointed out that the report contained a summary of the previous years' work and the current years' work plan.

15/119 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee received and noted the report of the Patient Safety Group for June 2015.

Mrs Illingworth, on behalf of Dr Land highlighted the following:

(1) There continued to be a reduction in the number of delayed DATIX reports, with 130 outstanding actions out of which there were only 53 raised over 10 days waiting for final approval.
(2) In house Training would commence throughout July on the new DATIX system and the option of using pilot areas to test the system in clinical teams had been discussed.
(3) It was planned that the project would go live during the first week of August 2015.
(4) There were no SUI actions overdue for longer than 1 month.

Following discussions it was noted that:

(1) There would be a revised lessons learned bulletin produced, which would be going to the Patient Safety Group for approval.

The NEDs considered that there needed to be assurances given in future reports around how lessons learned were then translated into changing practice within services and how these changes were then sustained.

Action: Mrs Moody/Mrs Illingworth

(2) A new project around Clinical Risk Management and Harm Minimisation had been scoped and would be presented to EMT in July 2015.
(3) There were concerns in IAPT services around the changing needs of the client group and the ability for this to be managed. This would be taken to the Trust wide IAPT meeting and then fed back to the Patient Safety Group 2015.
(4) The SUI process Kaizan event held on 13 March had been followed up by an Away Day in June 2015, which had been very positive.

15/120 PATIENT EXPERIENCE GROUP ASSURANCE REPORT

The Committee received a verbal update that the Patient Experience Group had not met in June 2015, due to not being quorate.

It had been agreed that localities would continue to work on their assigned tasks and feedback to the next QuAC meeting.

In response to this matter Mrs Bessant queried the frequency of the Patient Experience Group meetings and whether they needed to be bi-monthly rather than monthly.

Action: Mrs E Moody

15/121 SAFEGUARDING CHILDREN ASSURANCE REPORT

Mrs Agar provided a verbal update on the safeguarding children issues:

It was noted that:
(1) The serious case review involving a 17 year old in Durham had now been completed. The case would be going to inquest and then the LSCB would hold a media meeting for all organisations involved in the review.
(2) There were 6 serious case reviews underway in Durham, with another 1 potentially to come on board. It was likely that there could be some media attention for the LSCB due to the number of serious case reviews underway.

(3) The trial regarding the alleged murder of service user of the Trust by 2 teenagers had commenced this week. There had been media attention around this case.
(4) Redcar LSCB had put forward a serious case review to the National Panel regarding the abuse of 3 young people known to CAMHS.

15/122 SAFEGUARDING ADULTS ASSURANCE REPORT

Mrs Agar provided a verbal update on safeguarding adult issues:

It was noted that:

(1) As above there would to be a serious case review regarding the Hartlepool murder, which would not start until September 2015.
(2) There would be a serious case review regarding an adult being managed at level 2 within MAPPA. This would also to go to Durham LSCB.
(3) There had been an increase in the number of domestic abuse cases within all areas. This would impact upon the work of both the adult and children safeguarding teams.

15/123 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS ASSURANCE REPORT

The Committee noted the CQC registration and information assurance update.

Mrs Illingworth, on behalf of Mrs Stanbury outlined developments over the last month, which included:

(1) Mental Health Act monitoring reports had been received for Langley and Bek Ward.

The main issues raised were:

- Privacy and dignity issues around visibility of patients' bedrooms.
- Record keeping and lack of information in patient records.
- Information not displayed for patients of their right to contact the CQC.

(2) There had been mock inspections carried out by the Compliance Team on Hawk Ward, Ridgeway, Ward 15, Northallerton and Cedar Ward at Harrogate.
(3) The challenge made by the Trust on the CQC rating given following the inspection was now being reviewed by the CQC and a note to this effect was on the Trust website. The Trust had also been informed by the CQC that the acquisition of York and Selby would not negatively affect our current rating.

15/124 PATIENT SAFETY & PATIENT EXPERIENCE DATA REPORT

The Committee noted and considered the new format and styling of the Patient Safety and Patient Experience Data report for May 2015 including (1) – (3).

The Committee was asked to note that:

(1) There were no significant risks in relation to the key areas covered in the report.
(2) The report had been updated to include an executive summary and narrative around the Quality Dashboard indicators.
(3) A rag rating status had been suggested for targets in future reports, to enable more focused exception reporting.

Following discussion it was **agreed** that the presentation of the data set out in the report was more in line with the needs of external commissioners.

In addition, the Committee considered the new format and styling of the report. On this matter it was agreed that future reports:

(a) Would consider using line graphs, rather than bar charts to present the data.
(b) Comparisons for data should be displayed as quarterly averages and rolling monthly averages.
(c) That rag rating should not be used.

(d) The narrative around the statistics should provide analytical observations, as well as descriptive.
(e) It would be useful to include in the executive summary any significant trends or extraordinary numbers.
(f) Level 3 SUIs were not required, only level 4s and 5s.
(g) PALS information should continue to be included in the report.
(h) Would include rates per 100,000, as well as absolute numbers, in order for improved analysis of data.
(i) Would Include a retrospective comparison with other providers.

Action: Mrs J Illingworth

15/125 WORKFORCE STAFFING REPORT

The Committee received the first Workforce Staffing Report.

Currently a quarterly Workforce Report was presented to the Board of Directors, together with a monthly Workforce Report that went to EMT.

Mr Levy asked the Committee to consider items for inclusion in future Workforce Staffing Reports, based on suggestions in the report which included:

(1) The 5 key staff engagement factors from the Strategy Scorecard:
   (a) Enabling involvement and decision making.
   (b) Delivering great management and leadership.
   (c) Supporting training and development.
   (d) Ensuring every role counts.
   (e) Promoting health and wellbeing amongst our staff.

(2) The requirements of Regulation 18: Staffing Report, with staffing indicators consistent with the terms of Regulation 18 around:
   (a) Staff numbers and skill mix.
   (b) Staff business and continuity planning.
   (c) Induction
   (d) Appraisal
   (e) Supervision arrangements.
   (f) Statutory and mandatory training and CPD.

Following discussion it was **agreed** to bring a quarterly Workforce Staffing report to QuAC, looking at a topical issue in more detail, with the first report identifying the current problems around recruitment and retention, including difficult to fill posts and actions in place to address this.

Action: Mrs D Oliver/QuAC reporting summary/Mr D Levy

15/126 MANDATORY TRAINING REPORT

The Committee received and considered the Mandatory Training Report.

From the report if was highlighted that:

(1) Mandatory training was currently at 88%, against the Trust target of 95% with a national expectation of 100%.
(2) Non-compliance with contractual standards could carry fiscal penalties and lack of skills through non-attendance at mandatory training could impact on patient and staff safety, which could ultimately lead to litigation.
(3) There had been a discussion at EMT about whether training around the Mental Health Act should be considered as part of mandatory training, however no conclusions had been reached.

    On this matter Mrs Illingworth noted that there was potentially some funding for an e-learning package that would support this.

(4) To support completion of mandatory training in community teams some services would close for 1-2 days.

(5) The introduction of e-learning, performance tracking and the Pay Progression procedure as levers to increase mandatory training compliance, had given some improvement over the last 5 years, however the Trust may need to investigate further the use of sanctions as leverage to increase compliance.

The NEDS considered that since mandatory training was for all staff, this should in fact mean 100% compliance and felt that looking at remuneration penalties for staff, as well as the Pay progression procedure would improve compliance levels.

On this matter it was noted that the performance targets around mandatory training levels across other Trusts nationally were set between 85-90%.

(6) The Trust would need to look creatively at models and methodology for delivering training to increase access, using more current technology and social media to respond to the range of learning styles of staff groups.

(7) Video and teleconferencing, on line discussion groups, filmed presentations and live 'chat' sessions could be incorporated into a multi-media approach to training that could be more cost effective and more appealing to staff.

Following discussion it was noted that:

(a) The feedback from IIP had revealed that these kinds of learning styles did not suit all.

(b) That appraisals were now made easier by having access to the dashboard for instant feedback on compliance with mandatory training.

15/127 DRUG AND THERAPEUTICS REPORT (MAR – JUN 2015)

The Committee received and noted the Drug and Therapeutics Report for the period March to June 2015.

The following areas were highlighted:

(1) There was a potential lack of compliance around NICE guidelines 178 & 184, which were in connection to secondary care services being responsible for physical health monitoring for the first 12 months of antipsychotic treatment.

Mr Williams confirmed that this had been discussed at a recent EMT meeting and an improvement event would be held to look into how the Trust could improve this position. GPs were also raising this issue at interface meetings.

(2) The Trust was involved with influencing the design of the Electronic prescribing and medicines administration project (EPMA) and the Trust would be acting as the beta testing partners with Civica for the system.

It was hoped that this project would start in October 2015, with 6 months of testing after which, if successful, a business case would be put together for implementation of the full system within the Trust.

Dr Khouja commented that, before implementation of the prescribing system, it would be ideal if access to path lab results was available at the same time, through PARIS.

15/128 EXCEPTION REPORTING (LMGBs, QAC sub groups)

There was nothing to note under this item.

15/129 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD

There were no matters arising.

15/130 ANY OTHER BUSINESS

There was no other business to note.

15/131 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 3 September 2015, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

Email to Donna Oliver donnaoliver1@nhs.net

The meeting concluded at 4.35pm

……..

Mr Hugh Griffiths
Acting Chairman
2 September 2015

Annex A

Page 2 – 15/73 (5) – Action log

Reference to Ramptons, should have been 'Rampton'.

Page 4 – 15/97 – (4) Learning Disabilities (LD)

"This provided guidelines on the usage of CCTV which was for observational and **safety** teaching purposes.

6) "The security issues around Redcar **CMHT** were due to drunk and disorderly behaviour and substance taking outside…"

Mr Brown confirmed that there had been a reduction from 17 to 7, **out of locality** admissions.

Page 6 - 15/101 – Patient Safety Group Assurance Report

3) "Mrs Stanbury confirmed that **proposals for revision of the** Supervision Policy…"

Key risks identified were:

1) "If the service was to add 20 to 30 minutes onto the assessment process for patients that would be to the detriment of **the number of** other patients **that could be seen**".

Page 7 – 15/104 – Safeguarding Adults Assurance Report

Change all reference to 'Mr S' to 'Mr F'.

Page 8 – 15/106 – Compliance with CQC Registration Requirements.

2) "The summaries of MHS inspections would now be reported to QuAC, since compliance requirements with the Mental Health Act **were now included in the CQC registration requirement and were subject to enforcement powers".**

In response to questions it was noted that:
1) The Trust had received a rating of requires improvement for the question "are services safe?" due to an issue about privacy and dignity and same sex accommodation in a rehabilitation ward **and some concerns regarding covert medication and ligature risks".**

2) "In the **intelligent** monitoring report one of the identified elevated risks….".

"The same problems **of lack of context applied** when looking at the thresholds **set** for snap shots of whistle blowing…".
3) On a positive note for the Trust there were only 3 areas of **minor** elevated risk".

Page 9 – 15/106 – Compliance with CQC Requirements.

"This appeared to be related to the increase in the number of older people detained under the Act who had then died of **natural** causes".

Appendix 2

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Assurance Committee (QuAC)

Patient Safety and Patient Experience Data Report

Reporting Period:

01/06/2015 to 31/07/2015

making a difference together

Tees, Esk and Wear Valleys NHS Foundation Trust
Quality Assurance Committee (QuAC) -
Patient Safety and Patient Experience Data Report
01/06/15 to 31/07/15

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SECTION 1 – EXECUTIVE SUMMARY

1.0 Executive Summary

1.1 Introduction

The purpose of this report is to inform the Quality Assurance Committee (QuAC) of the current levels of performance for the period of 1st June to 31st July 2015.

The Trusts quality dashboard provides a high level overview of performance across the financial year of 2015/16 and utilises a number of quality indicators within the Trust. The dashboard provides assurance and highlights any areas that may require escalation to the Board.

An explanation of each quality metric has been provided within the detailed reporting section of this report.

This report will continue to be developed during the financial year 2015/16 ensuring that the report meets the needs of the Quality Assurance Committee

1.2 Summary of Performance

This report focuses on the period of 1st June 2015 to 31st July 2015 with the following items:

	Trend on previous period (April - May 2015)
• There were 8 serious untoward incidents	↘ (19)
• There were 12 level 4 incidents	↘ (26)
• There were 104 level 3 incidents (self-harm only)	↗ (97)
• There were 41 complaints	↗ (35)
• There were 202 PALS	↗ (169)
• There were 742 incidents of control and restraint	↘ (753)
• There were 22 seclusions	↗ (13)

It is important to highlight that the increase in relation to seclusion equated to 41% which would warrant it being highlighted as extraordinary.

1.3 Significant Risk

No significant risks have been identified in relation to:

- Serious untoward incidents
- Level 4 incidents
- Level 3 incidents (self-harm only)
- Complaints

- PALS
- Use of control and restraint

1.4 Recommendations

The Quality Assurance Committee are asked to:

- Receive assurance on the overall achievement on quality and performance indicators
- Provide ongoing feedback on the narrative style report including any areas of development would be appreciated to ensure that the report meets the needs of the QuAC group.

Joanne Salvin
Quality Data Manager
August 2015

2.0 Quality Dashboard

The quality metrics have been defined as a single dashboard providing at a 'glance' a summary of performance across the Trust.

The table below provides the number of occasions that each metric has been triggered on a monthly basis across the financial year 2015/16.

	2015 - 2016												
	April	May	June	July	August	September	October	November	December	January	February	March	YTD
Serious Untoward Incidents Raised	12	7	4	4									27
Level 4 Incidents	12	14	6	6									38
Level 3 Incidents (Self Harm Only)	45	50	54	50									201
Complaints	26	9	19	22									76
PALS	81	88	99	103									371
Use of Control and Restraint	421	333	366	393									1513
Seclusions	9	4	7	15									35

The detail exception reporting can be found in section 3 of this report.

3.0 Detailed Reporting

Further analysis is provided within this section of the report for all metrics identified within the quality dashboard.

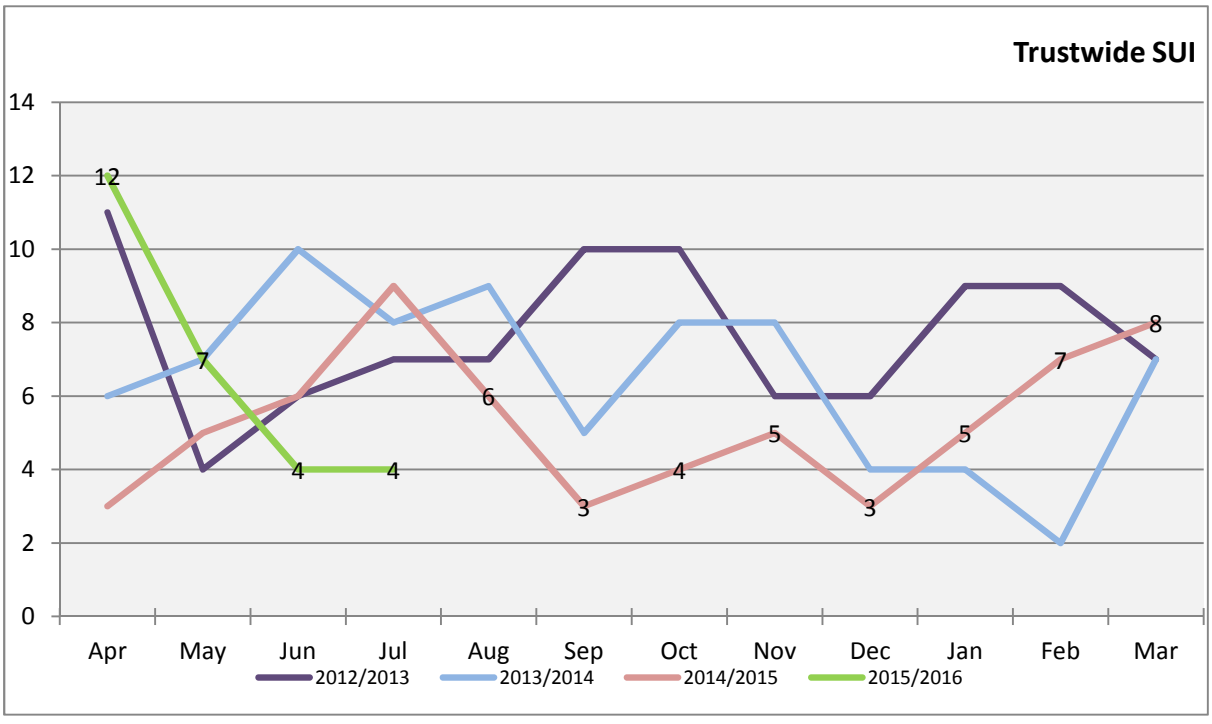
Detailed exception reports are provided for:-

- Serious Untoward Incidents
- Level 4 incidents
- Level 3 incidents (Self Harm Only)
- Complaints
- PALS
- Use of control and restraint
- Seclusions

3.1 Serious Untoward Incidents

During the reporting period there were 8 serious untoward incidents across the Trust which was a reduction of 8 on the previous period. 7 of which were classified as 'unexpected death (outpatient)' and 1 was classified as 'unexpected death (inpatient)'.

The trend over the last 36 months can be shown as follows:



The table below shows which locality the 8 serious untoward incidents have occurred and the trend is provided on Quarter 1 2014/15:

Locality	Total number of SUI's June - July 2015	Total number of SUI's Quarter 1 (2015/16)	Trend on Quarter 1 (2014/15)
Durham & Darlington	3	7	↗ (5)
Forensic	1	0	↘ (1)
North Yorkshire	2	8	↗ (1)
Teesside	2	8	↗ (7)
Tier 4 CAMHS	0	0	→ (0)

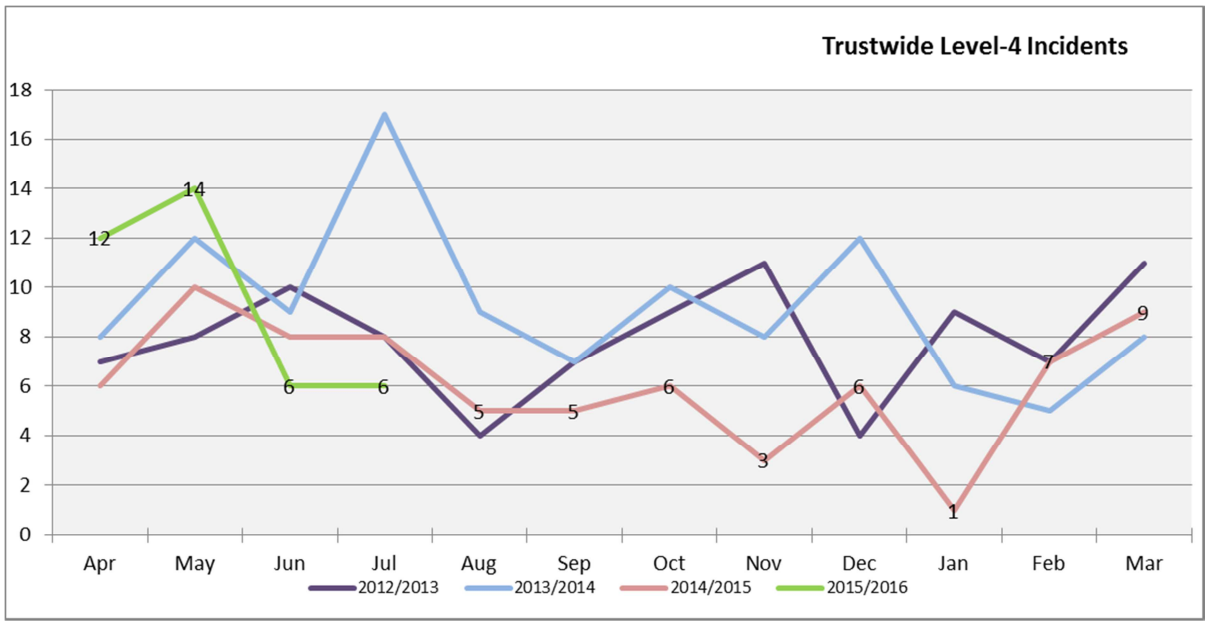
The table below shows which ward or team the serious untoward incidents have occurred during the reporting period:

Total No.	Locality	Service	Ward / Team
3	Durham & Darlington	AMH	AMH Durham City Affective Disorders
			AMH Easington Affective Disorders
			AMH Sedgefield Affective Disorders
1	Forensic	OH	OHC Middlesbrough L&D
2	North Yorkshire	AMH	AMH Hambleton and Richmondshire West Community
			AMH Harrogate Briary Cedar
2	Teesside	AMH	AMH Middlesbrough Access
			AMH Tees Primary Care

3.2 Level 4 Incidents

During the reporting period there were a total of 12 level 4 incidents reported which is a reduction of 14 on the previous month.

The trend over the last 36 months is illustrated as follows:



The table below shows which locality the 12 incidents have occurred and the trend is provided on Quarter 1 2014/15:

Locality	Total number of Level 4 incidents June - July 2015	Total number of Level 4 incidents Quarter 1 (2015/16)	Trend on Quarter 1 (2014/15)
Durham & Darlington	5	11	↗ (6)
Forensic	1	7	↘ (10)
North Yorkshire	5	9	↗ (3)
Teesside	0	5	→ (5)
Tier 4 CAMHS	1	0	→ (0)

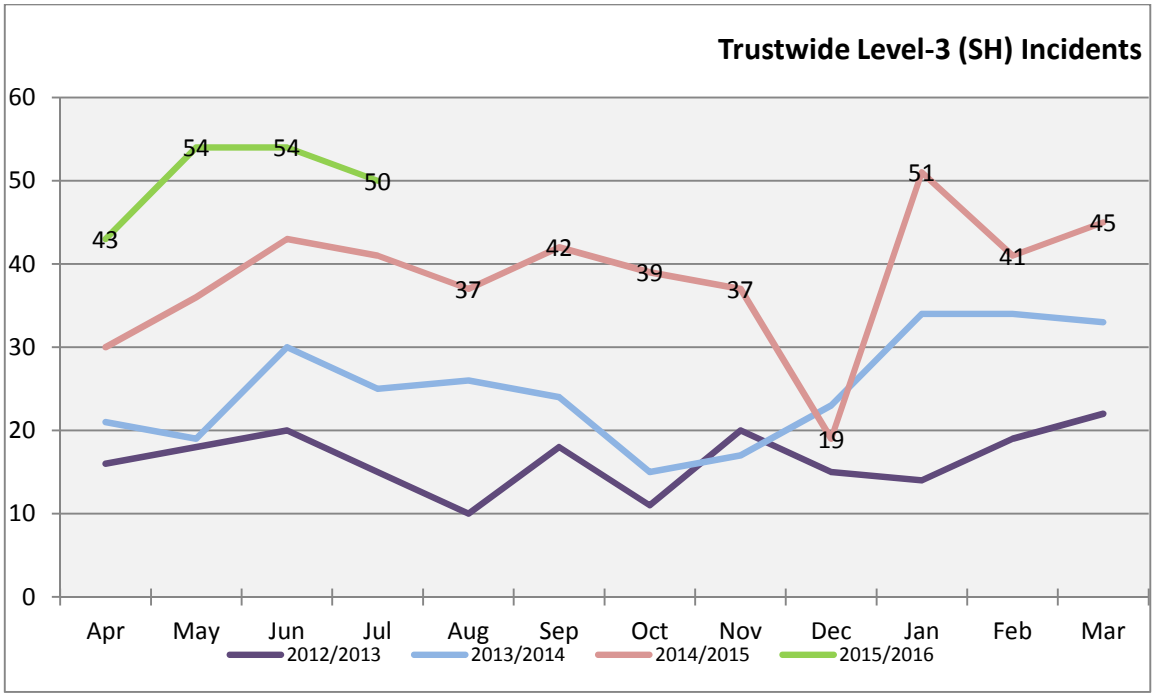
The incident categories used to define the level 4 incidents are as follows:

Number of Incidents	Category	Wards / Team
6	Self-Harm	CAMHS South Durham Tier 3
		MHSOP Scarborough Cross Lane Rowan Lea
		CAMHS Harrogate
		FMH Sandpiper Ward
		AMH HHR Early Intervention Psychosis
		AMH Crisis and Recovery House
1	Fire (No death)	MHSOP Easington Community
1	Attempted Homicide (Perpetrator)	AMH Sedgefield Affective Disorders
1	Inappropriate Behaviour	AMH Ayckbourn Unit, Esk Ward
1	Unexpected Death (Inpatient)	AMH Maple Ward
1	Violence and Aggression	CAMHS West Lane Hospital Westwood Centre
1	Other	MHSOP Harrogate Briary Rowan

3.3 Level 3 (Self Harm) Incidents

There have been 104 incidents categorised as level 3 within the reporting period. This is an increase of 7 incident from the previous period (April – May 2015).

The graph below shows the number of level 3 incidents that have occurred by month covering a 36 month period:



The table below shows the total number of level 3 incidents raised within each locality during the reporting period and the trend is provided on Quarter 1 2014/15:

Locality	Total number of Level 3 incidents June - July 2015	Total number of Level 3 incidents Quarter 1 (2015/16)	Trend on Quarter 1 (2014/15)
Durham & Darlington	46	72	↗ (50)
Forensic	7	11	↘ (17)
North Yorkshire	22	31	↗ (20)
Teesside	27	36	↗ (19)
Tier 4 CAMHS	2	1	↘ (3)

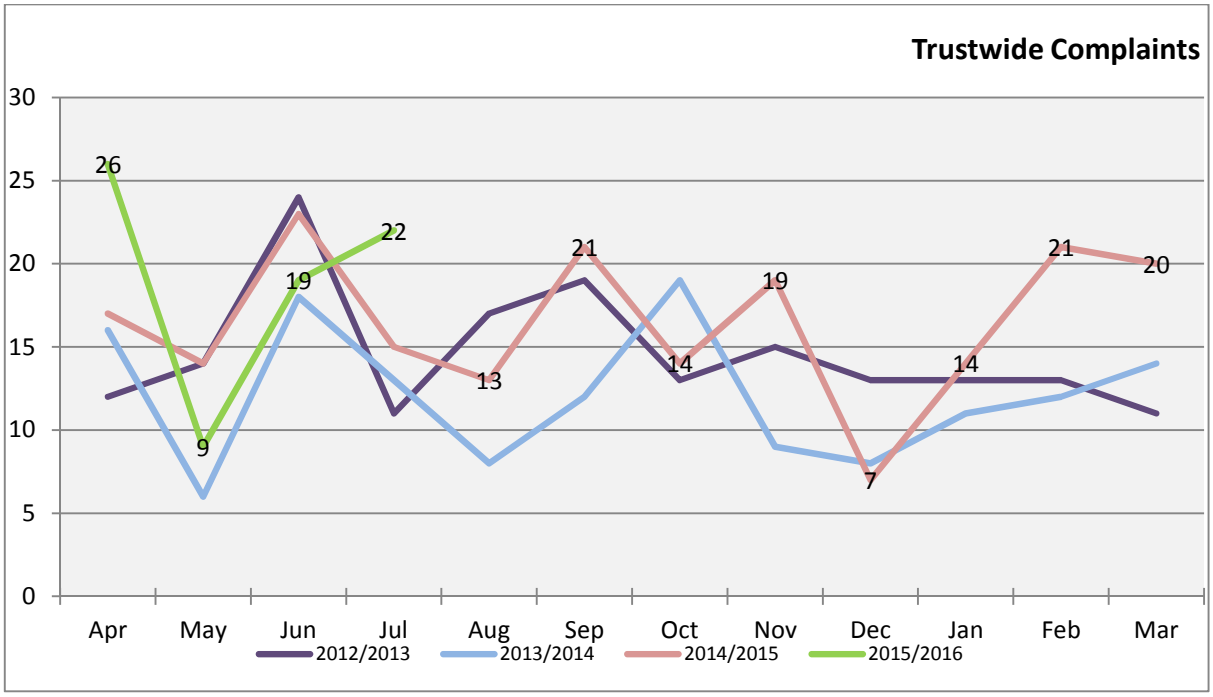
The level 3 incidents that have occurred during the reporting period were categorised as follows:

- Actual self harm (95)
- Actual or suspected suicide (1)
- Attempted or suspected attempted suicide (4)
- Drug abuse (3)
- Attempted self harm (1)

3.4 Complaints

There have been a total of 41 complaints raised in the reporting period which is an increase of 6 on the previous period (April – May 2015).

The total number of complaints raised over the last 36 months is as follows:



The complaints that have been raised during the reporting period can be categorised into 4 areas as follows:

- Clinical Care (31)
- Attitude (5)
- Communication (2)
- Discharge Arrangements (1)
- General Advice (2)

During the reporting period complaints were raised in the following localities and the trend is provided on Quarter 1 2014/15:

Locality	Total number of complaints (June – July 2015)	Total number of complaints Quarter 1 (2015/16)	Trend on Quarter 1 (2014/15)
Durham & Darlington	12	17	↘ (19)
Forensic	4	5	↗ (4)
North Yorkshire	9	11	→ (11)
Teesside	15	18	↗ (19)
Tier 4 CAMHS	1	3	→ (0)

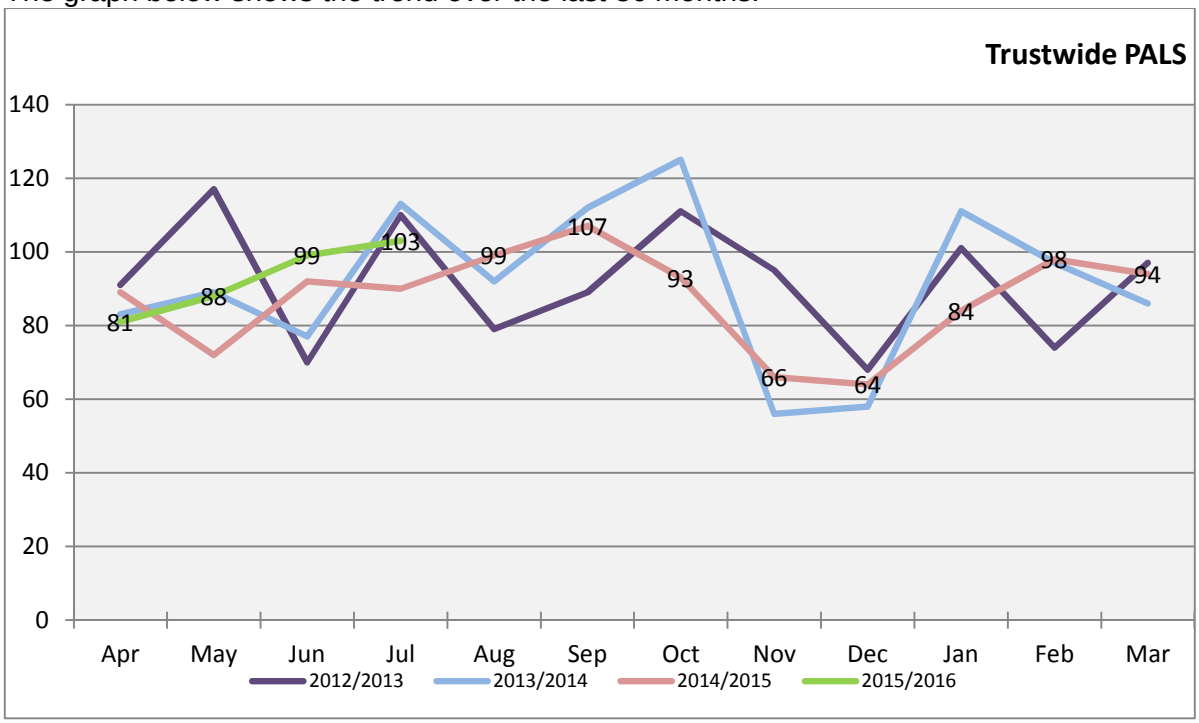
The table below provides a breakdown of the types of complaints received during the reporting period:

Locality	Categories of complaints
Durham & Darlington	Clinical care (9) Attitude (2) and Communication (1)
Forensic	Clinical care (3) General Advice (1)
North Yorkshire	Clinical care (8) Attitude (1)
Teesside	Clinical care (10) Attitude (2) Communication (1) Discharge Arrangements (1) and General Advice (1)
Tier 4 CAMHS	Clinical care (1)

3.5 PALS

During the reporting period there have been 202 PALS related issues, an increase of 33 on the previous period (April – May 2015).

The graph below shows the trend over the last 36 months:



The table below shows the reasons given for raising a PALS issue and the trend on the previous period:

Category	Number of PALS raised June - July 2015	Trend on previous period (April to May 2015)
Clinical Care	93	↗ (86)
General Advice	52	↗ (29)
Attitude	17	→ (17)
Sign Posting	14	↘ (17)
Environment	10	↗ (7)
Communication	11	↗ (5)
Staff Compliments	2	↘ (3)
Other	3	↘ (5)

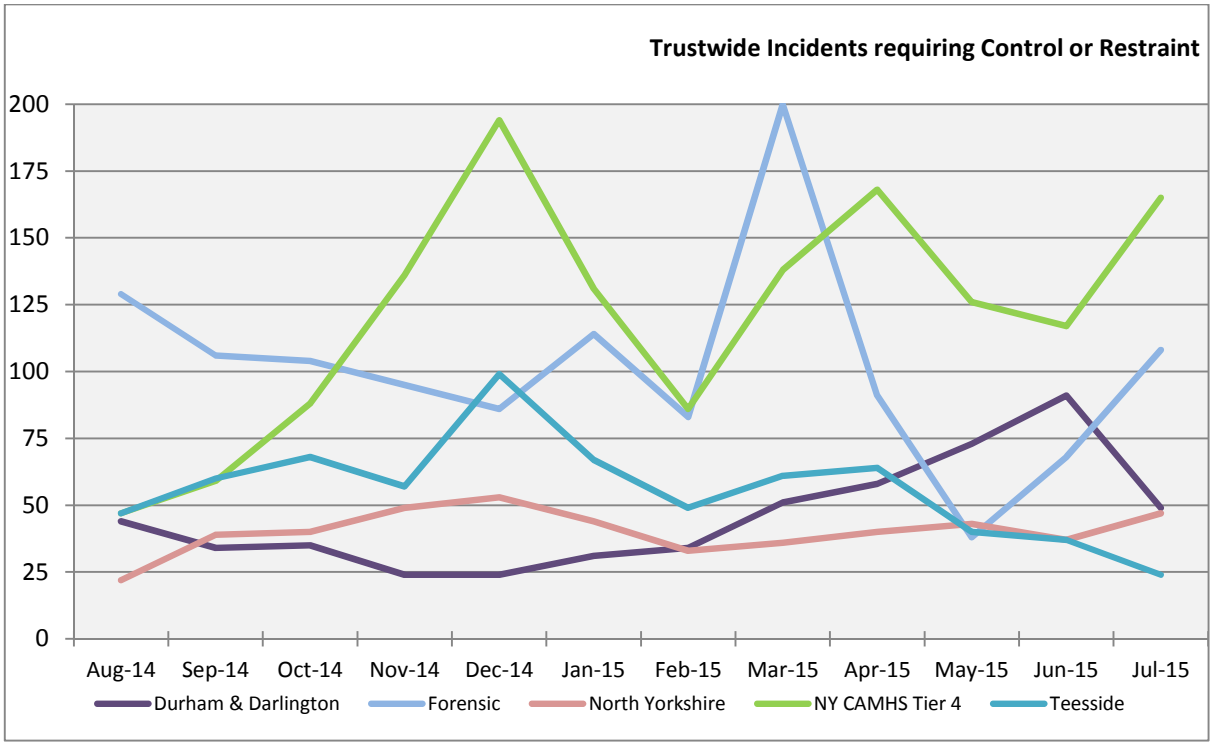
PALS were raised in the following areas and categorised as follows:

Locality	Total number of Issues (June-July 2015)	Categories of Issues	Trend on Previous Period (April to May 2015)
Durham & Darlington *52 issues raised*	4	Attitude	(2)
	27	Clinical care	(28)
	4	Communication	(1)
	0	Environment	(3)
	14	General Advice	(5)
	1	Signposting	(1)
	1	Staff Compliments	(0)
	1	Other	(0)
Forensic *49 issues raised*	4	Attitude	(8)
	27	Clinical care	(17)
	2	Communication	(0)
	6	Environment	(2)
	7	General Advice	(5)
	2	Other	(1)
	1	Signposting	(0)
Locality	**Total number of Issues**	**Categories of Issues**	**Trend on Previous Period (April to May 2015)**
North Yorkshire *25 issues raised*	3	Attitude	(3)
	9	Clinical care	(11)
	2	Communication	(1)
	1	Environment	(1)
	10	General Advice	(4)
	0	Staff Compliments	(2)
Teesside *50 issues raised*	6	Attitude	(4)
	27	Clinical care	(22)
	2	Communication	(2)
	1	Environment	(1)
	11	General Advice	(4)
	2	Signposting	(1)
	1	Staff compliments	(1)
	0	Other	(2)
Tier 4 CAMHS *1 issue raised*	1	Clinical care	(1)

3.6 Control and Restraint

During the reporting period there have been a total of 742 incidents that required control and restraint, a decrease of 11 on the previous period (April – May 2015).

A 12 month breakdown of the number of incidents requiring control and restraint can be found as follows:



During the reporting period the number of incidents requiring control and restraint by locality is as follows:

Locality	Total number of incidents June-July 2015	Trend on previous period (Apr-May 2015)	Total controls or restraint used June-July 2015	Trend on previous period (Apr-May 2015)
Durham & Darlington	140	↗ (131)	182	↗ (180)
Forensic	176	↗ (129)	299	↗ (215)
North Yorkshire	83	↗ (74)	338	↗ (116)
Teesside	61	↘ (104)	93	↘ (151)
Tier 4 CAMHS	282	↘ (293)	570	↘ (574)

Note: more than one type of restraint may be used in each incident

During the reporting period the top five reasons for control or restraint used per locality is as follows:

	Durham & Darlington	Forensic	North Yorkshire	Teesside	Tier 4 CAMHS
1	Violence & Aggression (towards staff) ***114 incidents***	Violence & Aggression (towards staff) ***103 incidents***	Violence & aggression (towards staff) ***54 incidents***	Violence & aggression (towards staff) ***44 incidents***	Self-harming behaviour ***161 incidents***
2	Self-harming behaviour ***10 incidents***	Violence & aggression (towards patient) ***7 incidents***	Violence & aggression (towards patient) ***6 incidents***	Self-harming behaviour ***11 incidents***	Violence & aggression (towards staff) ***101 incidents***
3	Violence & aggression (towards patient) ***13 incidents***	Self-harming behaviour ***50 incidents***	Self-harming behaviour ***6 incidents***	Violence & aggression (towards patient) ***5 incidents***	AWOL (escape and abscond) ***14 incidents***
4	AWOL (Escape & Abscond) ***5 incidents***	Inappropriate behaviour (towards staff) ***4 incidents***	AWOL (escape and abscond) ***5 incidents***	Ill health (patient) ***4 incidents***	Violence & aggression (towards patient) ***4 incidents***
5	Inappropriate behaviour (towards staff) ***1 incident***	Struck an object ***3 incidents***	Near miss ***3 incidents***	Inappropriate behaviour (towards patient) ***3 incidents***	Equipment (patient) ***3 incidents***

The table above has highlighted that there were:

- 416 episodes as a result of violence and aggression towards staff
- 238 episodes as a result of self-harming behaviour
- 35 episodes as a result of violence and aggression towards patients

There were a total of 82 incidents that occurred during the reporting period where restraint type Prone was used. This can be broken down per service area as follows:

	June - July 2015		April – May 2015
	Incidents	Prone Used	Trend on Prone used in previous period
Adult Mental Health Services	35	12	↘ (22)
LD Services	73	8	↗ (2)
Forensic LD	25	2	↘ (4)
Forensic MH	151	13	↗ (8)
Tier 4 CAMHS	282	47	↗ (31)
	566	**82**	

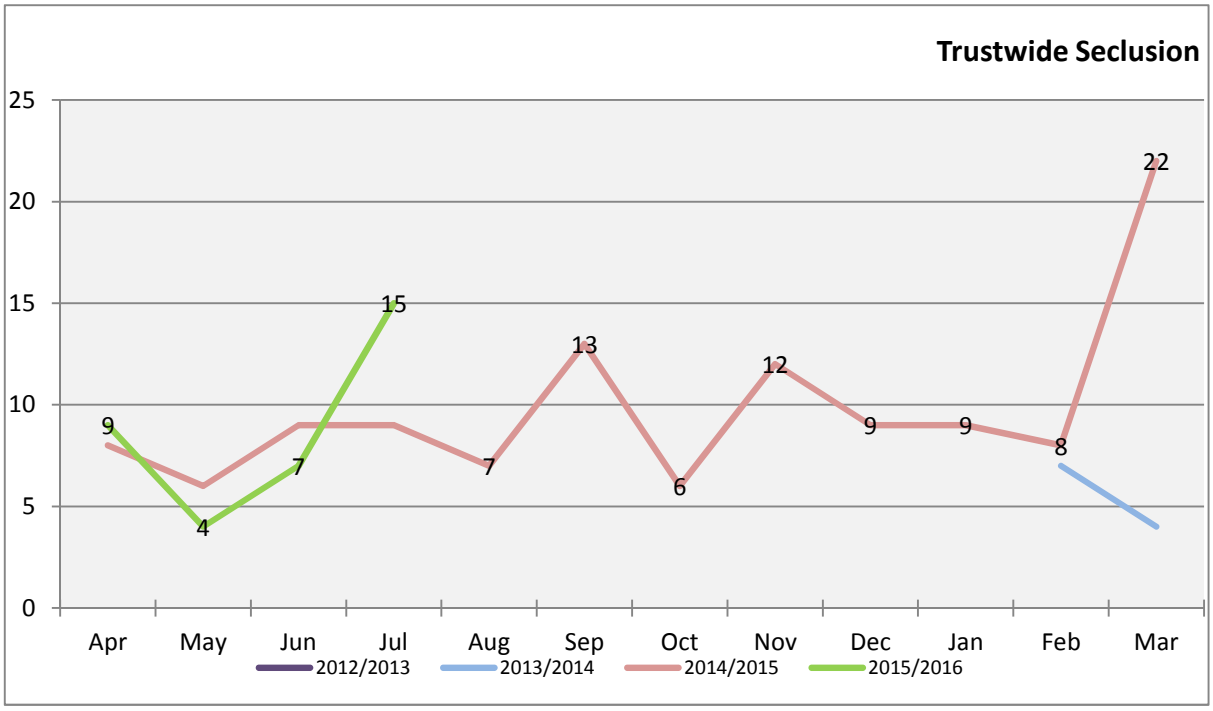
The Trust's Force Reduction project continue to focus on high users of Prone restraint although this relates to a small number of wards and individual patients within those wards and the various factors which may be contributing to this form part of the project remit.

The type of control or restraint used over the last 3 months can be found within the appendices of this report.

3.7 Seclusions

There have been 22 episodes of seclusion during the reporting period, an increase of 13 compared to the previous period (April – May 2015).

The graph below shows the number of episodes of seclusion that have occurred over the last 12 months:



During the reporting period there were 22 incidents during which seclusion was used;

Directorate	Ward	Number of occasions where Seclusion was used
Forensic Mental Health	Swift	6
	Kirkdale	2
	Merlin	2
	Jay	1
Forensic Learning Disabilities	Thistle	2
	Ivy	1
North Yorkshire AMH	Danby	3
Tier 4 CAMHS	Westwood	4
	Newberr	1

It is important to highlight that 7 episodes of seclusion lasted more than 24 hours. The table below identifies those episodes:

Directorate	Ward	Seclusion Hours	Report received over 24 hours
Forensic Mental Health	Swift Ward	46h 10m	Yes
		49h 37m	Yes
		39h 30m	Yes
		47h 50m	Yes
	Jay Ward	3 days 16hours	Yes
	Merlin Ward	67h 45m	No
	Kirkdale Ward	46h 5m	No

For full details of Seclusions in the reporting period please refer to the appendices.

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SECTION 4 – NEXT STEPS

4.0 Next Steps

We are committed to evolving our approach in this area and are taking a number of steps to improve such as:

- Receiving feedback in relation to the format of the report.
- Aligning a Quality Data Manager to each locality; this will allow closer working with our clinical services which will aid more detailed narratives being provided in future reports.
- Working closely with our corporate colleagues looking at ways of capturing data and responding to feedback.

Tees, Esk and Wear Valleys NHS Foundation Trust
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SECTION 5 – RECOMMENDATION

5.0 Recommendation

The Quality Assurance Committee are asked to:

- Receive assurance on the overall achievement on quality and performance indicators.
- Ongoing feedback on the narrative style report including any areas of development would be appreciated to ensure that the report meets the needs of the QuAC group.

Joanne Salvin
Quality Data Manager
August 2015

6.1 Level-4 Incidents (Reporting Calendar Month)

Locality	Service	Ward / Team	Incident Category
Durham and Darlington	CAMHS	CAMHS South Durham Tier 3	Self-harm
North Yorkshire	MHSOP	MHSOP Scarborough Cross Lane Rowan Lea	Self-harm
Durham and Darlington	MHSOP	MHSOP Easington Community	Fire (No death)
North Yorkshire	CAMHS Tier 3	CAMHS Harrogate	Self-harm
Durham and Darlington	AMH	AMH Sedgefield Affective Disorders	Attempted Homicide (Perpetrator)
North Yorkshire	AMH	AMH Ayckbourn Unit Esk Ward	Inappropriate Behaviour
Forensic	FMH	FMH Sandpiper Ward	Self-harm
Durham and Darlington	AMH	AMH Maple Ward	Unexpected Death (Inpatient)
North Yorkshire	MHSOP	MHSOP Harrogate Briary Rowan	Other
North Yorkshire	AMH	AMH HHR Early Intervention Psychosis	Self-harm
North Yorkshire	CAMHS Tier 4	CAMHS West Lane Hospital Westwood Centre	Violence & Aggression
Durham and Darlington	AMH	AMH Crisis and Recovery House	Self-harm

6.2 Complaints (Reporting Calendar Month)

Locality	Service	Ward/Team	DATIX ID	First received	Subject (primary)	Sub-subject (primary)	Description	Outcome
Durham & Darlington	AMH	AMH Derwentside & CLS Affective Disorders	1250	01/06/2015	Clinical Care	Discharge	Patient raised concerns about their discharge from the CMHT and about the negative attitude of the CMHT Manager at a meeting.	Ongoing
Teesside	AMH	AMH Hartlepool Psychosis	1249	01/06/2015	Clinical Care	Treatment and Care	Concerns raised by patient about care and treatment whilst an inpatient and from staff within the Psychosis Team.	Ongoing
Teesside	AMH	AMH R&C Access	1251	10/06/2015	Clinical Care	Treatment and Care	Concerns raised about lack of secondary care received following an assessment	Complaint not upheld.
Durham & Darlington	AMH	AMH IP WPH Eating Disorders	1252	11/06/2015	Clinical Care	Care Planning	Patient considers the care received is unjust and unfair	Complaint withdrawn. No further action.
Forensic	LD	FLD RP Hawk Ward	1254	12/06/2015	Clinical Care	Medication	Patient raised a number of concerns with the Care Quality Commission (CQC) relating to medication and contact with nursing staff on the ward. CQC requested a response to the complaint.	Response sent from the Head of Service responding to each of the concerns raised. Complaint not upheld.
Durham & Darlington	AMH	AMH Wear Dales Affective Dis	1257	15/06/2015	Attitude	Other Staff	Concerns raised about a member of staff's attitude	Ongoing
North Yorkshire	AMH	AMH SWR Crisis Resolution	1259	15/06/2015	Clinical Care	Request for help for deteriorating mental health	Relative raised concerns in relation patient's deteriorating mental health.	Ongoing
Teesside	MHSOP	MHSOP RP Westerdale South	1256	15/06/2015	Clinical Care	Treatment and Care	Complaint about aspects of clinical care given to relative	Ongoing
Teesside	MHSOP	MHSOP Tees Intenve Com Liaison	1255	15/06/2015	Clinical Care	Medication	Concerns about relative's medication.	Ongoing
Durham & Darlington	AMH	AMH Derwentside & CLS Affective Disorders	1258	16/06/2015	Clinical Care	Continuity of Care	Complaint about failure of duty of care to patient and relative.	Ongoing

Teesside	AMH	AMH Lustrum Vale (24 hour Nursed Care Services)	1260	16/06/2015	Communication	Involvement of Carers	North of England Commissioning Support (NECS) referred a complaint that had been raised relating to escorting of a carer with a patient. Agreed would investigate and respond to carer with NECS copied in.	Ongoing
North Yorkshire	CAMHS Tier 4	CAMHS IP WLH Newberry Centre	1261	17/06/2015	Clinical Care	Treatment and Care	Concerns raised of relatives treatment at the Newberry Centre.	Ongoing.
Durham & Darlington	AMH	AMH Sedgefield Affective Dis	1262	19/06/2015	Clinical Care	Waiting Times/Cancelled appointment	Delay in referral.	Ongoing
Durham & Darlington	CYPS	CAMHS North Durham Community	1264	23/06/2015	Communication	Inadequate Information Received	Concerns regards to lack of communication from the team.	Complaint Upheld. Actions Plan required.
Durham & Darlington	AMH	AMH S Durham Darlington Liaison Psychiatry	1263	24/06/2015	Attitude	Nursing Staff Negative	Rudely spoken to in assessment.	Ongoing.
North Yorkshire	AMH	AMH Harrogate Community	1266	25/06/2015	Clinical Care	Treatment and Care	Concerns about contact with the CMHT	Ongoing
Durham & Darlington	MHSOP	MHSOP Derwentside CH Liaison	1268	26/06/2015	Clinical Care	Assessment	Unhappy with an assessment and the report which was sent to GP.	Ongoing
Teesside	CAMHS	CAMHS Stockton Community	1265	29/06/2015	Clinical Care	Disagree with diagnosis	Concerns raised about length of time taken to diagnose relative.	Ongoing
Forensic	MH	FMH RP Jay Ward Low Sec Male	1267	30/06/2015	Clinical Care	Treatment and Care	Carer has raised concerns about communication and specific aspects of patients care and treatment.	Ongoing
Teesside	AMH	AMH RP PICU	1269	01/07/2015	Clinical Care	Physical Medical Care	Relative raised concerns about levels of communication during a patient's transfer and regarding aspects of care and treatment.	Ongoing
Teesside	AMH	AMH Mboro Crisis Resolution	1272	02/07/2015	Attitude	Nursing Staff Negative	Patient unhappy with the attitude of a member of staff from the Team.	Ongoing

North Yorkshire	MHSOP	MHSOP Scarborough Community	1270	03/07/2015	Clinical Care	Medication	Concerns about aspects of relatives care and treatment, including medication	Ongoing
North Yorkshire	AMH	AMH SWR Crisis Resolution	1273	06/07/2015	Clinical Care	Treatment and Care	Concerns about lack of support from Crisis Team and lack of explanation as to why the patient cannot be seen at home.	Ongoing
Forensic	LD	FLD RP Hawthorne Ward	1274	06/07/2015	General Advice	Human Rights	Patient was prevented from using the telephone whilst an inpatient which prevented them from claiming benefits they were entitled.	Ongoing
Durham & Darlington	AMH	AMH Wear Dales Affective Dis	1271	06/07/2015	Clinical Care	Discharge	Disagrees with decision to discharge and feels that support is still required.	Ongoing
Teesside	CAMHS	CAMHS Stockton Community	1275	09/07/2015	Clinical Care	Disagree with diagnosis	Parent raised concerns regarding diagnosis of child and lack of support by CAMHS.	Ongoing
Durham & Darlington	AMH	AMH Derwentside & CLS Affective Disorders	1276	09/07/2015	Clinical Care	Lack of contact	Relative of deceased patient contacted following receipt of serious incident report with request for explanations and a financial remedy.	Ongoing
North Yorkshire	AMH	AMH Harrogate Community	1277	14/07/2015	Clinical Care	Treatment and Care	Concerns about relative's contact with Care Coordinator and comments made about their care.	Ongoing
Durham & Darlington	CYPS	CAMHS South Durham Tier 3	1278	14/07/2015	Clinical Care	Continuity of Care	Lack of support and help from team and a delay in referral.	Ongoing
Teesside	AMH	AMH RP Stockdale Ward	1281	14/07/2015	General Advice	General Information	Concerns raised that patient could not have a glass of water to take medication and it was therefore documented that patient refused medication.	Contacted patient to check their address following discharge from hospital and they confirmed they did not wish to pursue their complaint and ask for all information to be destroyed.

North Yorkshire	AMH	MHSOP IP Scarborough Rowan Lea	1282	17/07/2015	Clinical Care	Assessment	Relative has raised concern regarding relative who had been subject to extremely poor care and negligence during his stay in Rowan Lea, Scarborough.	Ongoing
Teesside	AMH	AMH Stockton Affective Dis	1283	17/07/2015	Discharge Arrangements	Discharge Planning	Relatives have raised concerns regarding the current discharge support package offered to patient.	Ongoing
Forensic	LD	FLD RP Robin Ward	1279	17/07/2015	Clinical Care	Transfer	Complaint received via patient's Independent Mental Health Advocate (IMHA) relating to aspects of care whilst on the ward and a request to be transferred to a place nearer to the family home.	Ongoing
Teesside	CAMHS	CAMHS Mboro Community	1280	17/07/2015	Clinical Care	Assessment	Concerns raised that relative has not been given a complete assessment.	Ongoing
Teesside	AMH	AMH Tees Primary Care	1284	21/07/2015	Clinical Care	Treatment and Care	Patient unhappy with the action taken by CPN regarding comments made that were then reported to the police made and unhappy that care has been withdrawn.	Ongoing
Durham & Darlington	AMH	AMH LRH Tunstall Ward	1285	21/07/2015	Clinical Care	Care Planning	Family raised concerns about patient not being able to be admitted to LRH due to needs of specialist bed and therefore admitted out of area	Ongoing
North Yorkshire	AMH	AMH Ham&Rich East Community	1286	23/07/2015	Clinical Care	Continuity of Care	Relatives have raised further concerns regarding the delays in decisions of the patients care.	Ongoing
North Yorkshire	AMH	AMH SWR Ayckbourn Unit	1287	27/07/2015	Attitude	Nursing Staff Negative	Patient raised concern about a member of staffs attitude	Ongoing

Teesside	LD	ALD Bankfields Court 4	1288	28/07/2015	Attitude	Nursing Staff Negative	Concerns raised about attitude of members of staff from Crisis Team and Community Team.	Ongoing
Teesside	AMH	AMH R&C Crisis Resolution	1289	29/07/2015	Clinical Care	Treatment and Care	Patient has raised concerns regarding poor care received from Foxrush Crisis Team and Overdale Ward, Roseberry Park.	Ongoing
North Yorkshire	AMH	AMH Harrogate Primary Care	1290	30/07/2015	Clinical Care	Assessment	Patient unhappy with the assessment and the decision not to accept into services.	Ongoing

6.3 Control and Restraint

The type of control or restraint used (may be more than one per incident) over the last 3 months (April to June) is as follows:

Trustwide (Apr-Jun)	Number of Incidents	Type of Control or Restraint Used (May be more than one per incident)																	Total Controls or Restraints used
Locality/Speciality Area		PRO	SUP	SEC	ERC	ERB	SBB	SCH	AWH	AFT	AFF	BDK	BCG	BWG	BBW	BHP	BST	TES	TNL	
Durham & Darlington AMH	60	10	12				5	5	33	3	16	3							9	**96**
Durham & Darlington LD Services	53	6	4					2	35	1	3	8	4	3		5	2		2	**75**
Durham & Darlington MHSOP	113		3					2	105		4	17	1	2					2	**136**
Forensic LD	61	4	8	3	1		12	8	35	7	18	6		3					2	**107**
Forensic MH	140	11	56	1	6			19	55	9	59	1		2					3	**222**
North Yorkshire AMH	46	12	4					15	23	5	23	4	1	1			1		3	**92**
North Yorkshire MHSOP	73		1					5	39	2	25	9	2	2					6	**91**
North Yorkshire CAMHS T4	410	52	122	3		1	174	23	236	16	123	3				1	1		17	**772**
Teesside AMH	64	6	12	2				9	40	1	13	1	1	1			1		8	**95**
Teesside CYPS	1																		1	**1**
Teesside LD Services	70		13				22	2	43	2	1	4	6	8		1	1		3	**106**
Teesside MHSOP	11		1					2	9		1	1		1						**15**
Grand Total	**1102**	**101**	**236**	**9**	**7**	**1**	**213**	**92**	**653**	**46**	**286**	**57**	**15**	**23**	**0**	**7**	**6**	**0**	**56**	**1808**

6.4 Seclusions (Reporting Calendar Month

Locality	Service	Ward / Team	MHA Section	Date Commenced	Time	Date Concluded	Time	Time in Seclusion (hours:minutes)	Report Received over 24hr
North Yorkshire	CAMHS Tier 4	Newberry	2	02/06/2015	21.30	02/06/2015	22.30	1hr	
Forensic	LD	Thistle	3	08/06/2015	11.50	08/06/2015	19.25	7h 35m	N/A
Forensic	MH	Swift	37/41	13/06/2015	13.50	15/06/2015	15.00	46h 10m	Yes
Forensic	LD	Thistle	37/41	20/06/2015	12.30	21/06/2015	03.11	4h 41m	
Forensic	MH	Swift	37/41	25/06/2015	20.00	26/06/2015	14.45	18H45M	Yes
North Yorkshire	CAMHS Tier 4	Westwood	3	30/06/2015	18.30	30/06/2015	20.05	1h 35m	
North Yorkshire	CAMHS Tier 4	Westwood	3	30/06/2015	20.35	30/06/2015	20.50	15m	
Forensic	MH	Jay	3	05/07/2015	18.00	09/07/2015	10.00	3d 16h	Yes
North Yorkshire	AMH	Danby	2	06/07/2015	18.40	06/07/2015	20.30	1h 50m	
North Yorkshire	AMH	Danby	2	07/07/2015	04.45	07/07/2015	12.20	7h 40m	
Forensic	MH	Merlin	3	09/07/2015	15.50	23/07/2015	14.30		Yes
Forensic	MH	Swift	37/41	10/07/2015	19.30	11/07/2015	13.35	18h	Yes
Forensic	MH	Swift	37/41	13/07/2015	17.38	15/07/2015	18.15	49h37m	Yes
North Yorkshire	AMH	Danby	2	13/07/2015	04.55	13/07/2015	12.50	7h 55m	
Forensic	MH	Kirkdale	3	18/07/2015	14.59	20/07/2015	13.05	46h 5m	No
North Yorkshire	CAMHS Tier 4	Westwood	3	20/07/2015	21.40	20/07/2015	22.53	1h 13m	
Forensic	MH	Merlin	CP(I)	21/07/2015	17.30	24/07/2015	13.15	67h 45m	No
Forensic	MH	Swift	37N	22/07/2015	21.00	24/07/2015	12.30	39h 30m	Yes
Forensic	MH	Swift	37/41	22/07/2015	16.00	24/07/2015	15.10	47h 50m	Yes
North Yorkshire	CAMHS Tier 4	Westwood	3	24/07/2015	20.50	24/07/2015	22.10	1h 20m	
Forensic	MH	Kirkdale	3	26/07/2015	10.15				Yes
Forensic	LD	Ivy	3	30/07/2015	16.37	30/07/2015	18.44	2h 7m	

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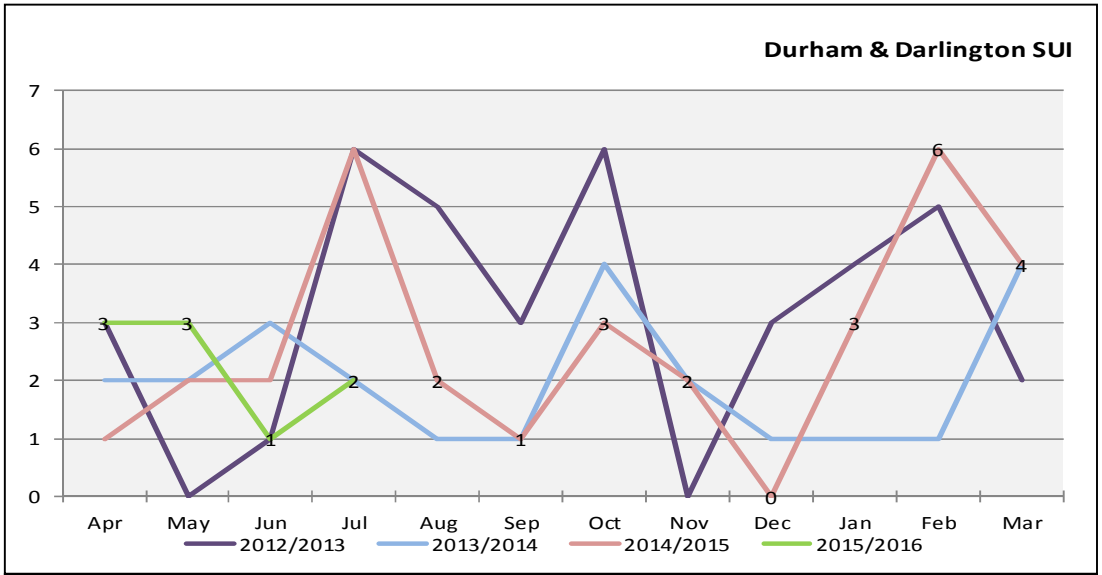
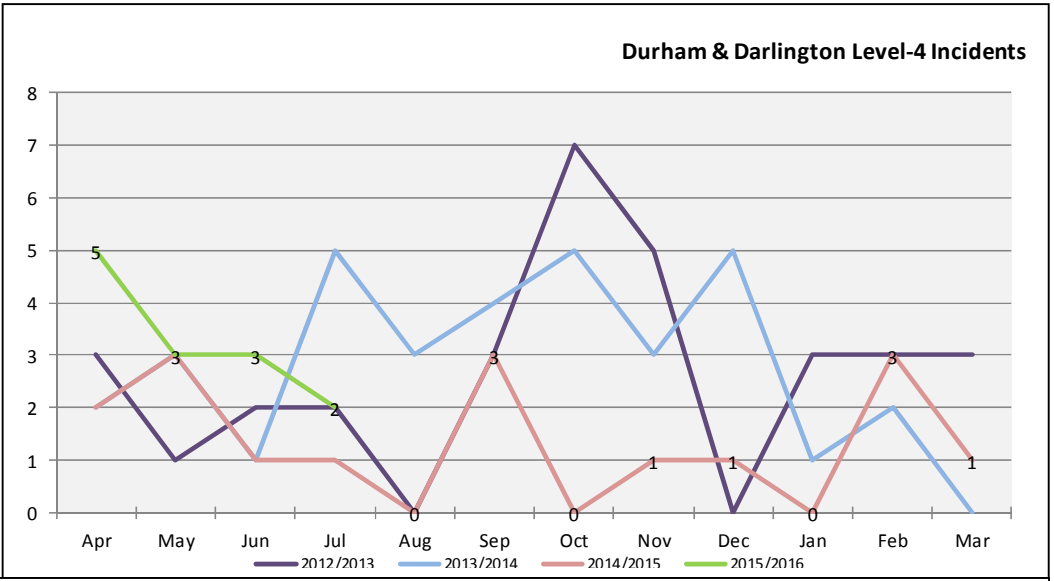
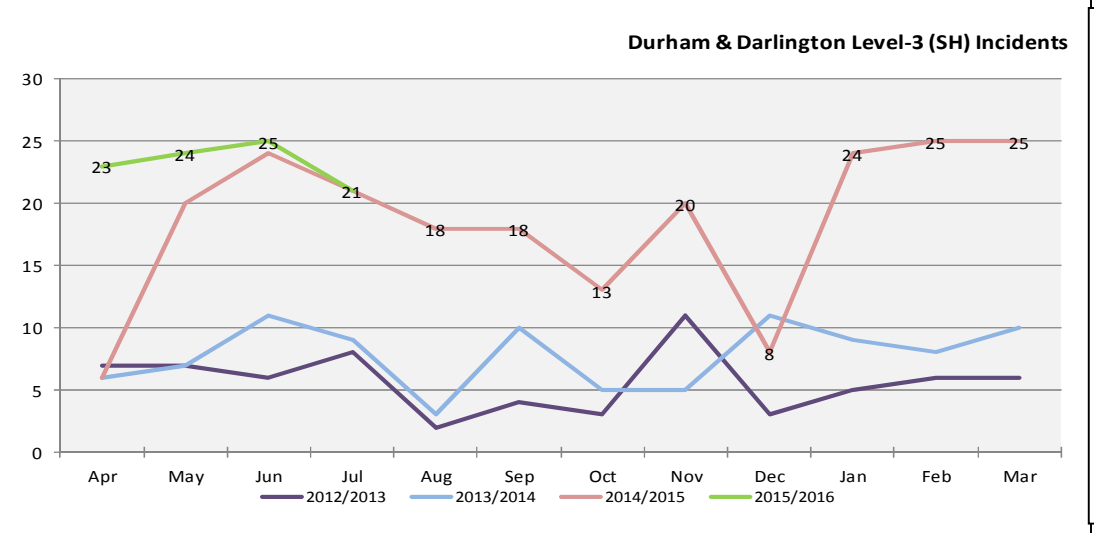
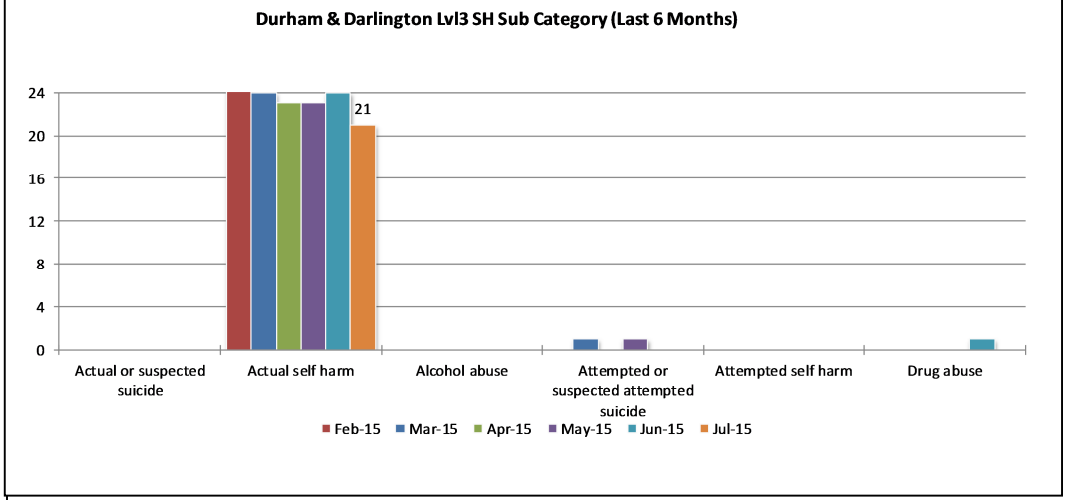
SECTION 7 – APPENDICES BY LOCALITY

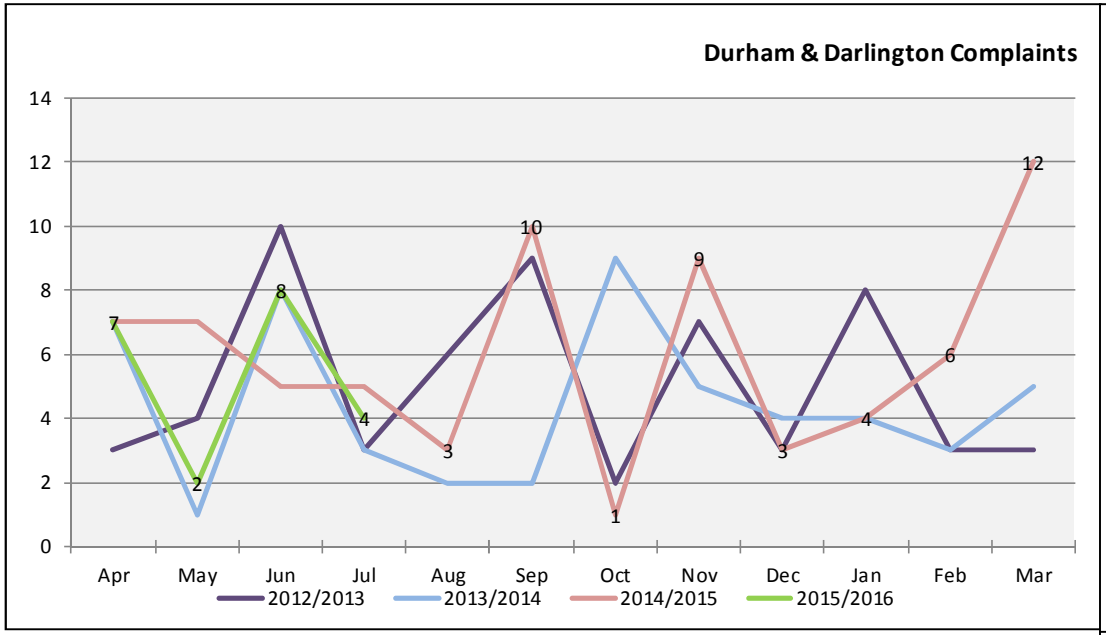
Durham & Darlington

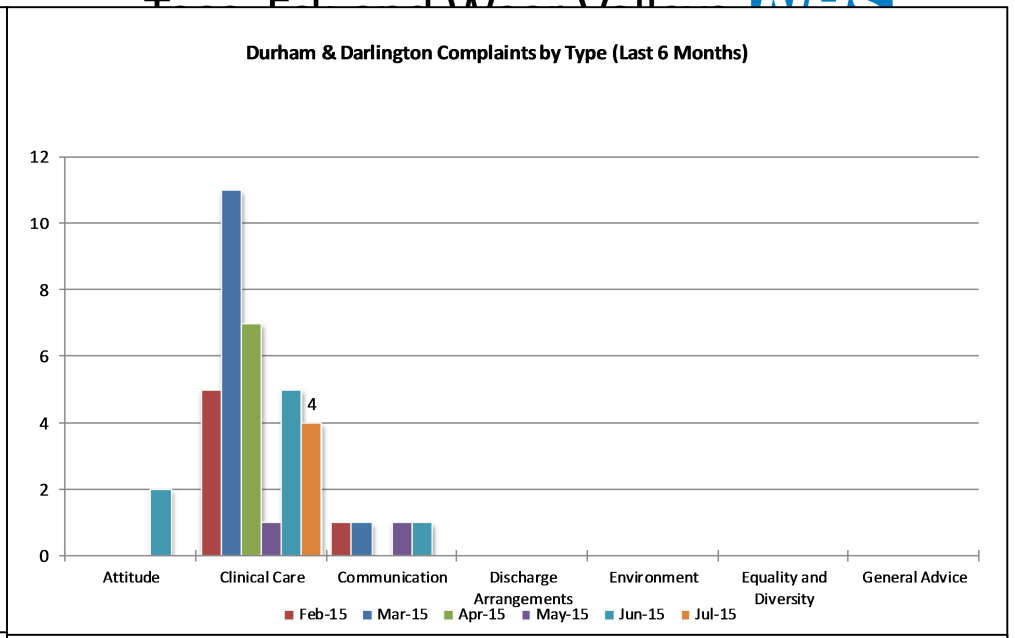


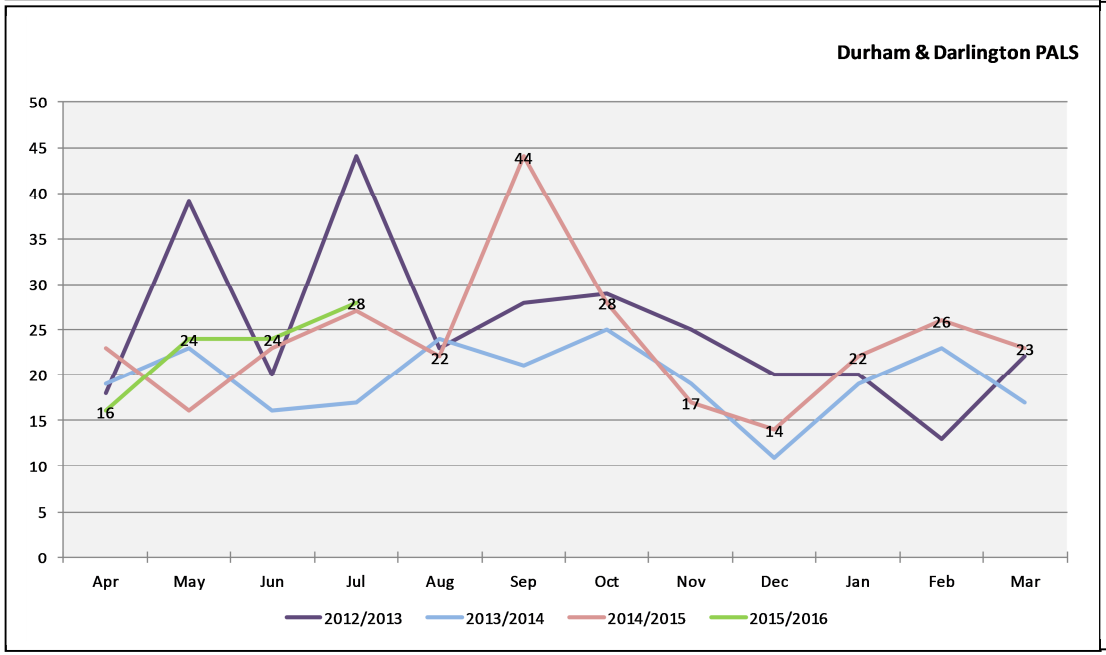


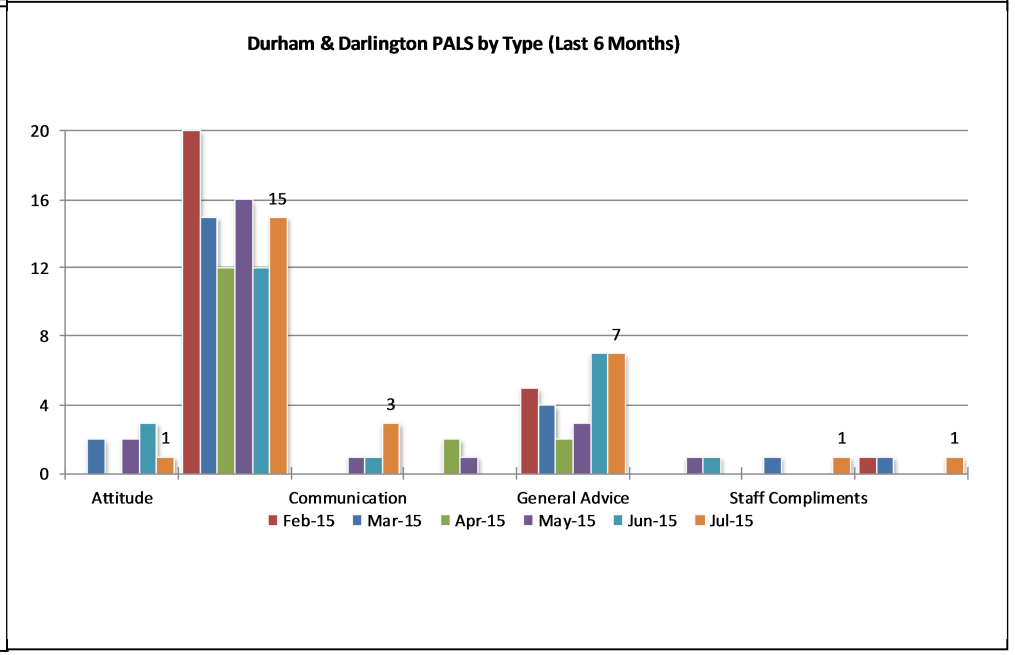





Durham & Darlington Complaints
14
12
10
8
6
4
2
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2012/2013
2013/2014
2014/2015
2015/2016

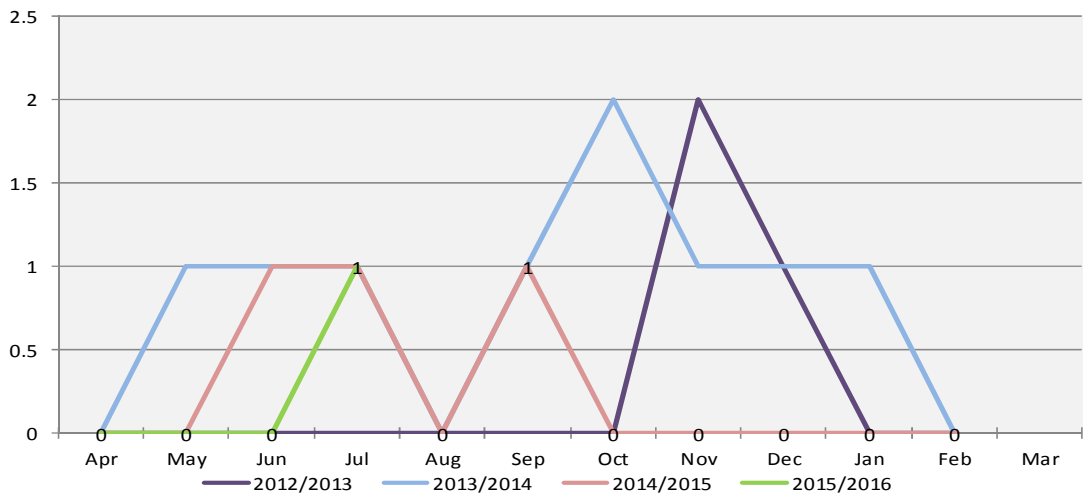

Durham & Darlington Complaints by Type (Last 6 Months)
12
10
8
6
4
2
0
Attitude
Clinical Care
Communication
Discharge Arrangements
Environment
Equality and Diversity
General Advice
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15


Durham & Darlington PALS
50
45
40
35
30
25
20
15
10
5
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2012/2013
2013/2014
2014/2015
2015/2016

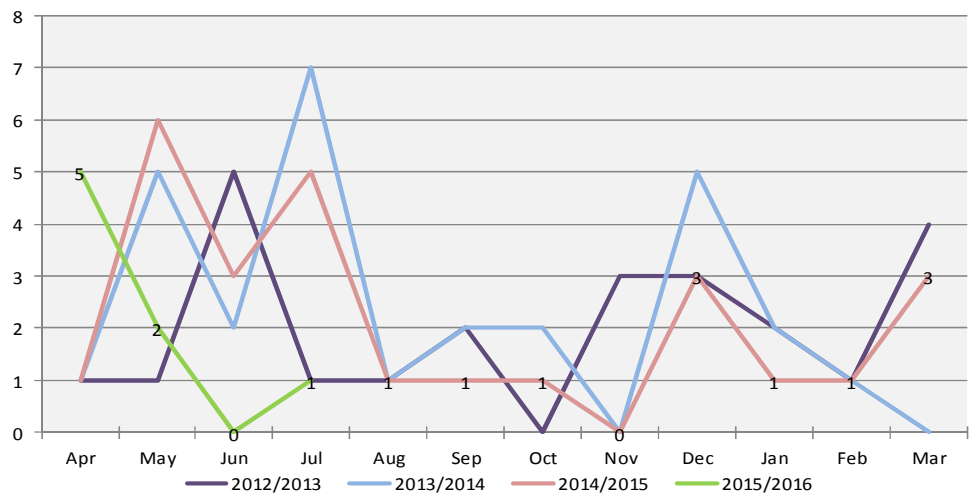

Durham & Darlington PALS by Type (Last 6 Months)
20
16
12
8
4
0
Attitude
Communication
General Advice
Staff Compliments
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15

Forensic

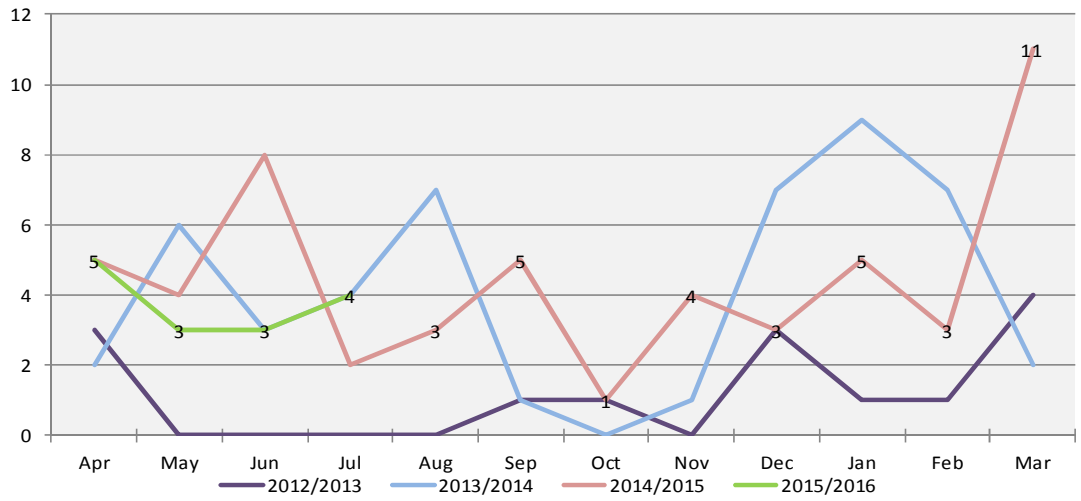
Forensic SUI



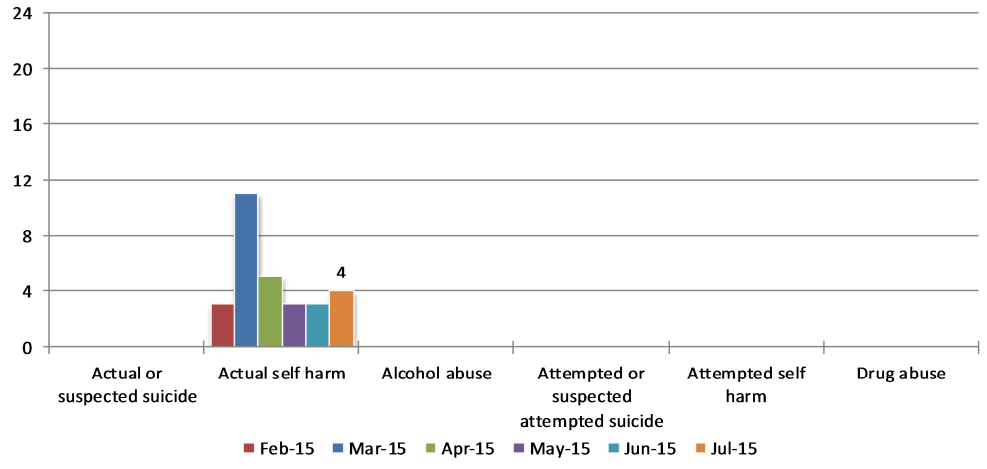
Forensic Level-4 Incidents

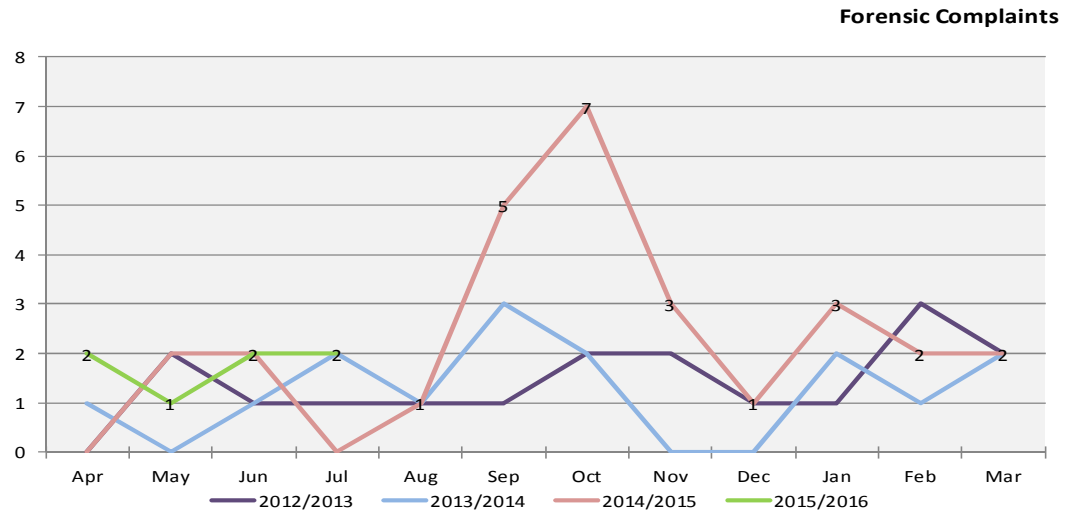


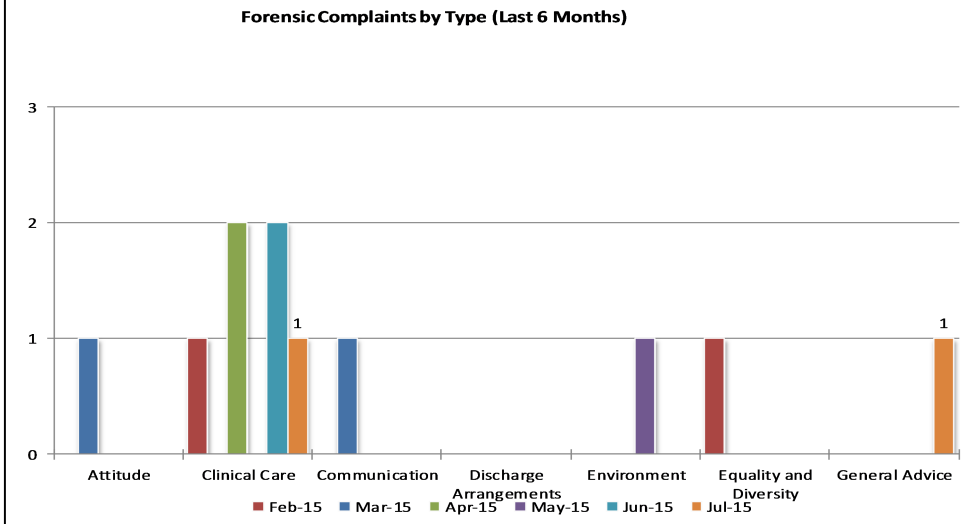
Forensic Level-3 (SH) Incidents

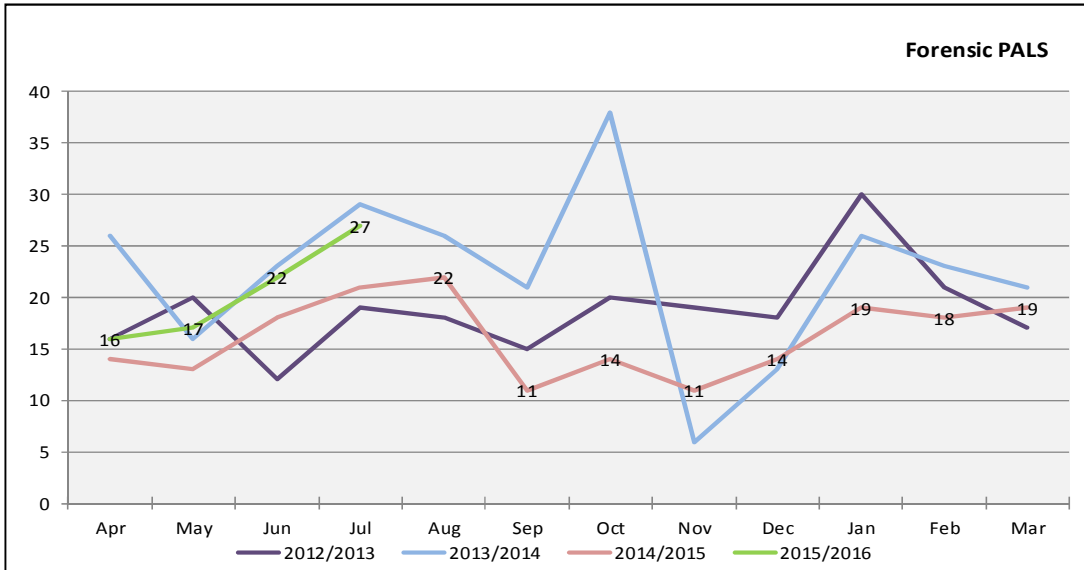


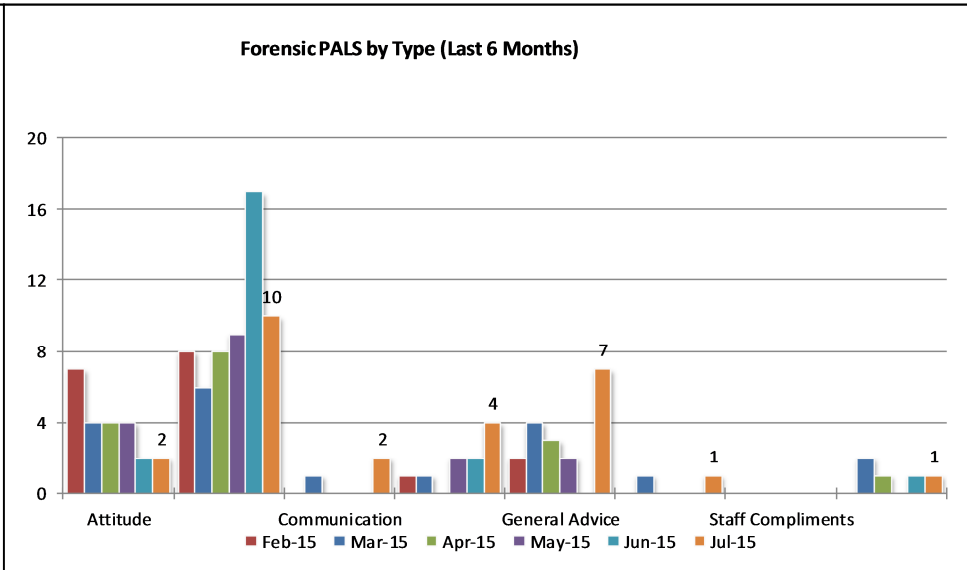
Forensic Lvl3 SH Sub Category (Last 6 Months)



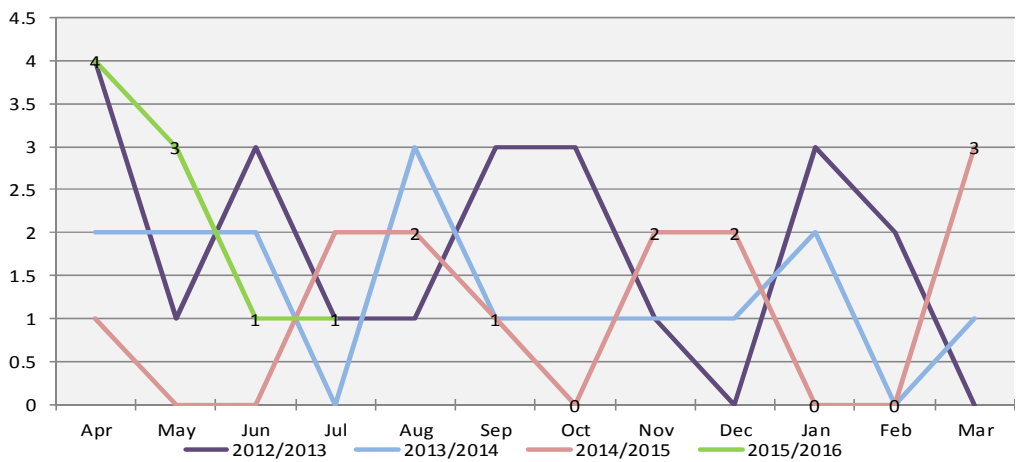

Forensic Complaints
8
7
6
5
4
3
2
1
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2012/2013
2013/2014
2014/2015
2015/2016

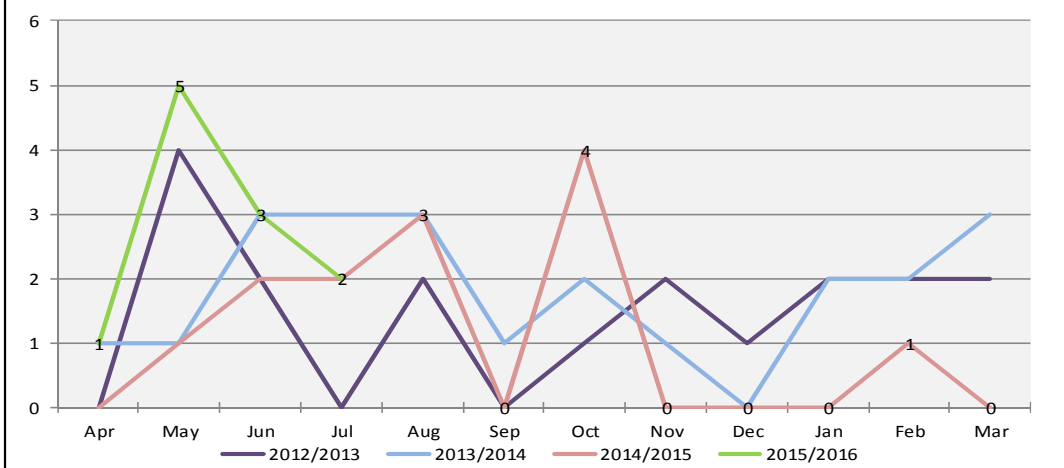

Forensic Complaints by Type (Last 6 Months)
3
2
1
0
Attitude
Clinical Care
Communication
Discharge Arrangements
Environment
Equality and Diversity
General Advice
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15

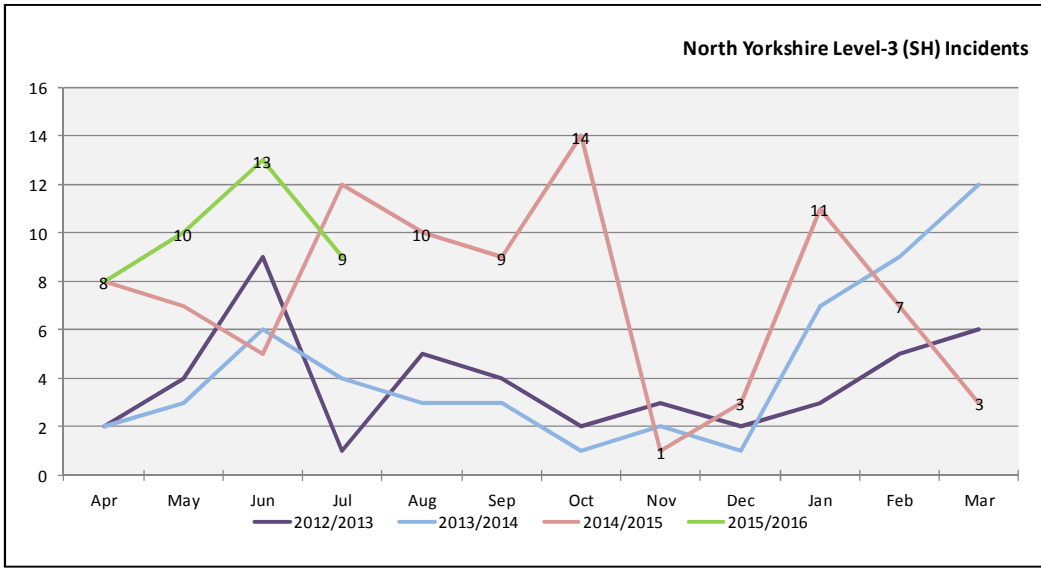

Forensic PALS
40
35
30
25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2012/2013
2013/2014
2014/2015
2015/2016

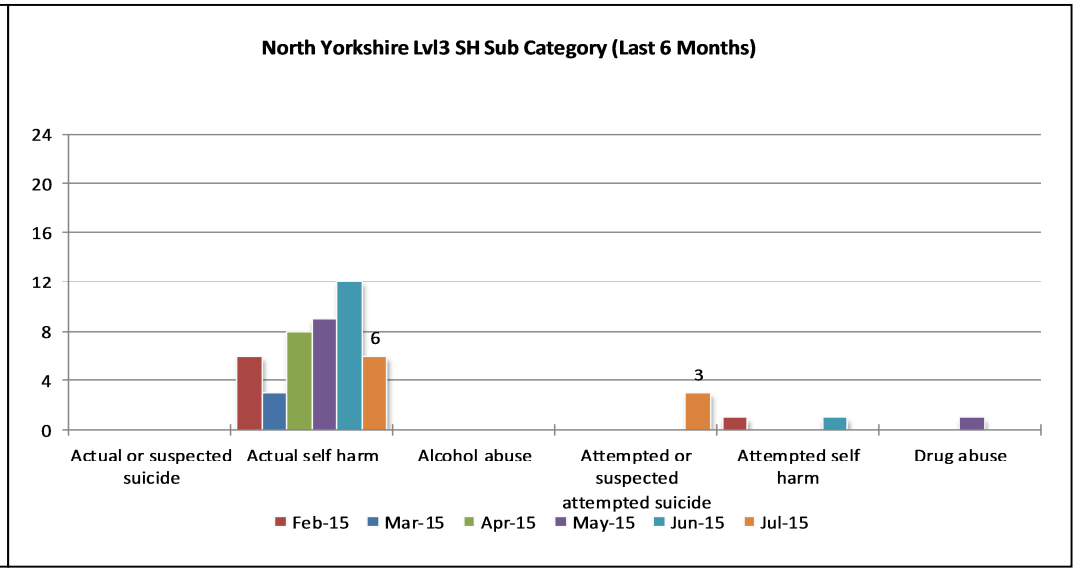

Forensic PALS by Type (Last 6 Months)
20
16
12
8
4
0
Attitude
Communication
General Advice
Staff Compliments
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15

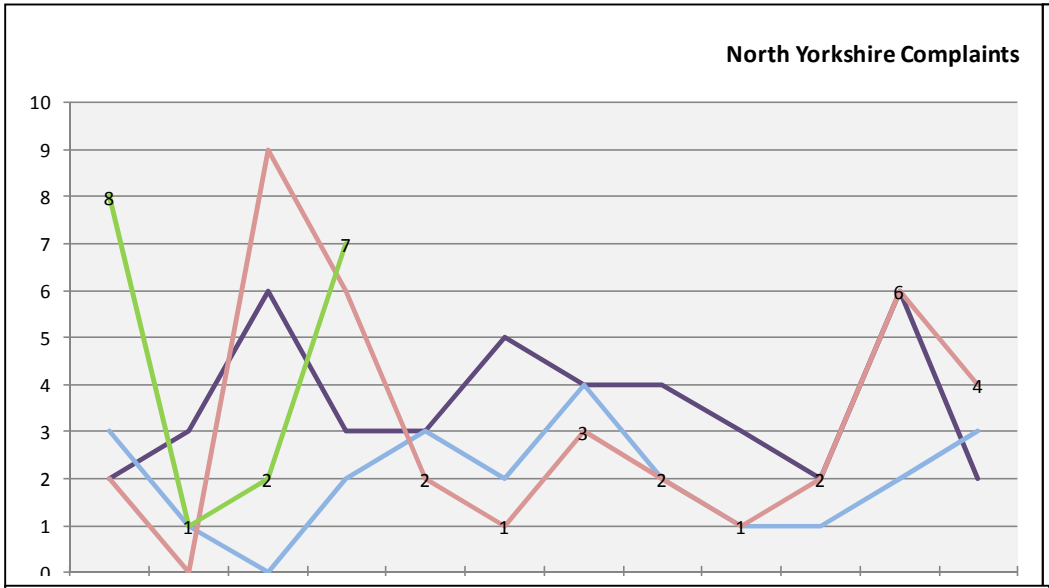
North Yorkshire

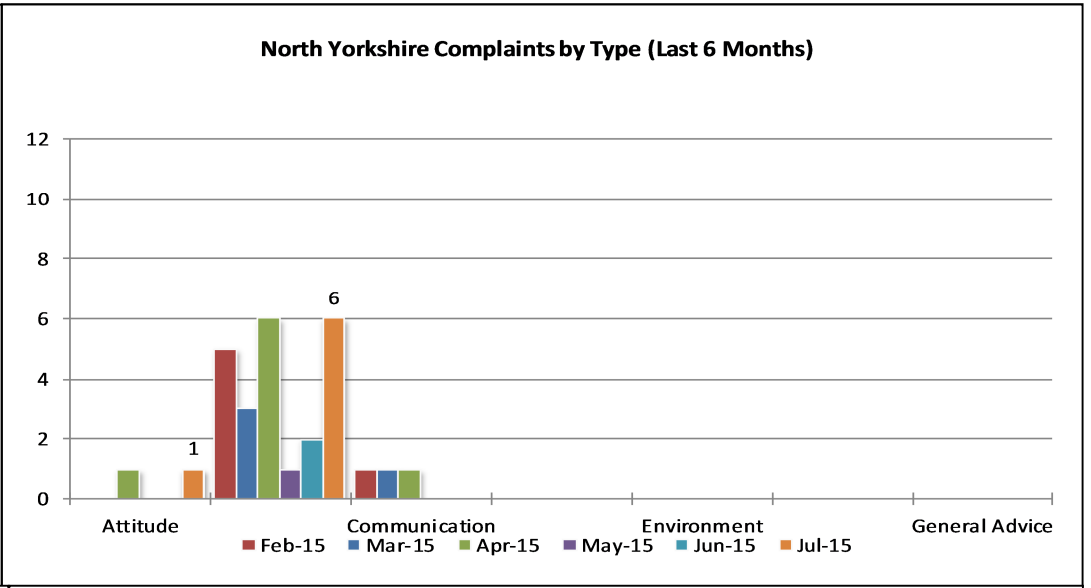


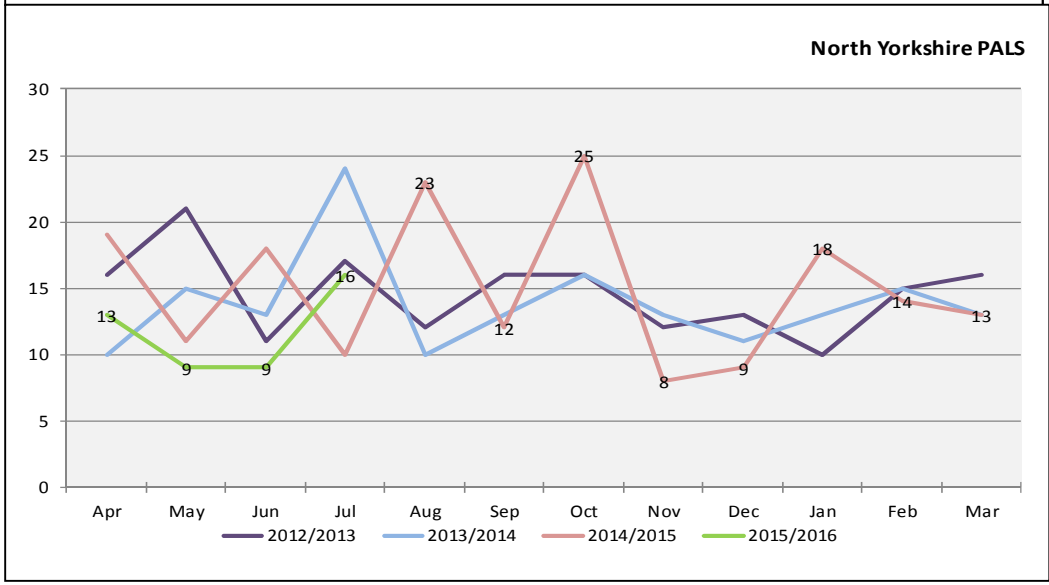


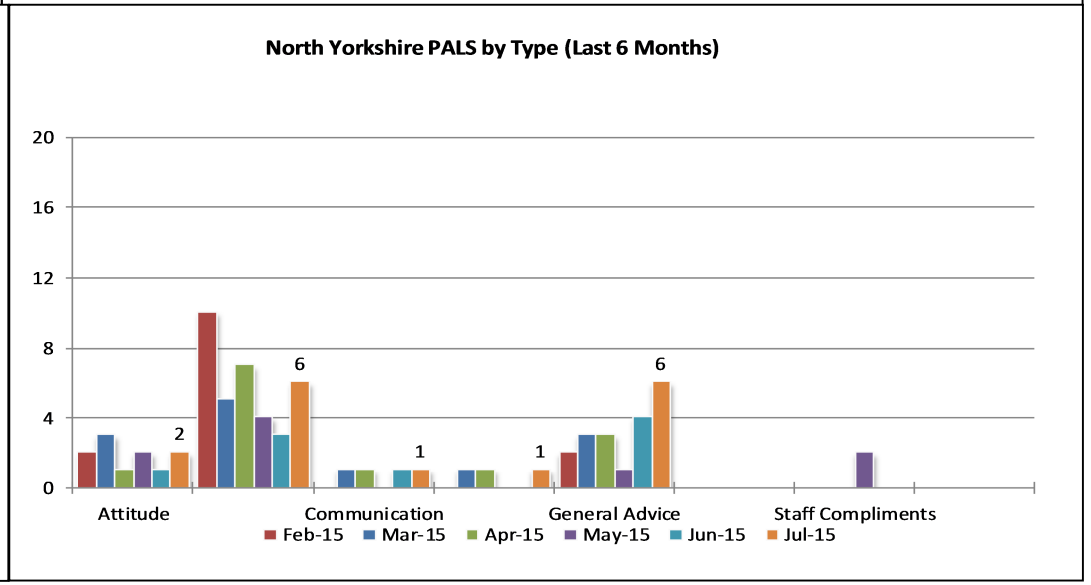





North Yorkshire Complaints
10
9
8
7
6
5
4
3
2
1
0
8
1
2
7
2
1
3
2
1
2
6
4

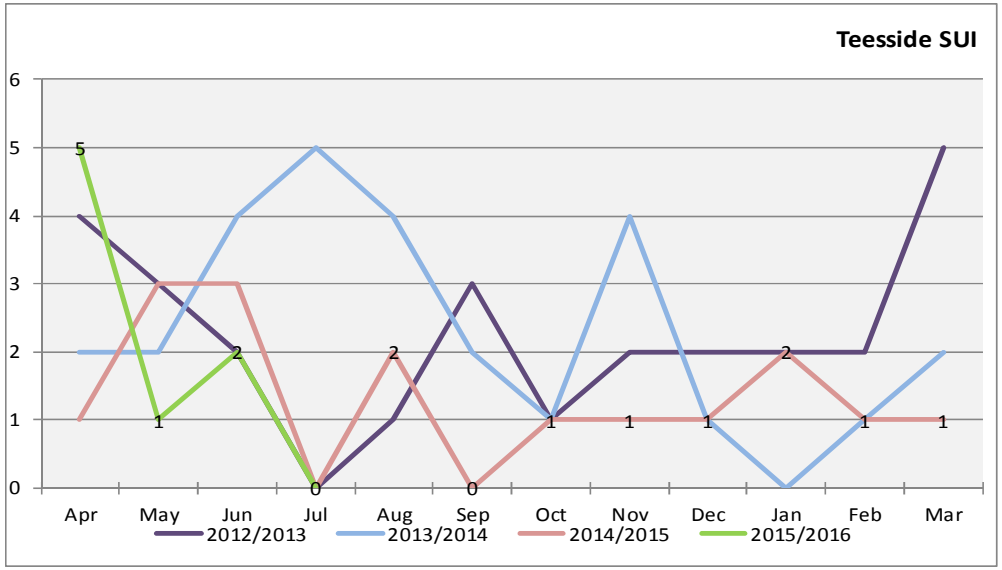

North Yorkshire Complaints by Type (Last 6 Months)
12
10
8
6
4
2
0
1
6
Attitude
Communication
Environment
General Advice
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15

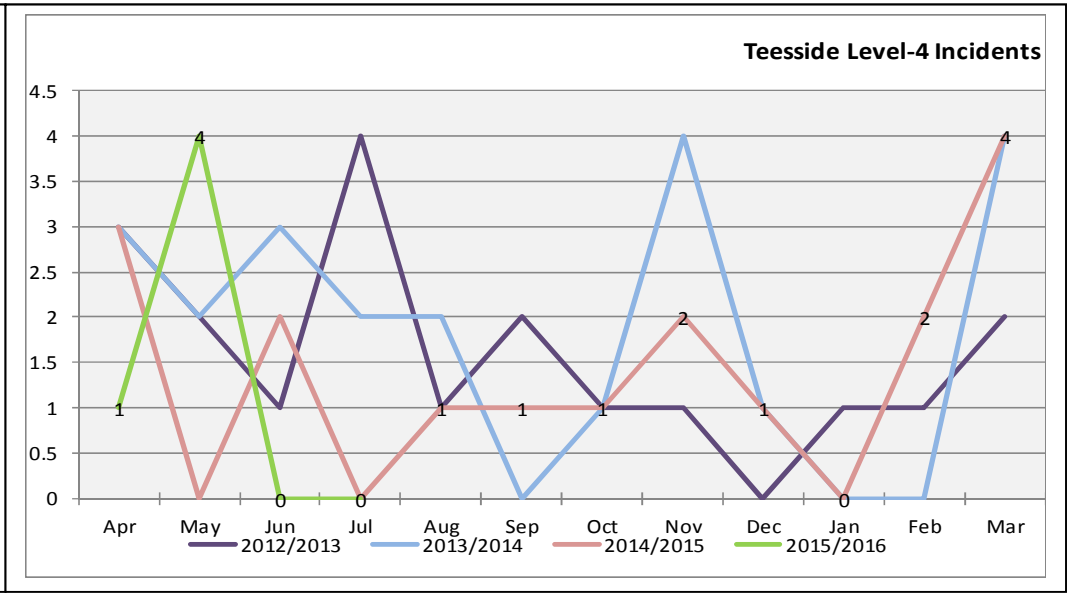

North Yorkshire PALS
30
25
20
15
10
5
0
13
9
9
16
23
12
25
8
9
18
14
13
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2012/2013
2013/2014
2014/2015
2015/2016

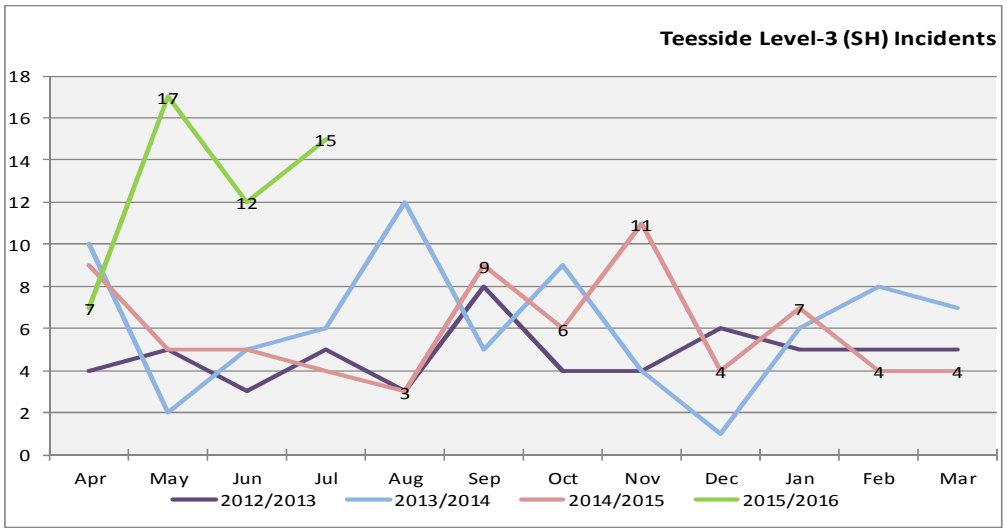

North Yorkshire PALS by Type (Last 6 Months)
20
16
12
8
4
0
2
6
1
1
6
Attitude
Communication
General Advice
Staff Compliments
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15

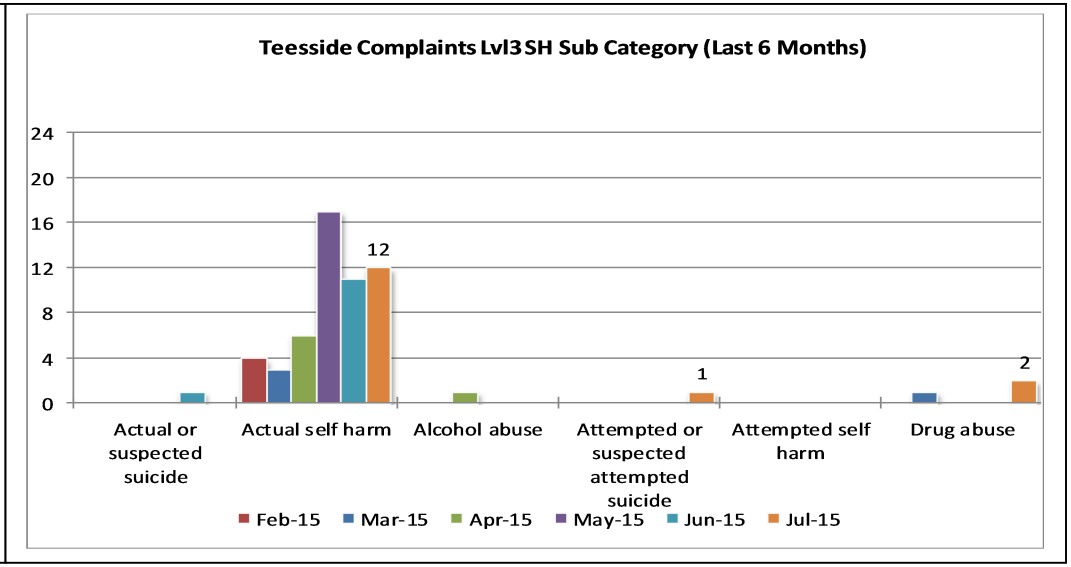
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

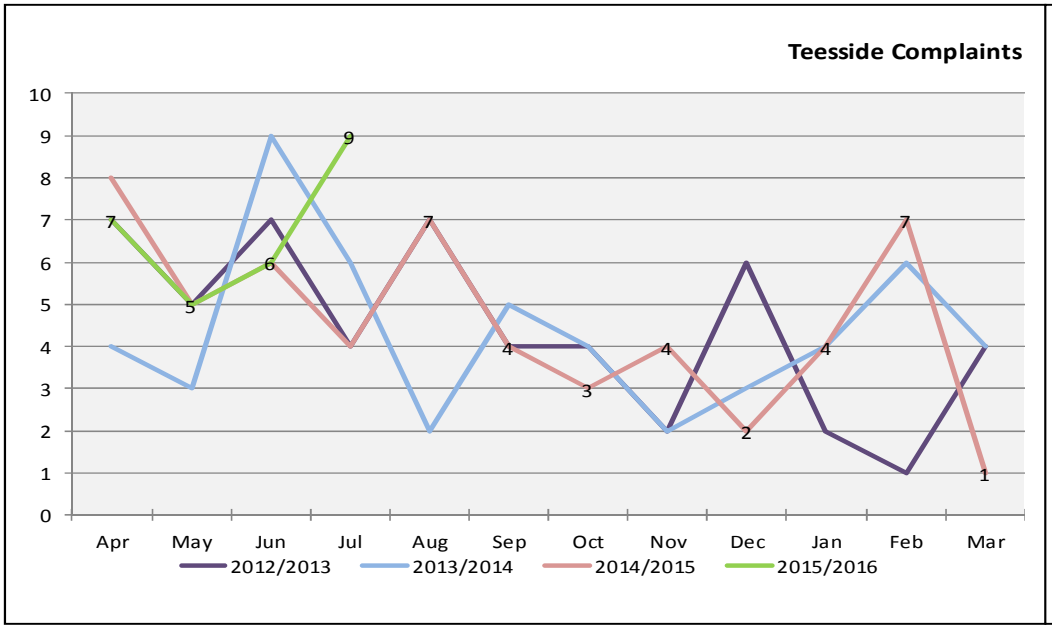
Teesside

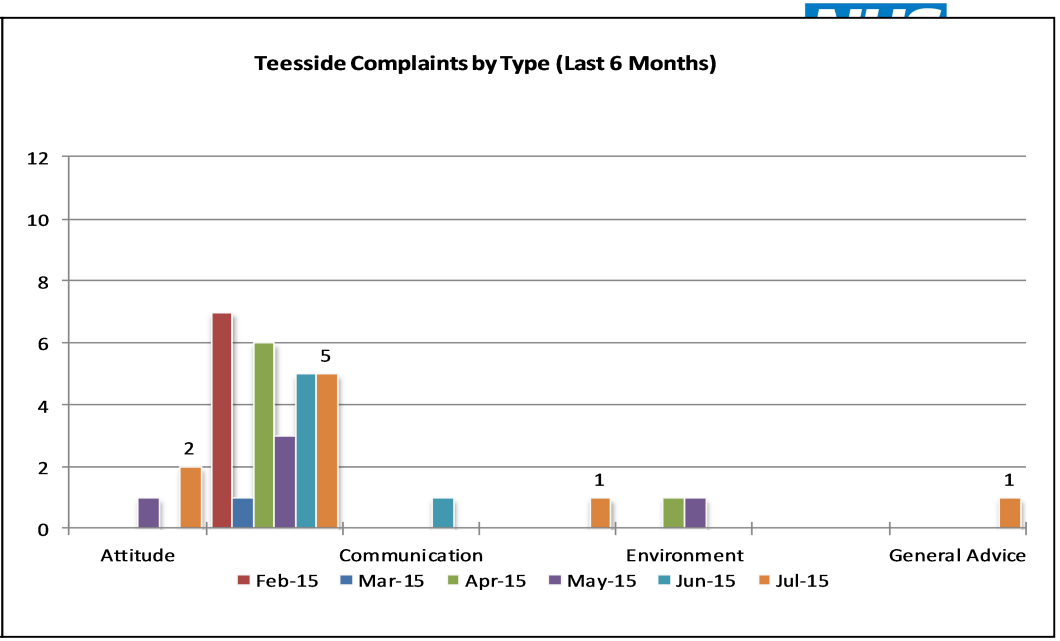


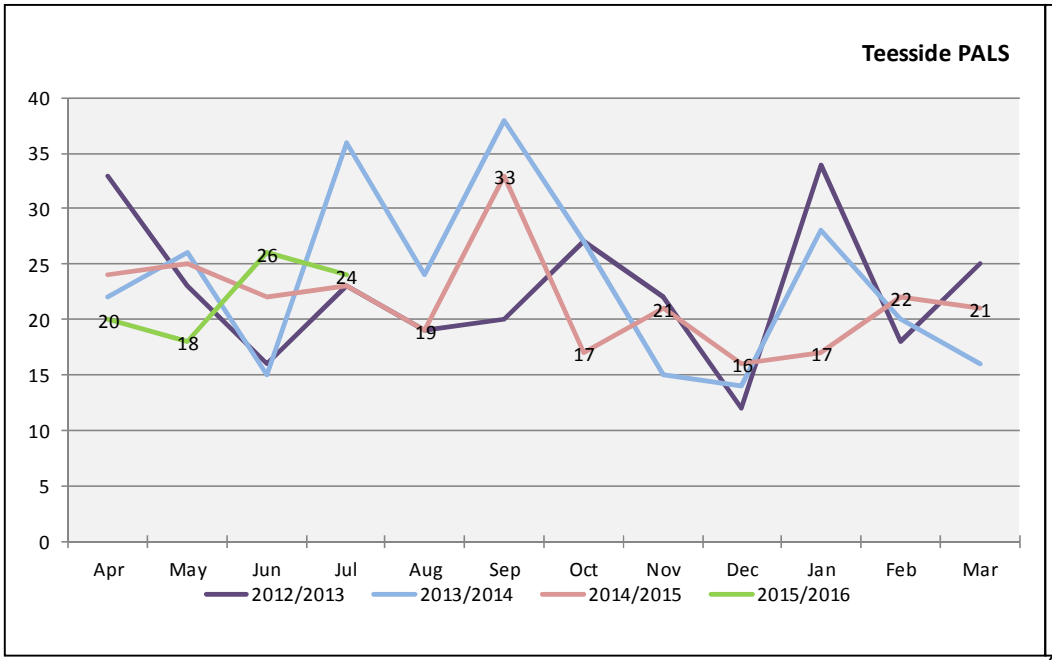


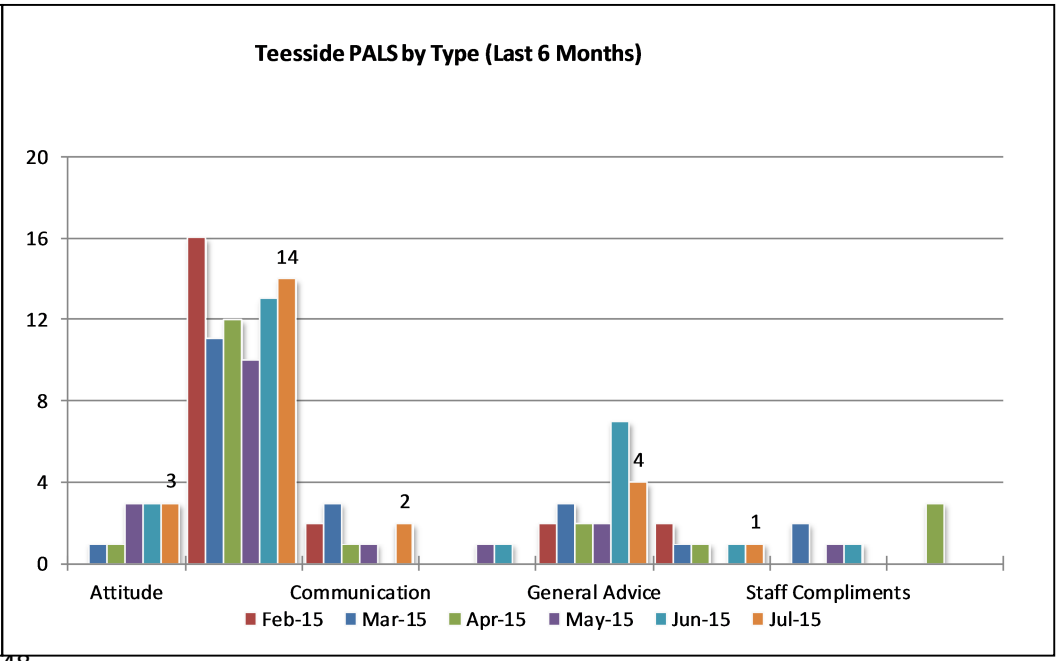




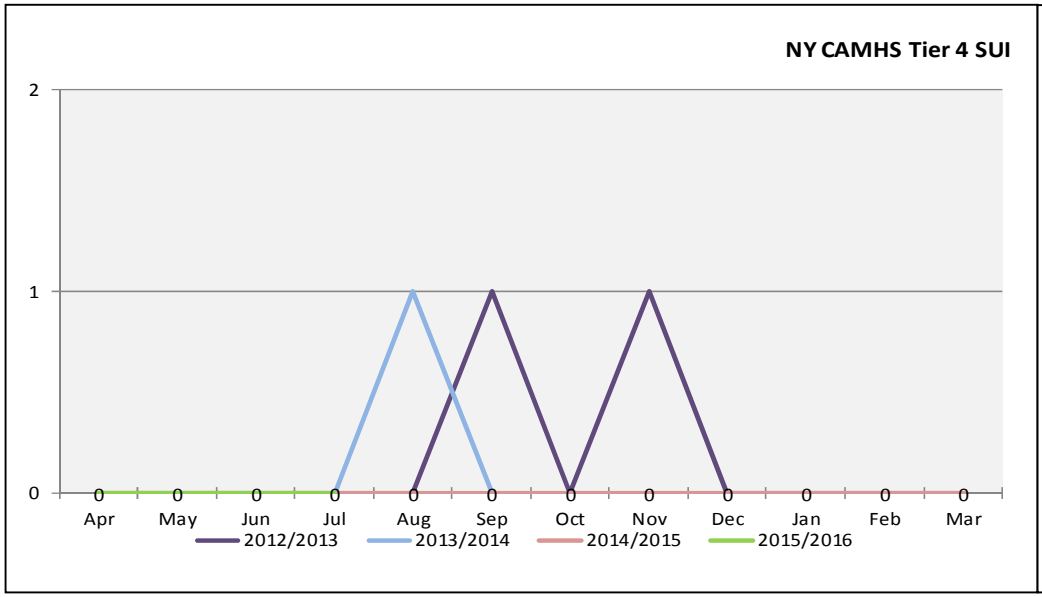

Teesside Complaints
10
9
8
7
6
5
4
3
2
1
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2012/2013
2013/2014
2014/2015
2015/2016

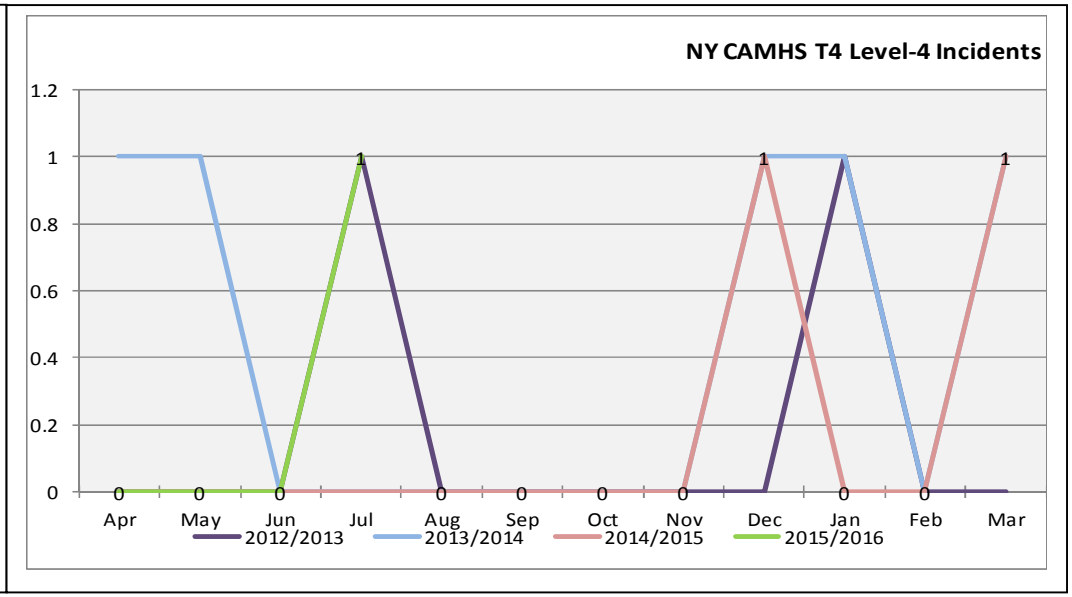

Teesside Complaints by Type (Last 6 Months)
12
10
8
6
4
2
0
Attitude
Communication
Environment
General Advice
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15

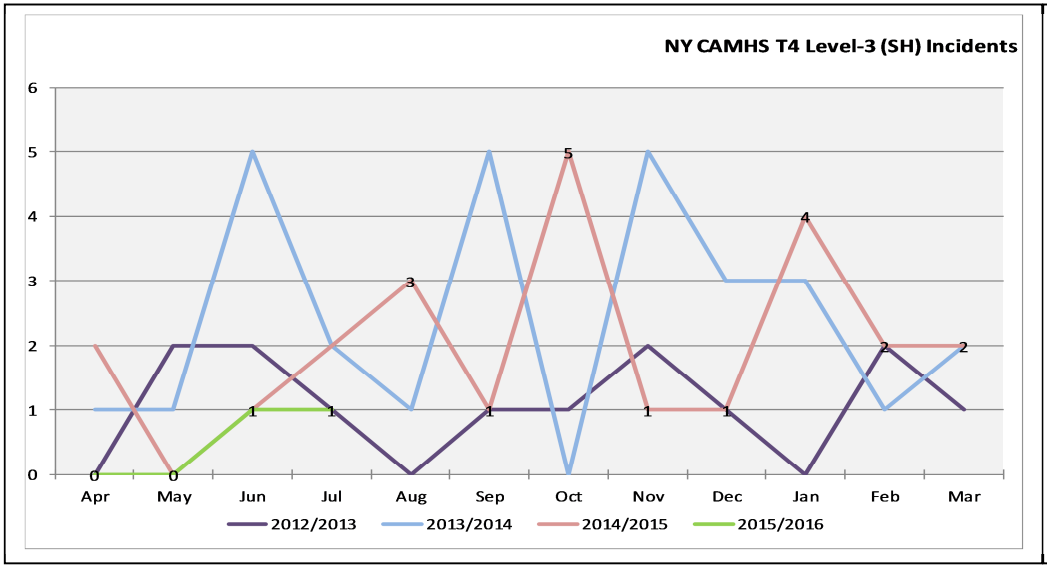

Teesside PALS
40
35
30
25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2012/2013
2013/2014
2014/2015
2015/2016

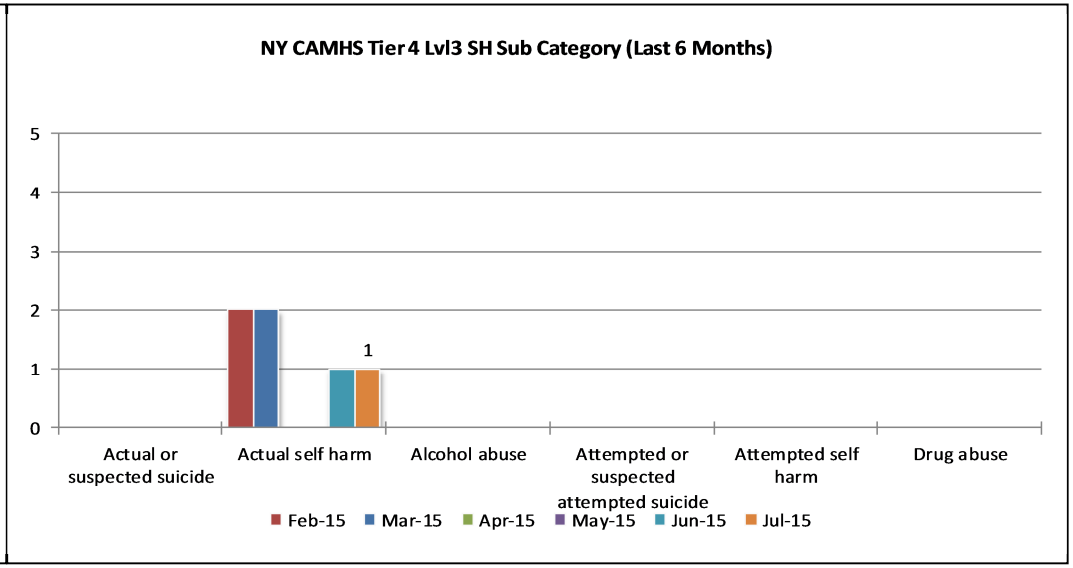

Teesside PALS by Type (Last 6 Months)
20
16
12
8
4
0
Attitude
Communication
General Advice
Staff Compliments
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15

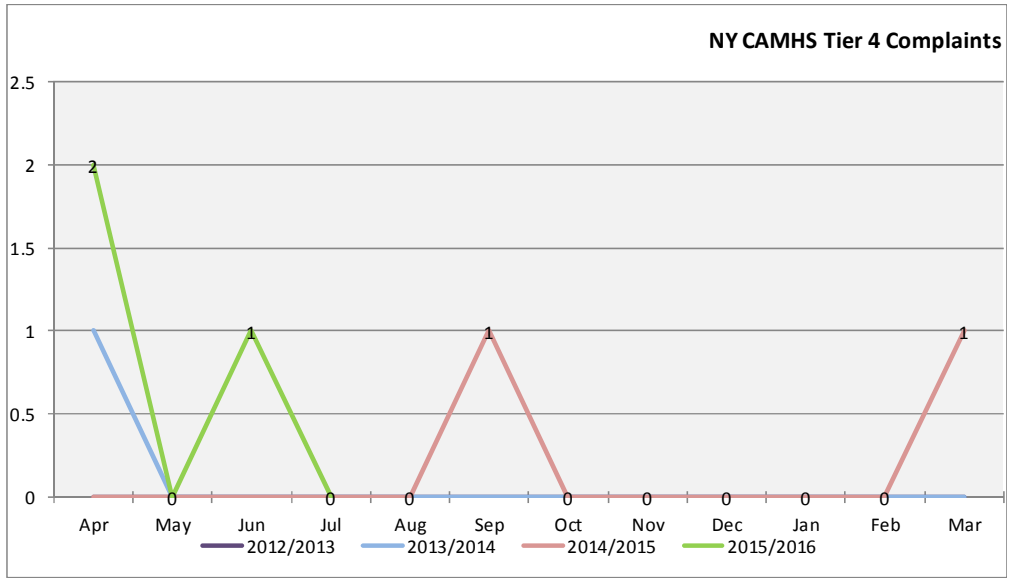
Tier 4 CAMHS

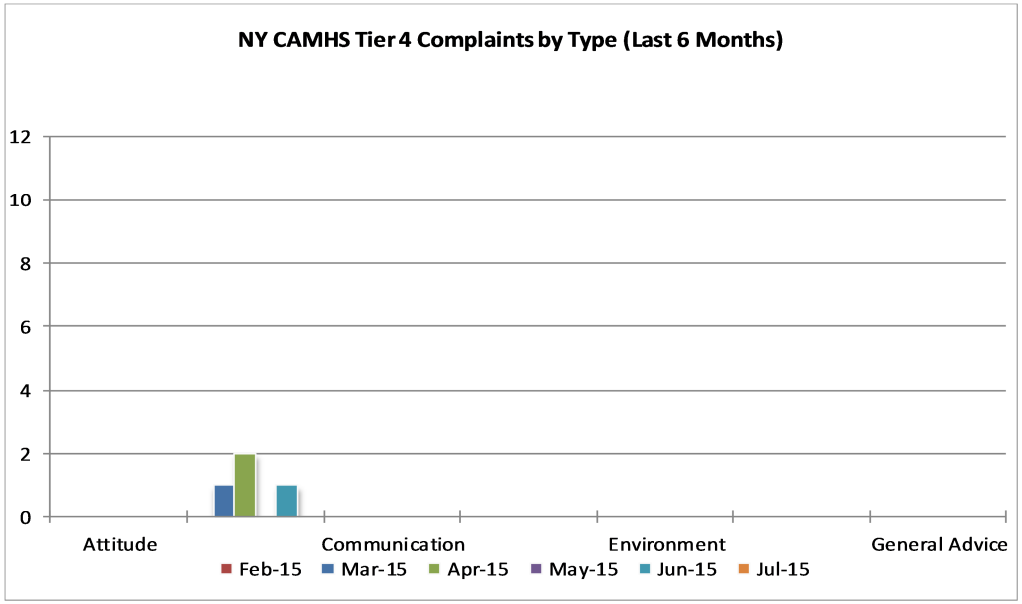

NY CAMHS Tier 4 SUI
2
1
0
0 0 0 0 0 0 0 0 0 0 0 0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2012/2013
2013/2014
2014/2015
2015/2016

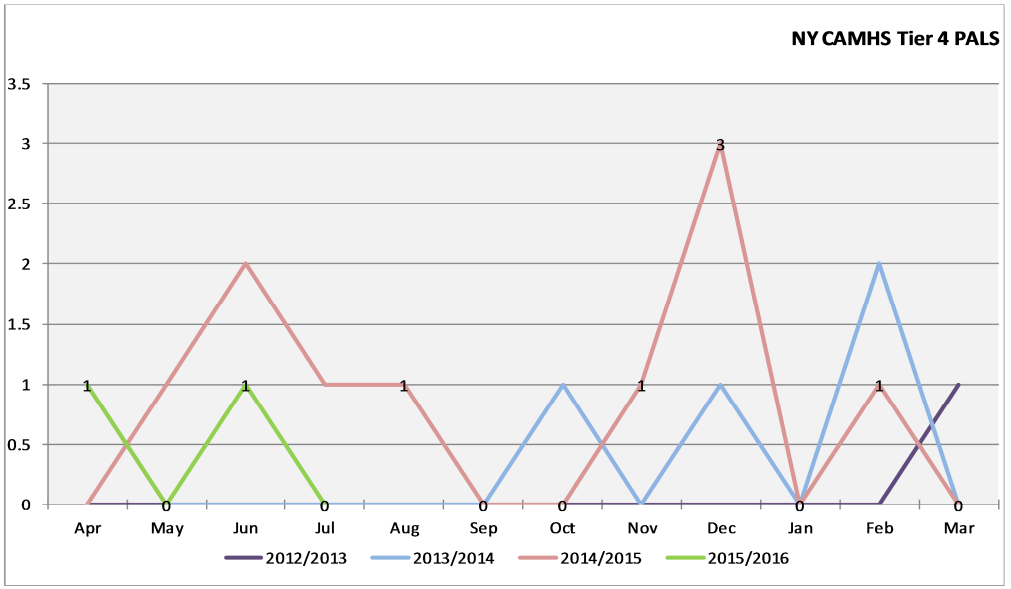

NY CAMHS T4 Level-4 Incidents
1.2
1
0.8
0.6
0.4
0.2
0
0 0 0 1 0 0 0 0 1 0 0 1
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2012/2013
2013/2014
2014/2015
2015/2016

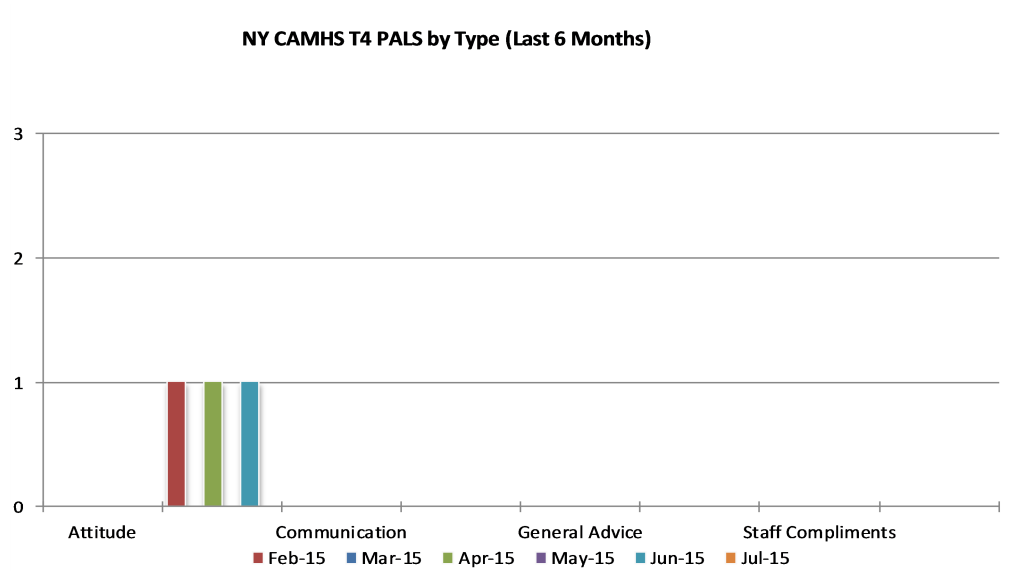

NY CAMHS T4 Level-3 (SH) Incidents
6
5
4
3
2
1
0
0 0 1 1 3 1 5 1 1 4 2 2
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2012/2013
2013/2014
2014/2015
2015/2016


NY CAMHS Tier 4 Lvl3 SH Sub Category (Last 6 Months)
5
4
3
2
1
0
1
Actual or suspected suicide
Actual self harm
Alcohol abuse
Attempted or suspected attempted suicide
Attempted self harm
Drug abuse
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15


NY CAMHS Tier 4 Complaints
2.5
2
1.5
1
0.5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2012/2013
2013/2014
2014/2015
2015/2016


NY CAMHS Tier 4 Complaints by Type (Last 6 Months)
12
10
8
6
4
2
0
Attitude
Communication
Environment
General Advice
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15


NY CAMHS Tier 4 PALS
3.5
3
2.5
2
1.5
1
0.5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2012/2013
2013/2014
2014/2015
2015/2016


NY CAMHS T4 PALS by Type (Last 6 Months)
3
2
1
0
Attitude
Communication
General Advice
Staff Compliments
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15

Item 7

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 29 September 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, 29 September – Referring to August 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 August 2015 data.

1.1 Summary of Key Issues

- The August report has highlighted that there is a deterioration across all of the 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 when compared to July. Forensic services have the highest number of red wards
- The staffing fill rates has highlighted Cedar (NY) as having the lowest fill rate but this is due to the incorrect configuration of the Healthroster system in that the roster is currently set up for 2 RN's when they are only working towards 1 on a night shift.
- Bilsdale and Swift also have a low staffing fill rate but it is evident that they are flexing their staff to back fill any vacant shifts.
- In terms of the triangulation of data:
    - Cedar ward was highlighted as having a high fill rate, use of bank, an SUI occurring and use of control and restraint
    - Merlin was highlighted as having a high fill rate, use of bank, a complaint and PALS issues raised
    - Westerdale South was highlighted as having a high fill rate and use of bank during the month.

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

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 29 September – Referring to August 2015 data**

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

1. INTRODUCTION AND 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 August 2015 data.

2. BACKGROUND

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.

Further to last month's Board discussion this month's report has been rationalised to focus exclusively on providing assurance that the staffing levels were safe. The triangulation of the staffing data against a range of quality metrics has been a feature of the monthly report for several months now and to date it has not identified any direct risks or implications to patient safety or experience making it difficult to draw any meaningful conclusion from this exercise. Therefore the triangulation of data has been omitted from the monthly report but will be included in the 6 and 12 month reviews. The process of collating a ward based narrative for any indicators that have shown as either 'red' or 'blue' has continued and has been used within the body of the report, this has been included as an appendix to this report.

3 KEY ISSUES

3.1 Safe Staffing Fill Rates

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

The total number of inpatient rosters during the month of August 2015 equates to 65 and remains unchanged 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.

3.2 The month on month trend report shows a deterioration across all metrics for both staff groups as follows:

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
Jul-15	90.80	↓	114.10	↑	99.40	↓	115.30	↑
Aug-15	87.90	↓	112.60	↓	98.10	↓	110.10	↓

The position in August 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 a deterioration on the previous month as illustrated below:

Month	August	July	June	May	April	March
No. of Red Wards	49	41	38	36	33	41

The majority of the red wards fall into the Registered Nurse on Day shifts category where there were 36 wards shown as red in August compared to only 30 in July 2015.

3.3 Durham and Darlington; and the Forensic services have seen a deterioration in the number of wards showing 'red'. The forensic services have the highest number of red wards with 24 during the reporting period. 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
	Aug-15	Jul-15	Jun-15	May-15	Apr-15	Mar-15	
Durham and Darlington	6	3	3	3	2	5	↑
Teesside	9	10	6	6	6	10	↓
North Yorkshire	10	11	8	7	6	9	↓
Forensics	24	17	21	20	20	17	↑

3.4 The lowest staffing fill rate relates to Cedar (NY) which was highlighted in July's report as having a significant decrease when compared to June's data. August's figure is reporting at 54.2% for RN on Night shifts which are an improvement on July as outlined below:

	Aug-15	Jul-15	Jun-15	May-15	Apr-15	Mar-15
Cedar (NY)	54.2%	48.0%	106.9%	115.8%	103.3%	124.0%

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 (152.7%) would suggest that they have flexed the staff to cover the shortfall. It is important to highlight that 3,361.00 actual hours were worked on Cedar (NY) during August; this can be broken down as follows:

	Total Hours	Percentage of total hours worked
Total hours worked across all shifts by all staff groups	3,361.00	
Bank	548.5	16.32%
Agency	0	0.00%
Substantive Workforce	2,812.50	83.68%

The second lowest fill rate relates to Bilsdale (RN on Day Shifts) which is reporting at 63.6% which is a decrease on the previous month whereby this was reporting at 68.8%. The 6 month trend for Bilsdale is as follows:

	Aug-15	Jul-15	Jun-15	May-15	Apr-15	Mar-15
Bilsdale	63.6%	68.8%	75.3%	83.6%	81.5%	83.4%

It is evident that they have flexed their staffing to cover the shortfall (HCA fill rate for days equates to 142.4%). It is important to highlight that 2,624.48 actual hours were worked on Bilsdale during August of which 97% were undertaken by their substantive workforce and 3% were covered utilising bank workers.

The third lowest fill rate relates to Swift (RN on Days) which is reporting at 65.6% which is a decrease on the previous month whereby this was reporting at 72.0%. the 6 month trend for Swift is as follows:

	Aug-15	Jul-15	Jun-15	May-15	Apr-15	Mar-15
Swift	65.6%	72.0%	84.2%	85.1%	81.8%	88.2%

It is evident that they have flexed their staffing to cover the shortfall (HCA fill rate for days equates to 125.4%). It is important to highlight that 3,210.60 actual hours were worked on Swift during August of which 66% were undertaken by their substantive workforce and 34% were covered utilising bank workers.

There were 7 other wards that had low fill rates between 68% and 74.4%, interestingly all of these were in relation to RN Day Shifts as articulated below:

	Aug-15	Jul-15	Jun-15	May-15	Apr-15	Mar-15
Overdale	68%	68.2%	79.7%	58.4%	73.2%	81.5%
Bransdale	69.3%	63.7%	69.9%	78.5%	92.6%	93.3%
Harrier/Hawk	69.7%	83.4%	80.7%	86.6%	75.3%	70.2%
Thistle	70%	84.7%	74.7%	66.4%	83.9%	89.9%
Jay	72.2%	78.2%	84.7%	85.2%	83.1%	87.8%
Kingfisher/Heron/ Robin	73.9%	72.9%	92.6%	90.5%	81.8%	84.8%
Eagle/Osprey	74.4%	75.3%	68.6%	73.3%	83.6%	95.1%

3.5 It is also important to review the fill rates that exceed their budgeted establishment (shown in blue). During the month of August there were 34 of the fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues.

Westerdale South saw the highest fill rate indicators during the month of August (290.8% and 202.0%) as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westerdale South	79.7%	290.8%	100.0%	202.0%

The ward has reported that that the excess was used to cover enhanced observations and vacancies.

The second highest fill rate indicator was Merlin ward with 211.9% as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Merlin	93.2%	154.2%	89.0%	211.9%

Feedback from the ward has highlighted that they have flexed their staffing between registered and unregistered staff; this is evident when looking at the fill rates. In addition they have advised that the additional staffing was in relation to enhanced observations and high acuity on the ward.

Cedar Ward had the third highest fill rate of 193.8% during the reporting period as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Cedar Ward	109.0%	193.8%	93.5%	143.1%

Cedar has advised that the blue metrics 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.

3.6 Appendix 6 highlights the usage of Bank Staffing, as a proportion of actual hours. These are 'RAG' rated independently of the overall fill rate. Those wards using greater than 50% bank staffing to deliver their fill rates are identified below:

Locality	Ward	Bank Usage	Comments
Teesside	Westerdale South	74%	Slight increase on the previous month whereby bank was 73%
Forensic Services	Merlin	66%	Increase on the previous month whereby bank was 46%
Durham & Darlington	Cedar Ward	52%	Reduction on previous month whereby bank was 57%

47 wards were reported as Amber (between 10 and 40%), this is an increase on the previous month of July (43 wards) and June (38 wards).

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

	August	July	June	May	April	March
Westerdale South	74%	73%	50%	45%	51%	39%
Merlin	66%	46%	28%	43%	36%	16%
Cedar Ward	52%	57%	55%	57%	60%	76%

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.

3.7 When considering staffing levels it is also important to consider the amount of agency worked within the reporting period. During August there was a total of 206,317.14 hours worked across the trust of which 629.50 were agency hours, equating to 0.31% 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
North Yorkshire	Rowan Ward	341.00	Vacancies, sickness and enhanced observations
North Yorkshire	Cedar (NY)	288.50	Service Need

This can be further correlated when compared to the total hours worked and the split between bank, agency and substantive workforce:

Ward	Total hours worked	Substantive Workforce	Bank	Agency
Cedar (NY)	3,734.85	2,461.90 (66%)	684.5 (26%)	288.5 (8%)
Rowan Ward	2,963.30	2,286.30 (77%)	336.0 (11%)	341 (12%)

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

3.8 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. Cedar Ward was identified as having high bank usage and an SUI occurred on this ward.
- There were no level 4 and 17 level 3 incidents occurred during August. The level 3 incidents occurred within a range of wards none of which were identified as having either low/high fill rates or high bank usage.
- There were 5 complaints that occurred within the reporting period of which 1 occurred on Merlin which was identified above as having a fill rate in excess of their budgeted establishment and high bank usage.
- There were 35 PALS related issues raised during August of which 1 occurred on Merlin and Westerdale South. Both of these wards were highlighted as having high bank usage.

- A number of incidents requiring control and restraint occurred during the reporting period. The second highest user was Rowan Ward with a total of 28 incidents requiring control and restraint (none of which required the use of PRO restraint), Rowan was highlighted earlier in this report as having used Agency staff. The final ward that was highlighted in this report was Cedar as having a high staffing fill rates, high bank usage and used agency; they also had 18 incidents that required control and restraint.

3.9 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.

3.10 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 / RISKS:

4.1 Quality: 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 Cedar (NY) but this is due to the incorrect configuration of the Healthroster system in that the roster is set up for 2 RN's when they are only working towards 1 on a night.

- Bilsdale and Swift also have a low staffing fill rate but it is evident that they are flexing their staff to back fill any vacant shifts.
- In terms of the triangulation:
    - Cedar ward was highlighted as having a high fill rate, use of bank, agency, an SUI occurring and use of control and restraint
    - Merlin was highlighted as having a high fill rate, use of bank, a complaint and PALS issues raised
    - Westerdale South was highlighted as having a high fill rate and use of bank during the month.

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: 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 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

5. CONCLUSIONS

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

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.

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

6. RECOMMENDATION

6.1 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

Appendix 1

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

				DAY		NIGHT	
WARD	**Locality**	**Speciality**	**Bed Numbers**	**FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)**	**FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)**	**FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)**	**FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)**
Abdale House	North Yorkshire	Adults	9	148.6%	105.9%	119.4%	164.5%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	13	94.6%	103.9%	100.0%	95.2%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	13	85.3%	112.1%	100.3%	98.4%
Bedale Ward	Teesside	Adults	10	78.1%	152.7%	106.9%	113.0%
Bilsdale Ward	Teesside	Adults	14	63.6%	142.4%	83.9%	101.6%
Birch Ward	Durham & Darlington	Adults	15	98.5%	133.2%	96.8%	130.0%
Bransdale Ward	Teesside	Adults	14	69.3%	117.8%	100.0%	100.1%
Cedar Ward	Durham & Darlington	Adults	10	109.0%	193.8%	93.5%	143.1%
Cedar Ward (NY)	North Yorkshire	Adults	18	94.9%	139.2%	54.2%	152.7%
Earlston House	Durham & Darlington	Adults	15	102.2%	101.9%	100.0%	100.0%
Elm Ward	Durham & Darlington	Adults	20	100.9%	111.3%	101.7%	125.8%
Farnham Ward	Durham & Darlington	Adults	20	111.1%	115.3%	109.7%	106.5%
Lincoln Ward	Teesside	Adults	20	104.2%	95.4%	97.3%	127.1%
Lustrum Vale	Teesside	Adults	20	99.2%	101.2%	108.4%	100.0%
Maple Ward	Durham & Darlington	Adults	17	88.6%	121.4%	96.8%	109.8%
Overdale Ward	Teesside	Adults	18	68.0%	131.9%	103.5%	105.1%
Park House	Teesside	Adults	14	105.6%	105.7%	100.6%	104.9%
Primrose Lodge	Durham & Darlington	Adults	15	84.7%	96.5%	100.0%	98.4%

Stockdale Ward	Teesside	Adults	18	88.1%	113.9%	106.5%	96.8%
Tunstall Ward	Durham & Darlington	Adults	20	85.1%	106.5%	93.5%	100.0%
Ward 15 Friarage	North Yorkshire	Adults	14	77.6%	116.4%	100.0%	100.0%
Willow Ward	Durham & Darlington	Adults	15	82.6%	145.8%	100.0%	125.8%
Baysdale	Teesside	CYPS	6	143.2%	89.0%	96.8%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	105.1%	137.7%	100.0%	109.5%
Newberry Centre	North Yorkshire	CYPS	14	76.0%	116.0%	88.3%	86.8%
The Evergreen Centre	North Yorkshire	CYPS	12	93.1%	111.0%	103.6%	107.1%
Westwood Centre	North Yorkshire	CYPS	12	108.7%	140.3%	107.9%	188.4%
Clover/Ivy	Forensics	Forensics LD	12	96.2%	115.8%	100.0%	97.8%
Eagle/Osprey	Forensics	Forensics LD	10	74.4%	90.4%	94.8%	91.4%
Harrier/Hawk	Forensics	Forensics LD	10	69.7%	93.9%	100.0%	99.4%
Kestrel/Kite	Forensics	Forensics LD	16	78.6%	92.7%	96.8%	101.1%
Kingfisher/Heron/Robin	Forensics	Forensics LD	14	73.9%	83.2%	81.1%	106.1%
Langley Ward	Forensics	Forensics LD	10	75.8%	80.5%	102.0%	97.1%
Northdale Centre	Forensics	Forensics LD	6	77.0%	89.0%	100.0%	91.6%
Oakwood	Forensics	Forensics LD	8	93.4%	111.3%	100.0%	100.0%
Thistle Ward	Forensics	Forensics LD	5	70.0%	101.2%	100.0%	100.0%
Brambling Ward	Forensics	Forensics MH	13	75.1%	119.5%	95.2%	103.2%
Fulmar Ward.	Forensics	Forensics MH	12	90.8%	110.0%	92.5%	95.2%
Jay Ward	Forensics	Forensics MH	5	72.2%	106.7%	104.7%	109.7%
Kirkdale Ward	Forensics	Forensics MH	16	86.2%	100.5%	102.3%	100.3%
Lark	Forensics	Forensics MH	15	83.4%	109.6%	102.3%	98.5%
Linnet Ward	Forensics	Forensics MH	17	81.6%	102.2%	98.8%	98.4%
Mallard Ward	Forensics	Forensics MH	16	86.9%	133.2%	105.2%	137.7%
Mandarin	Forensics	Forensics MH	16	82.0%	111.2%	103.6%	95.2%

Merlin	Forensics	Forensics MH	10	93.2%	154.2%	89.0%	211.9%
Newtondale Ward	Forensics	Forensics MH	20	81.9%	99.6%	82.2%	108.7%
Nightingale Ward	Forensics	Forensics MH	16	77.3%	106.5%	99.1%	104.9%
Sandpiper Ward	Forensics	Forensics MH	8	94.2%	95.3%	80.7%	108.8%
Swift Ward	Forensics	Forensics MH	10	65.6%	125.4%	103.1%	103.3%
Aysgarth	Teesside	LD	6	107.2%	140.0%	103.8%	100.0%
Bankfields Court Flats	Teesside	LD	6	0.0%	0.0%	0.0%	0.0%
Bankfields Court Unit 2	Teesside	LD	5	95.3%	104.3%	101.0%	109.7%
Bankfields Court	Teesside	LD	12	77.5%	106.1%	91.7%	102.0%
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	107.7%	105.6%	109.7%	103.4%
The Dales	Teesside	LD	5	0.0%	0.0%	0.0%	0.0%
The Lodge	Teesside	LD	1	0.0%	0.0%	0.0%	0.0%
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	90.9%	147.5%	101.1%	100.0%
Hamsterley Ward	Durham & Darlington	MHSOP	10	80.6%	158.0%	102.8%	101.6%
Oak Ward	Durham & Darlington	MHSOP	12	75.9%	101.6%	100.2%	100.0%
Picktree Ward.	Durham & Darlington	MHSOP	10	93.8%	143.9%	100.0%	111.3%
Roseberry Wards	Durham & Darlington	MHSOP	15	94.7%	95.5%	100.0%	99.9%
Rowan Lea	North Yorkshire	MHSOP	20	75.6%	106.6%	102.8%	98.9%
Rowan Ward	North Yorkshire	MHSOP	12	111.0%	77.5%	131.9%	108.8%
Springwood Community Unit	North Yorkshire	MHSOP	14	79.0%	109.6%	109.7%	119.4%
Ward 14	North Yorkshire	MHSOP	9	77.1%	128.0%	100.3%	119.4%
Westerdale North	Teesside	MHSOP	18	98.4%	122.5%	100.3%	101.8%
Westerdale South	Teesside	MHSOP	14	79.7%	290.8%	100.0%	202.0%
Wingfield Ward	Teesside	MHSOP	9	91.7%	102.9%	100.0%	100.0%

Appendix 2

August	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	-9%	5%
2	-7%	12%
3	-10%	12%
4	-7%	11%
5	-9%	10%
6	-4%	11%
7	-5%	9%
8	-8%	9%
9	-11%	13%
10	-9%	14%
11	-6%	10%
12	-7%	8%
13	-7%	13%
14	-11%	13%
15	-11%	13%
16	-11%	13%
17	-10%	14%
18	-9%	10%
19	-12%	18%
20	-8%	14%
21	-10%	8%
22	-9%	14%
23	-10%	19%

24	-10%	9%
25	-11%	12%
26	-8%	12%
27	-8%	9%
28	-10%	11%
29	-8%	9%
30	-8%	12%
31	-17%	12%

Appendix 3

DURHAM & DARLINGTON LOCALITY REPORT - August 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	742.5	372	1008	720	731.5	360	1342.45	936	98.5%	96.8%	133.2%	130.0%
Elm Ward	20	799.5	372	744	744	806.33	378.33	828.25	936	100.9%	101.7%	111.3%	125.8%
Maple Ward	17	794.5	372	729.5	744	703.6	360	885.83	816.67	88.6%	96.8%	121.4%	109.8%
Farnham Ward	20	858.5	372	704	744	953.92	408	812	792	111.1%	109.7%	115.3%	106.5%
Tunstall Ward	20	893.5	372	744	744	760.67	348	792	744	85.1%	93.5%	106.5%	100.0%
Willow Ward	15	901.5	372	744	744	744.5	372	1084.66	936	82.6%	100.0%	145.8%	125.8%
Earlston House	15	868.58	372	643	744	887.83	372	655	744	102.2%	100.0%	101.9%	100.0%
Primrose Lodge	15	901.5	372	718.16	744	763.82	372	693	732	84.7%	100.0%	96.5%	98.4%
Holly Unit	4	364.49	199.5	544.62	199.5	382.97	199.5	749.69	218.5	105.1%	100.0%	137.7%	109.5%
Cedar Ward PICU	10	849	372	696	1116	925	348	1349	1597.16	109.0%	93.5%	193.8%	143.1%
Ceddesfeld Ward	10	889.5	372	534.33	744	808.84	376	788.33	744	90.9%	101.1%	147.5%	100.0%
Roseberry Wards	15	901.17	372	792	744	853.5	372	756.67	743.5	94.7%	100.0%	95.5%	99.9%
Oak Ward	12	898.17	372	744	744	681.51	372.66	756	744	75.9%	100.2%	101.6%	100.0%
Picktree Ward.	10	902.34	372	609.17	744	846.66	372	876.5	828	93.8%	100.0%	143.9%	111.3%
Hamsterley Ward	10	901.5	372	524.83	744	726.75	382.5	829.29	756	80.6%	102.8%	158.0%	101.6%
Bek, Ramsey, Talbot Wards	16	889.5	372	3036	1788	958	408	3206.59	1848	107.7%	109.7%	105.6%	103.4%

FORENSICS LOCALITY REPORT - August 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	808.56	348.75	984.68	697.5	674.25	356.75	1079.3	687.25	83.4%	102.3%	109.6%	98.5%
Brambling Ward	13	852.45	341.75	997.5	697.5	640	325.25	1191.92	720	75.1%	95.2%	119.5%	103.2%
Fulmar Ward.	12	855	348.75	1278.75	697.5	775.95	322.5	1406.5	663.75	90.8%	92.5%	110.0%	95.2%
Jay Ward	5	844.87	348.75	1113.75	697.5	610.28	365	1187.87	765	72.2%	104.7%	106.7%	109.7%
Kirkdale Ward	16	821.75	348.75	1279	697.5	708	356.75	1285.25	699.5	86.2%	102.3%	100.5%	100.3%
Linnet Ward	17	849.75	348.75	1003.25	697.5	693.5	344.5	1025.25	686.25	81.6%	98.8%	102.2%	98.4%
Mallard Ward	16	842.5	348.75	1277	697.5	732.33	367	1700.75	960.75	86.9%	105.2%	133.2%	137.7%
Mandarin	16	838	348.75	1029.5	697.5	687	361.25	1144.5	663.75	82.0%	103.6%	111.2%	95.2%
Merlin	10	846.75	697.5	1052	697.5	789	620.75	1622.5	1477.75	93.2%	89.0%	154.2%	211.9%
Newtondale Ward	20	847.33	697.5	1625.47	697.5	694.08	573.5	1618.8	758.25	81.9%	82.2%	99.6%	108.7%
Nightingale Ward	16	843.25	348.75	1000.75	686.25	651.5	345.75	1065.7	720	77.3%	99.1%	106.5%	104.9%
Sandpiper Ward	8	855	689.5	1643.75	697.5	805.45	556.5	1566.58	759	94.2%	80.7%	95.3%	108.8%
Swift Ward	10	855	348.75	1271.25	690.48	561.25	359.5	1594	712.98	65.6%	103.1%	125.4%	103.3%
Clover/Ivy	12	760.02	348.75	2077.88	1046.25	731.5	348.75	2405.38	1023.75	96.2%	100.0%	115.8%	97.8%
Eagle/Osprey	10	868.75	348.75	1739.17	1046	646.62	330.5	1572.34	956.25	74.4%	94.8%	90.4%	91.4%
Harrier/Hawk	10	795.76	348.75	2058.17	1046.25	554.87	348.75	1933	1039.5	69.7%	100.0%	93.9%	99.4%
Kestrel/Kite	16	753.41	348.75	2057.3	1046.25	592.33	337.5	1907.25	1057.5	78.6%	96.8%	92.7%	101.1%
Kingfisher/Heron/Robin	14	719.92	346.75	1700.08	708.75	531.92	281.25	1414.5	751.75	73.9%	81.1%	83.2%	106.1%
Northdale Centre	6	841.25	348.75	2431.5	1395	647.5	348.75	2165	1277.75	77.0%	100.0%	89.0%	91.6%
Oakwood	8	749.5	348.75	660.2	348.75	700.05	348.75	735	348.75	93.4%	100.0%	111.3%	100.0%
Thistle Ward	5	813.75	348.75	1049.1	697.5	569.28	348.75	1061.75	697.5	70.0%	100.0%	101.2%	100.0%
Langley Ward	10	850.08	348.75	1041.17	348.75	644.35	355.75	837.67	338.5	75.8%	102.0%	80.5%	97.1%

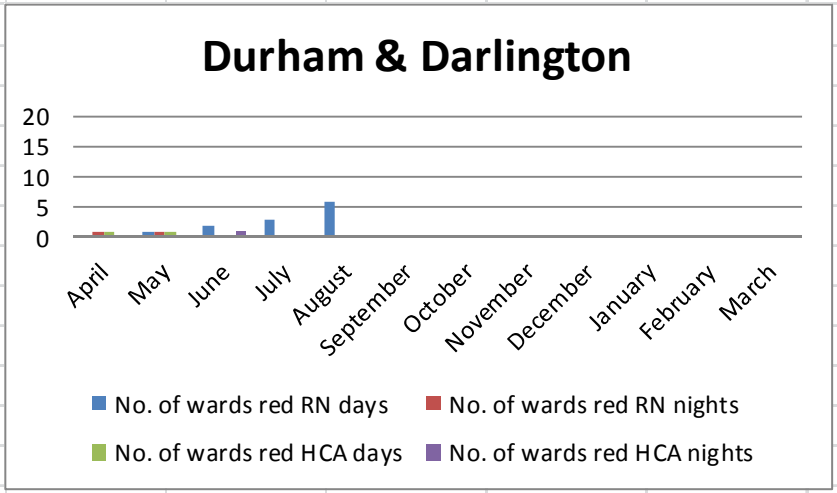
NORTH YORKSHIRE LOCALITY REPORT - August 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Ayckbourn Unit Danby Ward	13	875.5	290.28	915.5	581.87	828	290.28	951	553.7	94.6%	100.0%	103.9%	95.2%
Ayckbourn Unit Esk Ward	13	885.98	290.78	907	581.87	756	291.53	1016.98	572.48	85.3%	100.3%	112.1%	98.4%
Ward 15 Friarage	14	896.37	315	697.5	697.5	695.75	315	811.55	697.5	77.6%	100.0%	116.4%	100.0%
Cedar Ward (NY)	18	1053	666.5	975	666.5	998.85	361	1357	1018	94.9%	54.2%	139.2%	152.7%
Abdale House	9	577.5	356.25	465	356.5	858	425.25	492.5	586.5	148.6%	119.4%	105.9%	164.5%
Newberry Centre	14	1333	359.77	1311.49	730.52	1013.71	317.75	1521.92	634.27	76.0%	88.3%	116.0%	86.8%
Westwood Centre	12	1306.25	517.5	1391	667	1419.5	558.5	1951.25	1256.75	108.7%	107.9%	140.3%	188.4%
The Evergreen Centre	12	1025.8	345	1413.49	713.33	955.47	357.5	1568.49	763.98	93.1%	103.6%	111.0%	107.1%
Rowan Lea	20	1048.18	343.25	1278.01	1018	792.19	353	1362.01	1006.75	75.6%	102.8%	106.6%	98.9%
Rowan Ward	12	979	372	744	744	1086.9	490.5	576.4	809.5	111.0%	131.9%	77.5%	108.8%
Springwood Community Unit	14	967.5	348.75	921.7	697.5	763.87	382.5	1010.52	832.5	79.0%	109.7%	109.6%	119.4%
Ward 14	9	893	348.75	585	697.5	688.46	349.75	749.02	832.5	77.1%	100.3%	128.0%	119.4%

TEESSIDE LOCALITY REPORT - August 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	783	356.5	706	1069.5	611.5	381	1078.25	1208.5	78.1%	106.9%	152.7%	113.0%
Bilsdale Ward	14	819.5	356.5	690	713	521.5	299	982.5	724.5	63.6%	83.9%	142.4%	101.6%
Bransdale Ward	14	862	356.5	712	713	597.5	356.5	838.5	714	69.3%	100.0%	117.8%	100.1%
Lincoln Ward	20	813.5	387.5	1069	701.5	848	377	1020	891.5	104.2%	97.3%	95.4%	127.1%
Lustrum Vale	20	852.7	356.5	706.2	713	845.5	386.5	714.45	713	99.2%	108.4%	101.2%	100.0%
Overdale Ward	18	860	356.5	863	713	585	369	1138.5	749.5	68.0%	103.5%	131.9%	105.1%
Park House	14	724	356.5	678.5	701.5	764.5	358.5	716.92	736	105.6%	100.6%	105.7%	104.9%
Stockdale Ward	18	768.5	356.5	772.33	713	676.75	379.5	879.92	690	88.1%	106.5%	113.9%	96.8%
Baysdale	6	499.52	346.27	1156.88	692.23	715.11	335.1	1030.15	692.23	143.2%	96.8%	89.0%	100.0%
Westerdale North	18	839.75	356.5	701.5	701.5	826.5	357.5	859.5	714	98.4%	100.3%	122.5%	101.8%
Westerdale South	14	817	356.5	668.93	671.5	651.42	356.5	1945.25	1356.5	79.7%	100.0%	290.8%	202.0%
Wingfield Ward	9	684	387.5	610.5	713	627.17	387.5	628.5	713	91.7%	100.0%	102.9%	100.0%
Aysgarth	6	537.8	300	824	310	576.5	311.5	1154	310	107.2%	103.8%	140.0%	100.0%
Bankfields Court Unit 2	5	512.5	309.5	1026.81	310	488.33	312.5	1071.16	340	95.3%	101.0%	104.3%	109.7%
Bankfields Court	12	1483.67	744	3699.83	2232	1150.33	682.16	3924.75	2275.83	77.5%	91.7%	106.1%	102.0%

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	↓

Appendix 5


Durham & Darlington
20
15
10
5
0
April
May
June
July
August
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December
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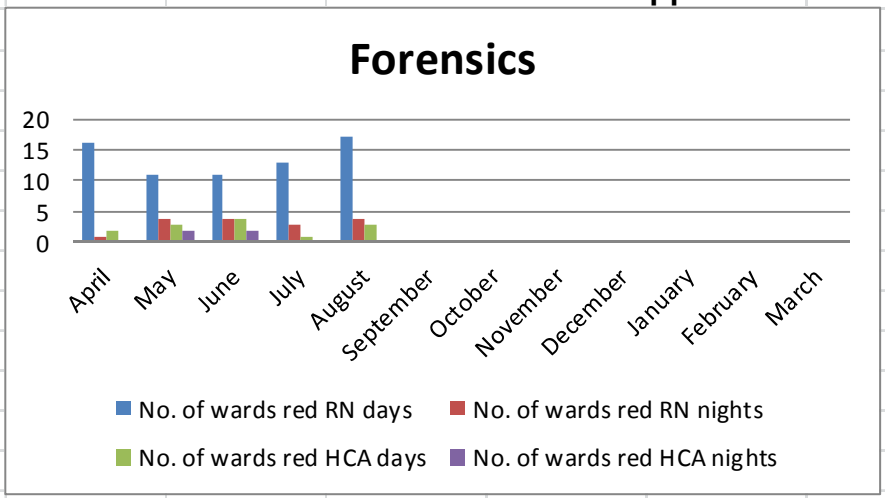
February
March
No. of wards red RN days
No. of wards red RN nights
No. of wards red HCA days
No. of wards red HCA nights


Forensics
20
15
10
5
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April
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February
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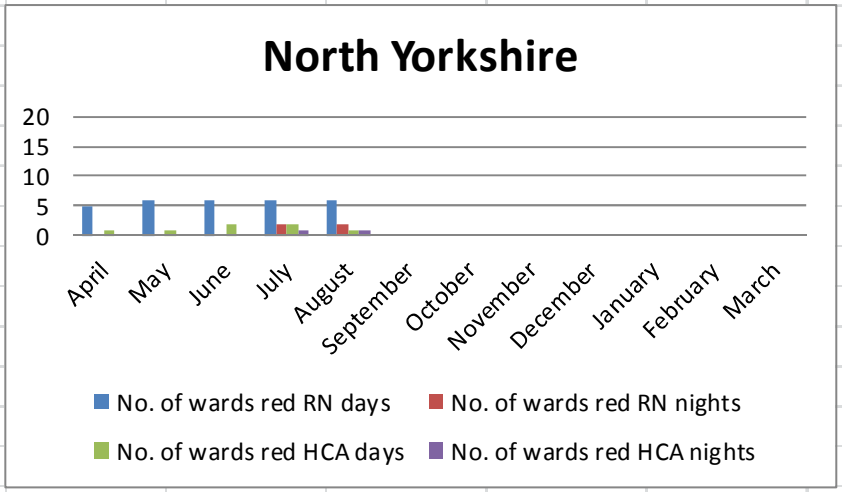
No. of wards red RN days
No. of wards red RN nights
No. of wards red HCA days
No. of wards red HCA nights


North Yorkshire
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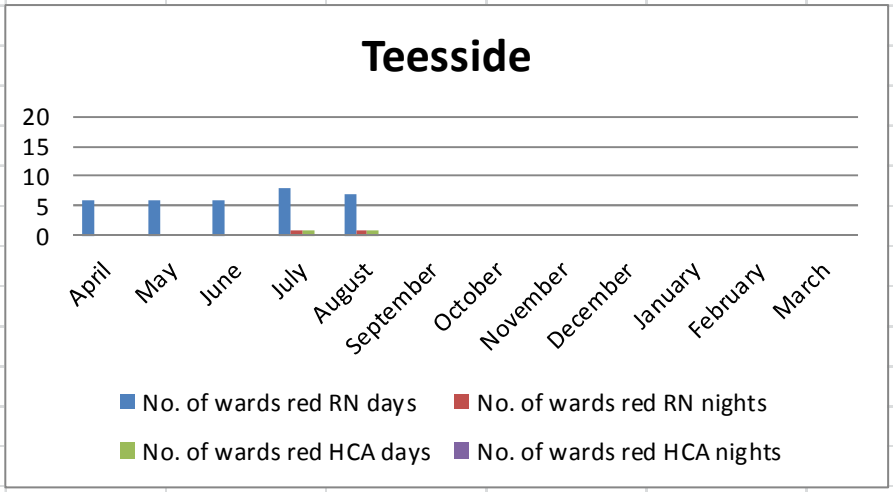
No. of wards red RN days
No. of wards red RN nights
No. of wards red HCA days
No. of wards red HCA nights


Teesside
20
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February
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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 - AUGUST					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)	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Aysgarth	Teesside	LD	6	9	2352	1069	45%									
Tunstall Ward	Durham & Darlington	AMH	20	12	2644.67	264	10%						1	1	1	2
Westerdale South	Teesside	MHSOP	14	13	4309.67	3194.53	74%					1	1	0	2	2
Earlston House	Durham & Darlington	AMH	15	9	2658.83	516	19%									
Bankfields Court Unit 2	Teesside	LD	5	11	2211.99	741.54	34%									
Holly Unit	Durham & Darlington	CAMHS	4	9	1550.66	199.35	13%									
Lincoln Ward	Teesside	AMH	20	7	3136.5	795	25%			3			2	0	3	3
Westerdale North	Teesside	MHSOP	18	11	2757.5	198.5	7%			1						
Westwood Centre	North Yorkshire	CAMHS Tier 4	12	9	5186	1429.5	28%			1			69	6	156	162
Farnham Ward	Durham & Darlington	AMH	20	9	2965.92	288	10%	1								
Hamsterley Ward	Durham & Darlington	MHSOP	10	13	2694.54	202.83	8%						7	0	8	8
Mallard Ward	Forensics	FMH	16	13	3760.83	1260.75	34%						6	0	7	7
Rowan Ward	North Yorkshire	MHSOP	12	10	2963.3	336	11%	1					28	0	45	45
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	11	2717.17	382	14%									
Elm Ward	Durham & Darlington	AMH	20	9	2948.91	756.67	26%						2	1	4	5
Stockdale Ward	Teesside	AMH	18	12	2626.17	437	17%			1		3	4	0	5	5
Northdale Centre	Forensics	FMH	6	10	4439	1430.75	32%					3	3	0	5	5
Bankfields Court Unit 3 & 4	Teesside	LD											10	0	18	18
Bedale Ward	Teesside	AMH	10	13	3279.25	1449.75	44%						3	0	4	4

Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	9	6420.59	723.4	11%			1			7	1	6	7
Brambling Ward	Forensics	FMH	13	12	2877.17	918.75	32%				1		7	0	7	7
Bransdale Ward	Teesside	AMH	14	13	2506.5	494.5	20%									
Lustrum Vale	Teesside	AMH	20	9	2659.45	240	9%									
Bilsdale Ward	Teesside	AMH	14	11	2527.5	703	28%			1			1	0	3	3
Birch Ward	Durham & Darlington	AMH	15	10	3369.95	1266	38%									
Cedar Ward (NY)	North Yorkshire	AMH	18	12	3734.85	984.75	26%			2		1	17	1	25	26
Eagle/Osprey	Forensics	FLD	10	10	3505.71	1140.42	33%									
Maple Ward	Durham & Darlington	AMH	17	12	2766.1	1248.51	45%					2	1	0	1	1
Picktree Ward.	Durham & Darlington	MHSOP	10	11	2923.16	1075	37%						2	0	5	5
Primrose Lodge	Durham & Darlington	AMH	15	11	2560.82	156	6%									
Bankfields Court Flats	Teesside	LD	6	7	0	0				2			1	0	1	1
Newberry Centre	North Yorkshire	CAMHS Tier 4	14	9	3487.65	658.96	19%						25	3	44	47
The Evergreen Centre	North Yorkshire	CAMHS Tier 4	12	11	3645.44	526.95	14%						26	0	55	55
Ward 14	North Yorkshire	MHSOP	9	13	2619.73	54.75	2%						6	1	9	10
Willow Ward	Durham & Darlington	AMH	15	13	3137.16	637.99	20%									
Baysdale	Teesside	CAMHS	6	9	2772.59	26.57	1%									
Langley Ward	Forensics	FLD	10	10	2176.27	317.25	15%						1	0	1	1
Merlin	Forensics	FMH	10	12	4510	2989.5	66%				1	1	6	1	9	10
Oak Ward	Durham & Darlington	MHSOP	12	13	2554.17	96	4%									
Oakwood	Forensics	FLD	8	11	2132.55	316.1	15%									
Bankfields Court	Teesside	LD	12	12	8033.07	806.7	10%									
The Lodge	Teesside	LD	1	7	0	0										
Park House	Teesside	AMH	14	9	2575.92	666.84	26%						1	0	2	2
Cedar Ward	Durham & Darlington	AMH	10	8	4219.16	2208	52%	1					9	1	17	18
Fulmar Ward.	Forensics	FMH	12	9	3168.7	883.75	28%					2	1	0	1	1
Jay Ward	Forensics	FMH	5	13	2928.15	1129	39%									

Kingfisher/Heron/Robin	Forensics	FLD	14	9	2979.42	477.75	16%										
Nightingale Ward	Forensics	FMH	16	13	2782.95	549.4	20%					3					
Sandpiper Ward	Forensics	FMH	8	11	3687.53	554	15%			1			5	1	7	8	
Springwood Community Unit	North Yorkshire	MHSOP	14	13	2989.39	506.25	17%						8	0	8	8	
Thistle Ward	Forensics	FLD	5	13	2677.28	345.5	13%						1	0	1	1	
Ward 15 Friarage	North Yorkshire	AMH	14	13	2519.8	433.5	17%	1			1	1	2	0	4	4	
Overdale Ward	Teesside	AMH	18	13	2842	597.5	21%			1		3	3	0	6	6	
Linnet Ward	Forensics	FMH	17	11	2749.5	497	18%			1		3					
Swift Ward	Forensics	FMH	10	13	3227.73	813.5	25%			1			10	0	14	14	
Ayckbourn Unit Esk Ward	North Yorkshire	AMH	13	12	2636.99	608.6	23%			1		4	6	2	6	8	
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	13	10	2622.98	315.06	12%										
Clover/Ivy	Forensics	FLD	12	10	4509.38	1540.84	34%						2	0	3	3	
Kirkdale Ward	Forensics	FMH	16	13	3049.5	377.5	12%					1					
Roseberry Wards	Durham & Darlington	MHSOP	15	10	2725.67	203.34	7%										
Lark	Forensics	FMH	15	12	2797.55	514	18%										
Wingfield Ward	Teesside	MHSOP	9	11	2356.17	0	0%										
Kestrel/Kite	Forensics	FLD	16	11	3894.58	841.5	22%				1	2	1	0	1	1	
Abdale House	North Yorkshire	AMH	9	12	2362.25	274	12%										
Mandarin	Forensics	FMH	16	12	2856.5	882.75	31%					3	2	0	3	3	
Rowan Lea	North Yorkshire	MHSOP	20	12	3513.95	175.51	5%				1	1	6	0	7	7	
Newtondale Ward	Forensics	FMH	20	11	3644.63	1150	32%										
Harrier/Hawk	Forensics	FLD	10	12	3876.12	861.25	22%					1	1	0	1	1	
The Dales	Teesside	LD	5	7	0	0											
Harland	Forensics	FLD															
TOTAL			859	740	206317.14	47738.61	23%	4	0	17	5	35	294	19	505	524	

ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 29 September 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, 29 September 2015**
Title: **To consider the report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE

1.1 To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 1, 2015-16; through consideration of the work of the Mental Health Legislation Committee, which is a Standing Committee of the Board.

2. BACKGROUND INFORMATION

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

3. KEY ISSUES

At the meeting held on 27th July 2015:

3.1 The minutes of the Committee meeting held on 27th April 2015 were reviewed and agreed as an accurate record. (See Appendix 2 for information).

3.2 The provision of a summary report for CQC MHA inspections has been re-established. It was noted from the report that there were minimal CQC MHA inspections during the quarter with none in April, one in May and three in June. It was felt that this may be due in part to the CQC recruitment ongoing with the expectation that this would increase once all Inspectors are in post, which has been borne out from July onwards. There were still instances picked up around difficulty in finding assessments of capacity on Paris and at the next Committee there will be discussion on a resolution for this as we move from holding a print out of the entry with the medicine Kardex to determining a standard for recording on Paris.

3.3 The Admissions, Changes and Detentions Themes Report was presented. During the first quarter of 2015/16 the increase in activity post Cheshire West has been sustained. Admissions under the MHA peaked at 114 in July 2014 and then in the months from July to year end ranged between 88 and 92 per month. The number for June 2015 was 105 demonstrating a potential climb in numbers that will require continued monitoring. Similar trends are emerging in the use of section 2 both in the number applied during the month and also in place at month end.

3.5 The Section 136 Report was presented. *This summary data is slightly amended from the information heard at the MHL Committee as the data received from Cleveland Police was amended post Committee and an updated report will be available at the October meeting*. In total there were 166 uses of section s136 across the whole Trust area in the quarter (an increase from 124 last quarter) of which 139 were brought to a Trust place of safety which means 84% were brought to a MHBPOS compared to 79% last quarter. Within the Cleveland Police area, which is the highest user of s136, there was a decrease from 11 to 10 of those taken to a police station

as a place of safety and a 37% increase in those brought to Roseberry Park. This equates to 13% of s136s within Cleveland being taken to a police PoS. Within Durham and Darlington 23% of people were taken to a police PoS and17% within North Yorkshire.

The report also includes data around the activity of the Street Triage Teams of Teesside and North Yorkshire, Teesside STT had 60 contacts in the quarter and Scarborough STT had 128 compared to 213 in the previous quarter. In both services the number of contacts for people already known to TEWV is very high with 73% in Teesside and 84% in North Yorkshire. The report also contains data around the number of people self-presenting at Roseberry Park, of which significant numbers are brought 'voluntarily' by the police. There were 217 self-presenters in quarter 1, compared to 92 in quarter 4, of which, 69 were brought by the police compared to 50 in quarter 4. The percentage of people brought by the police has reduced significantly when compared to the increase in numbers of self-presenters and that increase in numbers of self-presenters generally is almost certainly due to the presence of the Crisis Assessment Suite. 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.

3.6 The Use of Seclusion Report was presented. There were 21 episodes of seclusion across the Trust in quarter 1 compared to 36 in quarter 4 ranging in duration from 15 minutes to over 327 hours. Episodes of seclusion lasting over 12 hours, of which there were 7, compared to 23 last quarter, require a summary report to evidence the rationale for this. It was noted that the recording of seclusion will move from a paper based recording onto recording on Paris at the end of July. It was agreed that the seclusion information would be shared with the Force Reduction Project Team.

3.7 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 140 FTTs held in quarter 1 compared to 190 in quarter 4. The Tribunal ordered 11 absolute discharges (2 of which were patients subject to a CTO), 0 conditional discharges and 0 deferred discharges. 10 of the discharges were from Adult Services and 1 from C&YPS. 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.

3.8 Once each year a report is produced which sets out the activity and an update in relation to the work of the Associate Hospital Managers. This report covers the period of 1April 2014 to 30 June 2015. The Trust currently has 38 AHMs (including NEDs) 19 of whom are also trained to Chair panels with a further 2 NEDs and the Chair of the Trust also training for this role. There were several half day training events in this period covering the Cheshire West case. There have also been 8 additional sessions in May and June covering Information Governance, Equality and Diversity and Human Rights, case law updates and review of conduct, policy and procedures. The number of hearings arranged has risen steadily over the past five years from 679 in 2010/11 to 902 in 2014/15. It will be necessary to recruit additional

AHMs to both replace those lost through resignation or ill health and to ensure that there are sufficient available to meet the increasing demand.

3.9 The Law Commission consultation around the review of the Deprivation of Liberty Safeguards legislation was discussed and it was agreed that the Trust would respond to this consultation. A draft response would be produced which would then go to the Board of Directors for any comments prior to the 2 November date for submission back to the Law Commission.

3.10 A number of procedures were considered and agreed by the Committee which have been updated in light of the changes within the new Code of Practice to the Mental Health Act 1983. A revised Associate Hospital Mangers Policy was also considered and is at Appendix 2. This Policy is being brought before the Board because the policy describes responsibilities for the NEDs.

4. IMPLICATIONS / RISKS

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:** The budgets allocated for the Associate Hospital Managers function have been reviewed in light of the increasing number of hearings. Further resources have been agreed in relation to the York and Selby locality.

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. With regard to the position at the end of Quarter 1 there were no breaches in relation to Mental Health Legislation.

4.4 **Equality and Diversity:** Monitoring of equal access and positive management of diversity is incorporated into CQC inspections. No key issues or risks have been raised.

5. CONCLUSIONS

5.1 At their meeting in July 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. This assurance is externally supported by the feedback from the CQC Mental Health Act inspections and also from the Trust CQC inspection in January.

5.2 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.

6. RECOMMENDATIONS

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

6.2 The Board is asked to approve the revised Associate Hospital Mangers Policy at Appendix 2.

Elizabeth Moody
Director of Nursing and Governance

Background Papers:
Appendix 1 – Background Information
Appendix 2 – Associate Hospital Mangers Policy
Appendix 2 – Approved minutes of the 19th February 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.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Appendix 2

Associate Hospital Managers Policy

Ref MHA-0004

Status: Draft

Document type: Policy

Contents

Table of Figures

1. Introduction

Hospital Managers

In England, NHS hospitals are managed by NHS Trusts and NHS Foundation Trusts, such as Tees, Esk and Wear Valleys NHS Foundation Trust. For these hospitals, the trusts themselves are defined as the 'hospital managers' for the purposes of the Mental Health Act 1983 (MHA).

Hospital managers have the authority to detain patients under the MHA and have the primary responsibility for seeing that the requirements of the MHA are followed. In particular, they must ensure that patients are detained only as the MHA allows, that their treatment and care accord fully with its provisions and that they are fully informed of, and supported in exercising, their statutory rights.

The hospital managers have equivalent responsibilities towards patients who are subject to community treatment orders (CTO).

In practice, most of the responsibilities of the hospital managers, examples of which include admission of and transfer of detained patients, provision of information, reference to the Mental Health Tribunal are actually taken by individuals (or groups of individuals) on their behalf such as mental health legislation staff and ward staff.

Associate Hospital Managers

Consideration for, and decisions about, discharge from detention and CTOs are reserved to and taken by panels of people specifically selected for the role ("managers panels"). Manager's panels consist of three or more people and can include members, but not employees, of the organisation in charge of the provider, eg the Chair and non-executive directors of the Trust, as well as people appointed by the Trust for this purpose. Those appointed for this purpose must also not be employees of the Trust and are often referred to as Associate Hospital Managers (AHM)

	**Any reference to hospital managers in this policy refers only to associate hospital managers with the ability to consider and make decisions about discharge from detention or CTO under Section 23 MHA 1983.**

2. Why we need this policy

2.1. Purpose

- Patients have the right to have their detention or Community treatment order (CTO) reviewed by the hospital managers
- Tees, Esk and Wear Valleys NHS Foundation Trust must ensure that there are sufficient hospital managers to meet the requirements of the MHA

2.2. Objectives

This document will help to ensure that:

- Hospital managers are given clear guidance in performing their duties
- Hospital Managers and the Trust Board will have confidence in the

procedures adopted by the Trust in ensuring that the functions of hospital managers are discharged effectively and lawfully.

3. Scope

Although the hospital managers have a range of authorities, duties and responsibilities, this policy relates only to the power to discharge under Section 23 of the MHA.

3.1. Who does this policy apply to?

- All Trust staff
- Associate Hospital Managers

3.2. Roles and responsibilities

Role	Responsibility
The Trust	• As hospital managers, the Trust is responsible for ensuring that the requirements of the Mental Health Act are fully met and that there are sufficient associate hospital managers to fulfil the requirements in terms of consideration for discharge.
Director of Nursing and Governance	• Executive responsibility for the effective implementation and management of the Mental Health Act.
Non-Executive Director with responsibility for mental health legislation	• Appointment of associate hospital managers • Review of associate hospital managers • Terminating agreements with associate hospital managers
Head of Mental Health Legislation	• Operational management of the Mental Health Act, including the functions of hospital managers
MHL Officers	• Planning and coordinating meetings to consider discharge of patients subject to detention or CTOs • Attending review meetings
Associate Hospital Managers	• Reviewing detention and CTOs • Ensuring this policy is adhered to

4. Policy

4.1. Who is eligible to act as a hospital manager?

The chairman and non-executive directors of the Trust are eligible to sit on managers' panels.

	**The MHA does not allow employees of the Trust to sit on a hospital managers' panel**

Because of the number of reviews required, the Trust appoints Associate Hospital Managers who can also review detention.

4.2. Non-Executive Director with responsibility for the MHA

There is a non-executive director (NED) with responsibility for the MHA. That responsibility is given by the Chairman of the Trust, to whom they are accountable.
They will:

- Have overall responsibility for the appointment of Associate Hospital Managers;
- Help to identify training and development needs of Associate Hospital Managers and agree a programme of training;
- Oversee a performance review of each Associate Hospital Manager at least once every three years.
- Overall responsibility for matters relating to the competence and conduct of Associate Hospital Managers
- Report as required to the Trust Board
- Attend and participate in managers panels held under the MHA; and
- Maintain close links with the Mental Health Legislation Department

4.3. Recruitment and appointment of AHMs

The Trust will appoint enough Associate Hospital Managers to meet the demand for manager's panels.
Applicants will need to be able to demonstrate the following:

- An interest in mental health;
- A commitment to public service;
- An understanding of equality issues
- A good understanding of confidentiality;
- The ability to analyse complex problems;
- The ability to read and comprehend detailed reports;

- The ability to actively listen and question;
- The confidence to question and challenge sensitively;
- The ability to work as part of a team; and
- The ability to be objective and impartial.

When necessary, the Trust will advertise for Associate Hospital Managers.

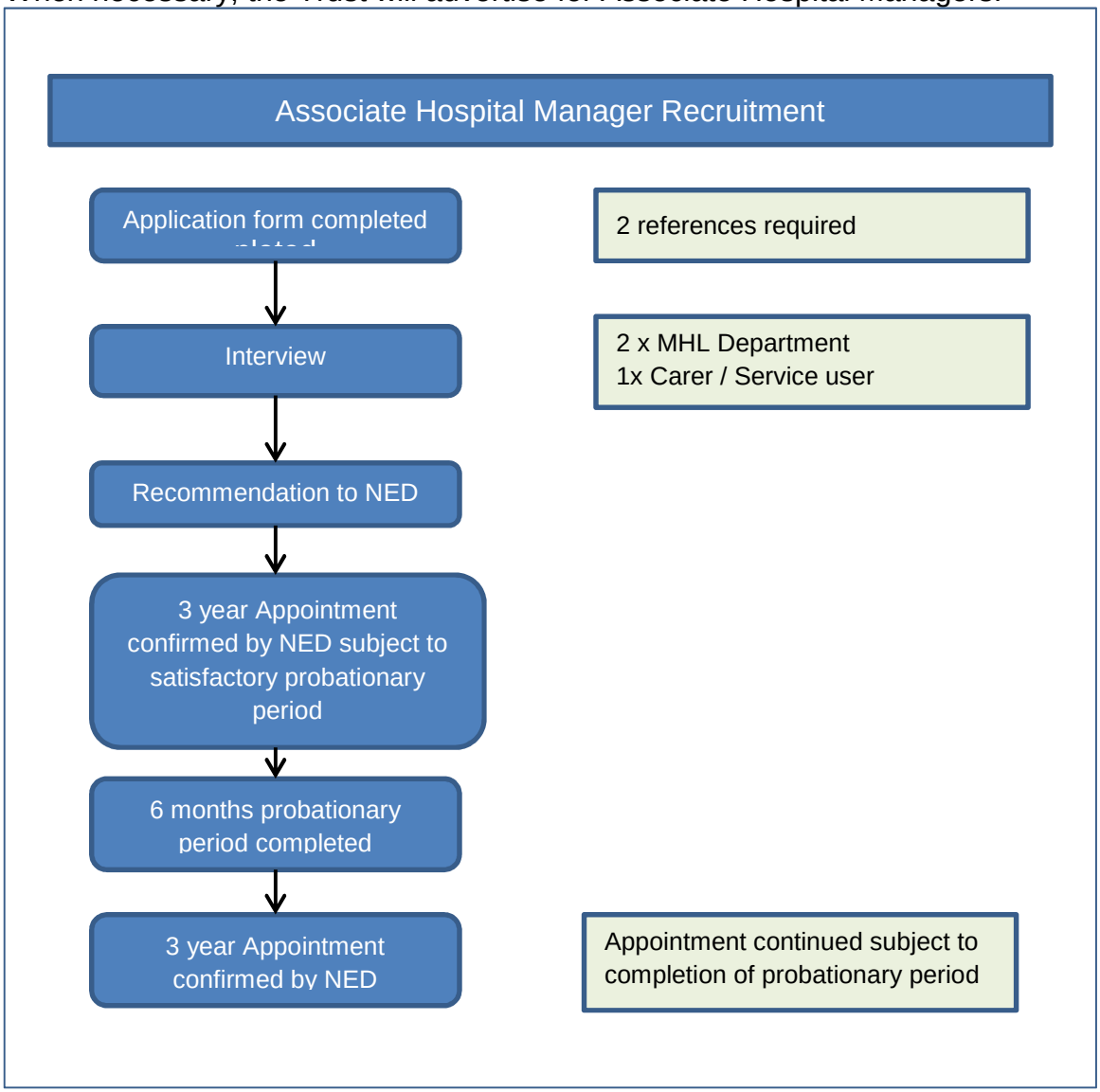


Figure 1 - AHM Recruitment

Prospective AHMs will be interviewed by a panel of 3 comprising Head of MH Legislation or MH Legislation advisor, another member of the MH Legislation team and a carer or service user representative.

The interview panel will make a recommendation to the NED with responsibility for MH legislation who will have responsibility for making the appointment.

AHMs are not employees of the Trust, but appointment will be made subject to a formal agreement.

Under the agreement	
The Associate Hospital Manager will:	**The Trust will:**
• Maintain confidentiality at all times	• Provide training for the role of the AHM
• Attend and participate in a minimum of 12 managers panels annually	• Insure the AHM whilst on Trust premises
• Attend annual training and development sessions	• Indemnify the AHM in respect of performance of the role
• Adhere to relevant Trust policies	• Provide necessary administrative support
• Abide by the principles of data governance	• Provide necessary library and information resources
• Participate in an annual paper review	

The initial appointment will be for a three year period. At the end of this period, the AHM will have a review of their continuing suitability, the outcome of which will be discussed with the NED with responsibility for MH legislation to decide whether to renew the appointment.

	**The appointment will be made for a period of up to three years.**
	**The Trust expects each manager to take part in at least 12 manager's panels per year.**
	**The Trust may terminate the agreement with the Associate Hospital Manager by giving one month's notice.** **If there has been a substantial breech of the undertakings in the agreement, the agreement may be terminated without notice.** **Any such decision will be taken by the Non-Executive Director with responsibility for the MHA in consultation with the Director of Nursing and Governance.**

4.4. Induction

	**The Trust is committed to providing a high quality service to patients. As part of achieving this goal, the Trust must train and monitor the effectiveness of the Associate Hospital Managers.**

Initial training will include:

- Meeting members of the MHL administration team;

- Familiarisation with key parts of the MHA and relevant sections of the Code of Practice;
- Attendance at training sessions.

	**The Associate Hospital Manager will receive training and sign an agreement on maintaining confidentiality before they have access to any patient information**

The induction process is supported by:

- A reading pack;
- Contact with the Non-Executive Director with responsibility for the MHA (or a designated deputy) for advice and support;
- Observation at managers panels;
- The opportunity to discuss with the panel chair and panel members following observation at manager's panels.

	**No AHM will sit as a member of a panel until they have completed their induction training.**

4.5. Probationary period

Newly appointed AHMs will be subject to a 6 month probationary period in line with the Trust's approach to the appointment of new staff.
The purpose of the probationary period is to provide a consistent means by which new AHMs can be supported to become effective as quickly as possible.
During the probationary period the AHMs performance, conduct and attendance will be reviewed by the MHL Advisor after they have observed 6 meetings.

	**The Trust expects that an AHM will attend a minimum of 6 meetings during their probationary period.**

A decision about whether the probationary period has been successful will normally be made at 6 months and a recommendation will be made to the NED.

4.6. Training

As well as initial training, the Trust will provide update training. As part of the agreement, hospital managers must attend annual refresher training, and will not be eligible to sit on a panel if they have not completed this.
The training will include:

- Developments in mental health;
- Developments in mental health law;

- Skill development, particularly in relation to chairing panels
- Equality and diversity training
- Information Governance and confidentiality training

.

	**AHMs will not be expected to chair review panels until they have sufficient experience of participating in reviews and have received training in chairmanship**

4.7. Annual review

	**The AHM will receive an annual report of their activity**

The annual review will include:

- Number of meetings attended
- Number of meetings chaired
- Training attended
- Any issues during the previous year

4.8. Three year Review

The Non-Executive Director with responsibility for the MHA (or designated deputy) will hold an individual review of continuing suitability with each Associate Hospital Manager once every three years.
This meeting will review:

- Commitment to the role of Associate Hospital Manager;
- Attendance at training sessions;
- Review of personal training and development needs;
- Consideration of any problems encountered;
- Feedback of Trust performance over previous 3 years,
- Any issues which an individual Associate Hospital Manager wishes to bring to the attention of the Trust.

	**The Trust will reimburse expenses for attendance at review meetings**

4.9. Confidentiality

Although AHMs are not TEWV employees they have the same duty as employees to maintain and protect the confidentiality of information relating to patients, colleagues and business information.

The Health and Social Care Information Centre (HSCIC) have established four confidentiality rules that **must** be followed:

1. Confidential information about service users or patients should be treated confidentially and respectfully.
2. Members of a care team should share confidential information when it is needed for the safe and effective care of an individual.
3. Information that is used for the benefit of the community should be anonymised.
4. An individual's right to object to the sharing of confidential information about them should be respected.

- Prying and gossiping are unethical. AHMs must not discuss personal confidential information about service users or colleagues.
- If there is a potential conflict of interest, for example an AHM has been asked to sit on a panel for someone they know, they must inform the MHL department
- If an AHM needs to refer to another case they have been involved in, for example if it is a difficult decision and they have been involved in a similar case, they must do so in a way that does not identify the service user concerned

4.10. Concerns/Complaints about Associate Hospital Managers

If there are any concerns raised about the practice or conduct of an AHM, the nature of the issue will be investigated by the MHL Advisor in the first instance. Dependent upon the seriousness of the issue, the outcome may be that a letter highlighting the concern will be sent from the Director of Nursing and Governance to the AHM. More serious issues will require further investigation and may necessitate a meeting between the AHM, Director of Nursing and Governance and MHL Advisor or Head of MH Legislation. The findings from this meeting will be reported by the Director of N&G to the NED with responsibility for MH Legislation. The NED will then make a decision regarding any further action which could include further training, suspension as Chair of manager's panels or even termination of the agreement as AHM. Any AHM who is unhappy with the decision of the NED will have the opportunity to formally raise this with the Chairman of the Trust.

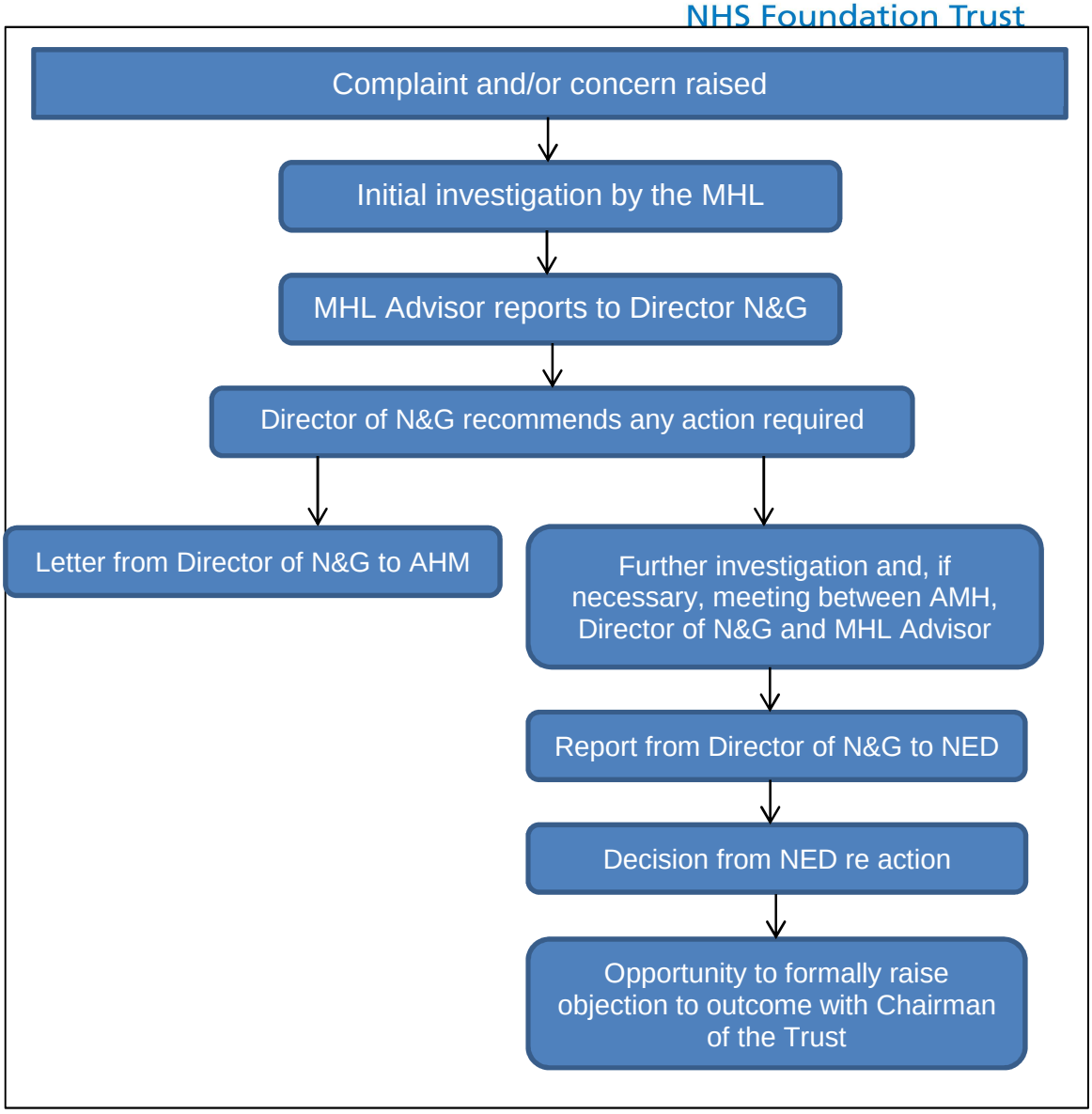


Figure 2 – Concerns/Complaints procedure

	Dependent upon the nature or seriousness of the issue raised, this may result in the AMH having their attendance at any planned managers panels cancelled and not being contacted to sit on new managers panels until the issue has been fully investigated and resolved

	Any complaints will be dealt with following the principles of TEWV Disciplinary procedure

5. Related documents

- Code of Practice Mental Health Act 1983, TSO, 2015

• CTO Policy
• Compliments, Comments and Concerns Policy
• Disciplinary procedure
• Probationary period procedure
• Confidentiality policy

6. Definitions

Term	Definition
Approved Clinician	A mental health professional approved by the Secretary of State (or the Welsh Ministers) to act as an approved clinician for the purposes of the MHA. Some decisions under the MHA can only be taken by people who are ACs.
Approved Mental Health Professional (AMHP)	A practitioner who has undertaken additional recognised professional training and is approved and authorised by the Local Authority and, where the AMHP is a Social Worker, registered with the General Social Care Council. The role of AMHP is to carry out legal functions in relation to the MHA which includes making an application for compulsion and supporting an application for A CTO. Other professional groups may become AMHPs.
Community Treatment Order (CTO)	The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Community patients are expected to comply with the conditions specified in the CTO.
Hospital Managers	The organisation (or individual) responsible for the operation of the MHA in a particular hospital. Hospital managers' decisions about discharge are normally delegated to a "managers' panel" of three or more people.
Managers' panel	A panel of three or more people appointed to take decisions on behalf of hospital managers about the discharge of patients from detention or community treatment order.
Responsible Clinician	Under the terms of the MHA this means the Approved Clinician with overall responsibility for a patient's treatment. Only detained patients or patients on a CTO have an RC.

7. How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- This policy will be used in initial and refresher training for all AHMs
- All AHMs will be provided with a copy of this policy

8. How this policy will be audited

A summary of the statistical information provided to the Trust Board will be reported to the quarterly MHL Committee meeting.

9. Document control

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

Change Record

Version	Date	Amendment details	Status

Appendix 1

Letter of appointment- Associate Hospital Manager

[Name]

[Address]

Further to your offer of appointment to the role of Associate Hospital Manager for Tees, Esk and Wear Valleys NHS Foundation Trust ("the Trust") this letter sets out the main terms of your

appointment. If you are unhappy with any of the terms, or need any more information, please let me know.

By accepting this appointment, you agree that this letter is a contract for services and is not a contract of employment and you confirm that you are not subject to any restrictions which prevent you from undertaking this role.

Subject to the remaining provisions of this letter, your appointment shall be for an initial term of 3 years commencing on [DATE] until [date] unless terminated earlier by either party providing confirmation in writing to bring the arrangement to an end. Neither party is required to provide advance notice of termination.

1. Duties and Responsibilities

You will be accountable to the Chair of the Trust. Section 23 of the Mental Health Act (the Act) gives Hospital Managers the power to discharge most detained patients and all Supervised Community Treatment patients. The Trust must arrange for its power to be exercised on its behalf by a Manager's Panel.

The Main duties of a Hospital Manager are:

- To consider the evidence presented, both written and verbal to ascertain whether grounds for continued detention or Supervised Community Treatment under the Act are satisfied.
- To adopt and apply a procedure that is fair and reasonable.
- Not make irrational decisions – that is, decisions which no manager's panel properly directing itself as to the law and on the available information, could have made.
- Not act unlawfully.
- To be prepared to consider the views of patient's relative and carers.
- To give full weight to the views of all the professionals concerned in the patient's care.

It should be noted that these duties and responsibilities may be subject to change in the light of changes to legislation and guidance.

2. Evaluation Process

At a point during your engagement the Trust will endeavour to undertake an evaluation process with you to discuss your development needs. This may include progression to Panel Chair (full training will be provided). The evaluation process will be conducted by a trained appraiser from within the Mental Health Act Department.

Your continued appointment under the terms of this letter is subject to your continued satisfactory performance.

3. Fees and expenses

The Trust will reimburse you for incidental and travel expenses necessarily incurred in the course of the performance of your duties. There is a fee of £25 that may be claimed by panel members on each occasion they attend a review and £30 for panel chair. These sums will be paid to you monthly in arrears through PAYE after deduction of any taxes and other amounts that are required by law. These rates may vary and will be advised from time to time. It is the personal responsibility of each individual Associate Hospital Manager to ensure that they take such steps as

necessary to inform any relevant body (eg HMRC, Department of Works and Pensions etc) of any income.

You are not entitled to receive any other fees or expenses other than as set out above.

4. Location of Performance of Duties

You will perform your duties at such sites agreed with you by The Trust. You may also be requested to undertake duties at locations outside the Trust.

5. Attendance at Panel

Your attendance at panel will be arranged through the Mental Health Legislation Advisors in accordance with the needs of the service and your own availability.

Associate Hospital Managers must attend at least 12 panels a year in order to ensure that consistency is achieved and their skills level maintained.

If it becomes apparent that the number of hearings that an Associate Hospital Manager is attending is giving cause for concern, they will be contacted by the MH Legislation Advisor to review the situation.

All Associate Hospital Managers must attend for training in relation to their role as required by the Trust. Failure to do so may result in the termination of this contract. Attendance at training does not attract a fee, only travelling expenses.

6. Confidentiality

In the course of your duties you will acquire and will have access to confidential information which must not be disclosed to any other person unless in the pursuit of your duties or with specific permission given by the Trust.

This applies particularly to information relating to patients, clients, individual staff records and details of contract prices and terms. You are required to ensure that information about patients is safeguarded to maintain confidentiality and is kept securely in accordance with NHS requirements. The Trust will provide regular training on Information Governance. If you are in any doubt, check with The Mental Health Legislation Advisor.

Breaches of confidentiality may lead to your appointment being terminated.

The Data Protection Act 1998 reinforces the long standing contractual obligation of confidentiality and regulates the use of all information relating to any living identifiable individual that the Trust may hold, regardless of the media in which it is held. This information may be as basic as name and address. Unauthorised disclosure of any of this information may be deemed a criminal offence. If you are found to have permitted the unauthorised disclosure of any such information, you and the Trust may face legal action.

You must not, whether during the term of your appointment with the Trust, or afterwards, unless expressly authorised , make any disclosure to any unauthorised person or use any confidential information relating to the business affairs of the Trust.

Nothing contained in this clause shall have an impact on your ability to make any disclosure in accordance with the Public Interest Disclosure Act 1998, as set out in the clause below.

7. Raising concerns/Whistle Blowing

You should raise any complaints against the Trust, initially with the MH Legislation Advisor.

You should raise any concerns or issues in relation to other Associate Hospital Managers initially with the MH Legislation Advisor

The Trust encourages individuals to raise concerns about malpractice, patient safety, financial impropriety, bribery, criminal offences or any other serious risks and to be protected from victimisation or recrimination for doing so. Further information can be found within the Trust Raising Serious Concerns/Whistle Blowing Procedure which can be found on the Trust Website.

8. Reporting of Accidents/Incidents

If, in the course of undertaking your duties, you are in any way involved in an accident/incident, however minor, you must report it to the Mental Health Legislation Advisor

9. Health and Safety

It is the policy of the Trust to do all that is reasonably practicable to prevent personal injury to employees, damage to property and to protect everyone from foreseeable work hazards.

You must therefore comply at all times with the Health and Safety at Work Act 1974, the Management of Health and Safety at Work Regulations 1999 and all other relevant statutory provisions.

10. Personal Property

The Trust will not accept responsibility for damage to, or loss of, personal property whilst undertaking your duties as Associate Hospital Manager.

11. General Misconduct

Complaints or allegations made against you will be dealt with accordingly.
Allegations or concerns raised which are deemed to be of a such a serious nature may result in the termination of your appointment without notice.

Termination of your appointment

Your appointment may be terminated by the Trust in circumstances where you have:

a) committed a material breach of your obligations under this letter;

b) committed any serious or repeated breach or non-observance of your obligations to the Trust;

c) been guilty of any fraud or dishonesty or acted in any manner which, in the Trust's opinion, brings or is likely to bring you or the Trust into disrepute or is materially adverse to the Trust's interests;

d) been convicted of an arrestable criminal offence

Or for any other reason as set out in this letter of appointment, or for any other reason, at the sole discretion of the Trust.

12. Notification of Changes of terms of appointment

You will be notified, in writing, of any variations to the terms of your appointment. Wherever possible any variations will be agreed prior to implementation.

13. Declaration of Interest

You must declare any interest, including paid or unpaid work or employment held personally or by a member of your family, in any commercial, private, voluntary or other organisation which provides or might reasonably be expected to provide goods and/or services to service users or relatives or to any NHS organisation in competition with the Trust. Failure to do so may result in the termination of this appointment.

Declaration of other appointments for panels outside of the Trust must be made to the MH Legislation Advisor.

Entire agreement

This letter constitutes the entire terms and conditions of your appointment and supersedes and extinguishes all previous agreements, promises, assurances, warranties, representations and understandings between you and the Trust, whether written or oral, relating to its subject matter.

Governing law and jurisdiction

Your appointment with the Trust and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales and you and the Trust irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this appointment or its subject matter or formation (including non-contractual disputes or claims).

14. Acceptance of the Terms and Conditions Specified

If you agree to accept the terms of your appointment as specified above, please sign the form of acceptance at the foot of this page and return one copy of the document to the Human Resources Department as soon as possible. A second copy of the document is attached, which you should also sign and retain for future reference.

SIGNED .....DATE .....
Associate Director of Human Resources
On behalf of Tees, Esk and Wear Valleys NHS Foundation Trust

FORM OF ACCEPTANCE

I hereby accept the appointment of Associate Hospital Manager on the terms of the engagement as outlined above. This offer, and the acceptance of it, shall together constitute an agreement between the parties.

Print Name: ……

Signed:…… Date:……..

Return address
Human Resources Department
Flatts Lane Centre
Flatts Lane
Normanby
Middlesbrough
TS6 0LZ

APPENDIX 3

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 27 APRIL 2015 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON

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

In Attendance:
Miss M Wilkinson, Head of Mental Health Legislation
Mrs P Griffin, Mental Health Legislation Advisor
Mrs U Klaerig-Jackson, Team Secretary

Apologies:

Apologies for absence were received from Mrs L Bessant, Chairman, Dr H Griffiths, Non-Executive Director, Mr D Jennings, Non-Executive Director and Mrs D Oliver, Deputy Trust Secretary (Corporate).

The Chairman welcomed attendees to the meeting and apologies were noted.

15/10 MINUTES

Agreed – *That the minutes of the last meeting held on 19 February 2015 be approved as a correct record and signed by the Chairman subject to the following change:*

'In response, Mrs Stanbury informed the Committee that data on rapid tranquilisation was more difficult to collect as medicine management records would have to be searched manually…'
to read 'In response Mrs Stanbury informed the Committee that data on rapid tranquilisation was captured by searching medicine management records manually, whilst data on control and restraint was collected via Datix.'

15/11 ACTION LOG

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

Arising from the Action log:

1. Further to minute 14/30 (24/10/14 and 19/02/15) Mrs Stanbury advised that the Council of Governors would receive information on the Crisis Care Concordat aligned with the Place of Safety evaluation at its next meeting to be held on 19th May 2015.

2. Further to minute 14/32 (24/10/14) the Committee was informed that DOLs authorisation did not apply to young children and therefore a leaflet about DOLs authorisation would not be useful to Children and Young People's services.

   Mrs Stanbury stated that a review needed to be undertaken to establish which leaflets were already in distribution throughout the Trust and report this at the next Mental Health Legislation Committee meeting in July 2015.

   Action Item – Miss Wilkinson/Mrs Stanbury

15/12 CARE QUALITY COMMISSION (CQC) FEEDBACK SUMMARY REPORT

Consideration was given to the summary report from CQC visits between 1st January 2015 and 31st March 2015.

The Committee noted the following from the report:

a) In the period from 1st January 2015 to 31st March 2015 the CQC undertook 18 visits to the Trust. 5 visits were made to Adult Services, 3 visits to Mental Health Services for Older People and 7 visits to Forensic Mental Health Services including Forensic Learning Disability, 2 visits to Learning Disability Services and 1 visit to Children and Young People's Services.
b) 93 issues had been raised following the visits.
c) No issues were raised for Oakwood ward, Evergreen ward and Ramsey ward, although 1 patient raised an individual issue on Talbot ward.
d) No feedback had been received for Brambling ward.
e) Where issues had been raised, all action plans, with the exception of Mallard ward and Brambling ward had been approved by the Executive Management Team (EMT) and forwarded to the CQC.
f) All actions were monitored via the Quality Assurance Groups and no actions had been reported as outstanding by more than one month to the EMT.
g) The action plan for Mallard Ward was due to be discussed at the EMT meeting on 22nd April 2015 and returned to the CQC by 1st May 2015.

Arising from discussion:

a) Mrs Stanbury advised the Committee that issues raised around control and security referred to Ridgeway at Roseberry Park, which consisted of low secure and medium secure wards, were being further reviewed because:.
    i. The new Code of Practice recognises that some wards of enhanced levels of security may be required to have in place 'blanket' rules and restrictions for their identified client group. However the CQC have consistently criticised blanket restrictions such as regular searches on medium secure wards and this criticism would seem to conflict with the new Code.
    ii. The Trust may be able to identify which wards would be covered by the guidance in the new Code of Practice and then put proposals to the

CQC regarding the operational policies for those wards. This approach was to be agreed at the Clinical Leaders Board.

iii. Clarity was sought on whether the CQC acknowledged its approach to restrictive practices differed from the guidance in the Code of Practice.

In response it was stated that at the next liaison meeting with the lead inspector at the CQC it would be necessary to raise this issue of conflict between inspection feedback and the Code of Practice guidance.

Action Item – Mrs Stanbury

b) It was questioned whether reports following the CQC visits were published in the media.

It was noted that previously Mental Health Act reports had not been published, however as from 1st April 2015 the Mental Health Act inspectors have new compliance powers and it has not been clarified by CQC what new processes are to be implemented regarding publication of reports and the enforcement power behind the recommendations for actions in those reports. The Trust has sought clarification.

c) Training around the new Code of Practice needs to be provided to staff. This would be provided in the form of Briefing Sessions as part of the overall implementation plan. There may be an informal period of 'grace' during which time the CQC may not inspect against the new requirements of the Code of Practice but there would be an expectation that all policies and procedures will be Code compliant within a reasonable timescale.

Action Item – Miss Wilkinson

15/13 MHA PERFORMANCE REPORTS

Consideration was given to:

- Admissions, Changes and Detention Themes Report
- The MHA Section 136 Report
- The Seclusion Report
- The Report on Discharges
- AMHP Information

1. <u>Admissions, Changes and Detention Themes Report</u>

Miss Wilkinson presented a summary report on the themes and trends with regard to patients subject to the Mental Health Act (MHA).

The Committee noted that:

1) The Trust anticipated that the majority of patients on our wards who were identified as being deprived of liberty would meet the criteria for detention under the MHA and as such the Trust had monitored the use of the Act specifically in relation to this.
2) The previous plateauing in admissions was now showing that the number of admissions had increased again in March 2015.

3) There had been an increase in the use of section 2's around May, June, July 2014, which could be attributed to the Cheshire West judgement, with a significant dip of section 2s in place on 31st December 2014.
4) The number of section 2's applied during May and June 2014 had been high due to the impact of the Cheshire West judgement, with a clear pattern present in both 2013/14 and 2014/15.
5) Danby ward still appeared to be an outlier in comparison to other Adult Mental Health wards, with a low percentage of detained to informal patients ratio.

Agreed:

1) *That for the next report the graphs for Admissions under the Mental Health Act would start with Quarter 1 2014/15, in comparison to Quarter 1 2015/16 and continue quarter on quarter to enable activity and trend identification. The Committee felt that figures for 2013/14 should also be kept in the graph for comparison.*

Action Item – Miss Wilkinson

2) *Bed numbers should be included in the graphs for detained patients on wards and further discussion was required outside the meeting on whether the current graphs were meaningful. The conclusion would be presented at the next meeting of the Committee.*

Action Item – Miss Wilkinson/Mrs Stanbury

3) *That reasons would be established as to the lower percentage of detained to informal patients on Danby ward to be reported back to the Committee at its next meeting.*

Action Item – Miss Wilkinson

2. Section 136 Report

Mrs Griffin presented the report, which detailed the use of section 136 by the Police and the use of Places of Safety.

The Committee noted that:

1) There was a consistently high number of people attending Roseberry Park as 'voluntary attenders', a significant amount of these were brought by the police 'voluntarily', rather than using section 136.
2) The number of individuals held by Cleveland Police under section 136 had decreased significantly, by 59% to a Police Place of Safety (PoS) and there had been a small increase of 6% for those taken to Roseberry Park.
3) Over the year there had been a significant and consistent decrease in the number of individuals brought by Cleveland Police to a police PoS, the vast majority of whom had been intoxicated.
4) The number of individuals brought to TEWV PoS had risen slightly over the year, corresponding to the police's decrease in some, but not all months of the year.
5) Durham Police showed an increase of 67% in their numbers of individuals going to a police PoS, but there had been no changes to the number of individuals going to a Trust PoS.

6) Over the last 12 months there had been highs of 5 and 6 individuals taken to a TEWV PoS, however significantly more lows of 1 and 2 individuals taken to a Trust PoS.
7) The number of individuals taken to a police PoS in Durham and Darlington plateaued between 7 and 10 for 6 months before they decreased to 2 in January 2015 and then increased to 14 in March 2015.
8) The number of individuals taken by North Yorkshire Police to a Police PoS had decreased by 71% and the number taken to a Trust PoS had decreased by 11% compared to the previous quarter.
9) In the last financial year the number of individuals taken to a police PoS had decreased significantly from 12 in June 2014 to 1 in February 2015, with an average of approximately 5 per month.
10) Of those using TEWV as PoS approximately:

    a. 45% of section 136s were returned to the community with follow up.
    b. 30% were returned to the community with no indication of follow up.
    c. 17% agreed to informal admission.
    d. 7% were admitted under a section of the Mental Health Act.
    e. 1% were transferred to another facility.

11) Of those held in a Police PoS approximately:
    a. 100% of individuals taken to Cleveland Police PoS were intoxicated.
    b. 62% were released to go home.
    c. 23% were assessed under the Mental Health Act with no outcome available.
    d. 15% were transferred to a TEWV PoS.
12) Cleveland police officers remained with the individuals held in the Trust's PoS for times ranging from 4 minutes on 1 occasion to over 5 hours on 4 occasions for this quarter. On all 4 occasions the individuals were under the influence of either alcohol or illicit substances or both, 1 individual had been taken to A&E for assessment.
13) Durham police officers remained in the Trust for times ranging from 1 hour 40 minutes to between 4 and 5 hours on 4 occasions.
14) North Yorkshire police officers remained in the Trust PoS for 5 minutes on 3 occasions to over 4 hours on 1 occasion; the individual requiring police presence for over 4 hours was admitted informally.
15) There was 1 individual under the age of 18 detained under section 136 in a Trust PoS via Street Triage and this individual was seen by the Children and Young People's Services.
16) During this quarter there was 1 individual under the age of 18 identified by Teesside Street Triage Team.
17) The numbers seen by the Scarborough Street Triage Team were significantly higher than those in Teesside.
18) There were 92 individuals who attended Roseberry Park, 50 of whom were brought by Cleveland Police and 7 of them subsequently admitted. Of those individuals attending voluntarily a further 7 were admitted informally.
19) From information available over 60% of voluntary presenters were between the hours of 5pm and 8am.

Arising from discussion:

1) It was noted that graph showing the increases/decreases in the number of section 136's in 2014 in Durham and Darlington was mislabelled.
2) The Committee noted that the police inspector in the Scarborough and Ryedale locality had been delighted with the operation and use of section 136.
3) Clarity was sought on the future of Street Triage in Scarborough.

   In response Mr. Kilmurray explained that discussions were still being held about the future of Street Triage in Scarborough. At present Street Triage was funded by the police with an understanding that it would be funded by the Commissioners in future.

Agreed – *That the Committee received and noted the report on the use of section 136.*

3. Seclusion Report

The Committee received the report on the use of seclusion and noted the following:

1) During January 2015 there had been 9 episodes of seclusion, ranging from 6 minutes to over 64 hours.
2) In February 2015 there were 7 episodes ranging from 1 hour 22 minutes to over 118 hours.
3) In March 2015 there were 20 episodes ranging from 45 minutes to over 216 hours.
4) Seclusion had been monitored as per policy and terminated after each patient had settled for a period of time.

Arising from discussion:

1) It was noted that a narrative had been added to this report stating the reason for seclusion.
2) The Committee noted that the present arrangements for debriefing patients following periods of seclusion could result in further challenging behaviour of the patient and Mr Buckley would be asked to consider appropriate mitigation.

Action Item – Mrs Stanbury

4. Discharges from detention report

The Committee received the report, which highlighted the number of discharges from detention by the First Tier Tribunal Service and Associate Hospital Managers.

The Committee noted that:

1) There were 3 conditional discharges, 1 deferred discharge and 12 discharges by the First Tier Tribunal. There were no discharges by the Hospital Managers.
2) 190 tribunals were held in this quarter, whereby 12 patients were discharged, 3 patients received a conditional discharge and 1 a deferred discharge.

3) The patients that were conditionally discharged by the Tribunal were discharged with the agreement/recommendation of the clinical team and full plans were in place to take effect upon the Tribunal's decision.
4) There was 1 deferred discharge for which the team were prepared, although did not recommend in their report.
5) 5 patients were discharged from a Community Treatment Order.
6) 4 patients detained under section 3 were discharged without the agreement of the clinical team.
7) 3 patients detained under section 2 were discharged by the Tribunal without the agreement of the clinical team.
8) 3 of the discharged patients had the same Responsible Clinician, however each patient had social circumstances and nursing reports provided by different individuals and 2 further patients who had the same Responsible Clinician also had a social circumstances and nursing reports provided by different people.
9) Out of all cases heard by the Tribunal, only 6% were discharged on the day.

Arising from discussion it was noted that:

a) There were still no trends or patterns visible where discharges had occurred against clinical recommendations.
b) Dr Land asked to be informed if a Responsible Clinician repeatedly failed to convince the Tribunal panel that the statutory criteria was met to keep a patient in detention.

Action Item – Mrs Griffin

Agreed *– that the Committee received and noted the discharge from detention report.*

5. Ambulance delays

The Committee received the information regarding Assessor and Ambulance delays provided by the Approved Mental Health Professionals (AMHPs).

Agreed *– that the issues around first medical assessor delays and ambulance delays be escalated to the appropriate Clinical Commissioning Group.*

Action Item – Mrs Stanbury

15/14 CODE OF PRACTICE UPDATE

Miss Wilkinson informed the Committee that some changes had been made to the previous draft of the Code of Practice prior to the final version which came into effect on 1st April 2015.

1) 2 hour roadshows for staff would be undertaken to raise awareness of the new Code of Practice and the main changes to the document.
2) The Mental Health Act Office were providing hard copies of the Code of Practice to all wards and teams across the Trust and it is also available electronically in inTouch on the MHA pages.

Action Item – Miss Wilkinson

15/15 REVISED ASSOCIATE HOSPITAL MANAGERS POLICY

The Committee received the revised draft of the Associate Hospital Managers policy.

It was noted that:

1) The policy had been drafted to aid the appointment of Associate Hospital Managers.
2) This draft did not include the letter of appointment for Associate Hospital Managers.
3) The document would be open for comments with a final version of the policy to be presented to the Committee.

Arising from discussion:

1) The title of the policy to be changed from 'Hospital Managers Policy' to 'Associate Hospital Managers Policy'.
2) A guide of ''Do's and Don'ts'' needed to be included in the policy.
3) Further clarity was sought in the policy around the difference between the role of Hospital Managers (the Trust) and Associate Hospital Managers.

Action Item – Miss Wilkinson

Agreed *– that a revised draft of the policy be received by the Committee at its next meeting to be held on 27th July 2015.*

Action Item – Mrs Oliver/Miss Wilkinson

15/16 NO VOICE UNHEARD, NO RIGHT IGNORED – CONSULTATION DOCUMENT

The Committee received a consultation document which focussed on recommendations for changes in relation to practice and also some legislative changes aimed specifically at people with learning disabilities, autism and, for some elements, general mental health conditions.

Miss Wilkinson informed the Committee that Dr Passmore (Consultant Psychiatrist/ Senior Clinical Director in LD (Teesside)) and Dr Khouja (Consultant Psychiatrist / Deputy Medical Director Forensics) would be responding to the document on behalf of the Trust, together with a response from a Mental Health Legislation perspective.

Arising from discussion it was noted that:

1) The document was not easy to read.
2) The majority of issues raised within the document related to learning disabilities with mental health appearing to be more of an afterthought.
3) This consultation would be open to the public, with an opportunity to respond. Mrs Stanbury explained that it was the Department of Health's responsibility to make service users and families aware of this document and the consultation.
4) Dr Land informed the Committee that MIND had been asked to respond to this consultation with opinions of their service users in mind.
5) The Committee suggested that this document and the consultation were shared via the Trust's website, Facebook page and Twitter account.

6) Consideration should also be given to sharing this information via the Patient and Public Involvement Officers and their networks.

Action Item – Mrs Oliver/Mr Bellas

15/17 ANY OTHER BUSINESS

Mrs Stanbury informed the Committee that the Director of Quality Governance would commence her role on 18th May 2015 with a responsibility to attend the Mental Health Legislation Committee.

The Terms of Reference with regards to membership of the Committee would need to be revised at the next meeting on 27th July 2015.

Action Item – Mrs Oliver

The Chairman closed the meeting at 1.05pm.

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date: **29 September 2015**

Title: **Finance Report for Period 1 April 2015 to 31 August 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: **29 September 2015**

Title: **Finance Report for period 1 April 2015 to 31 August 2015**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2015 to 31 August 2015.

2. BACKGROUND INFORMATION

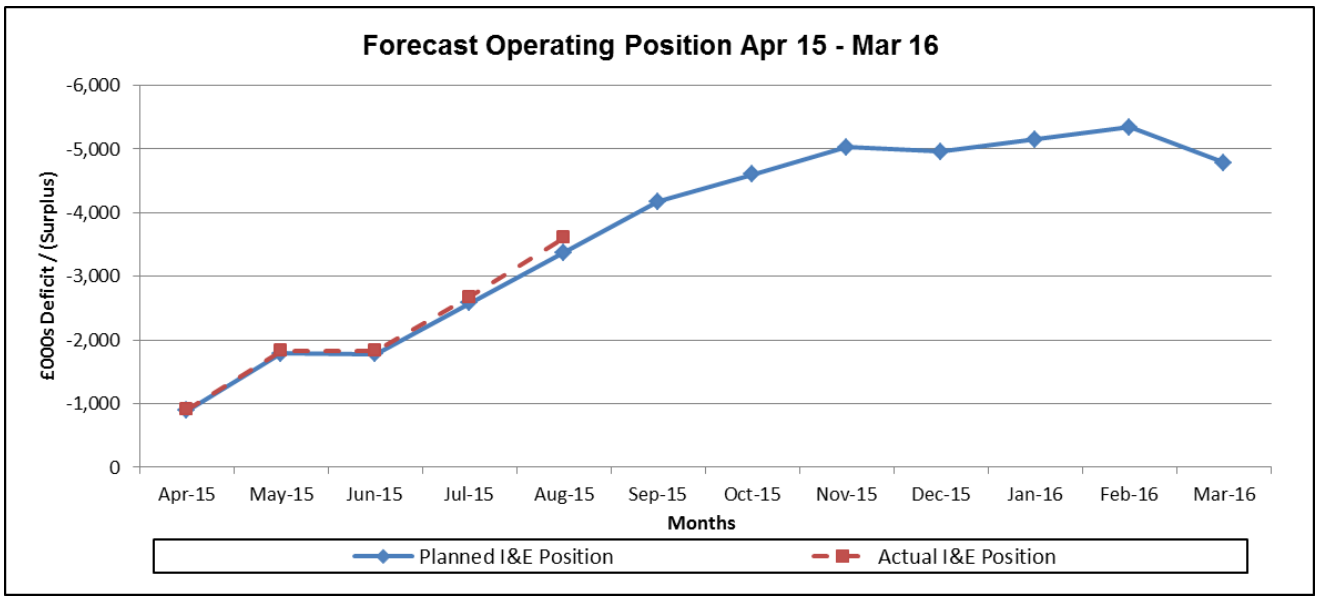
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

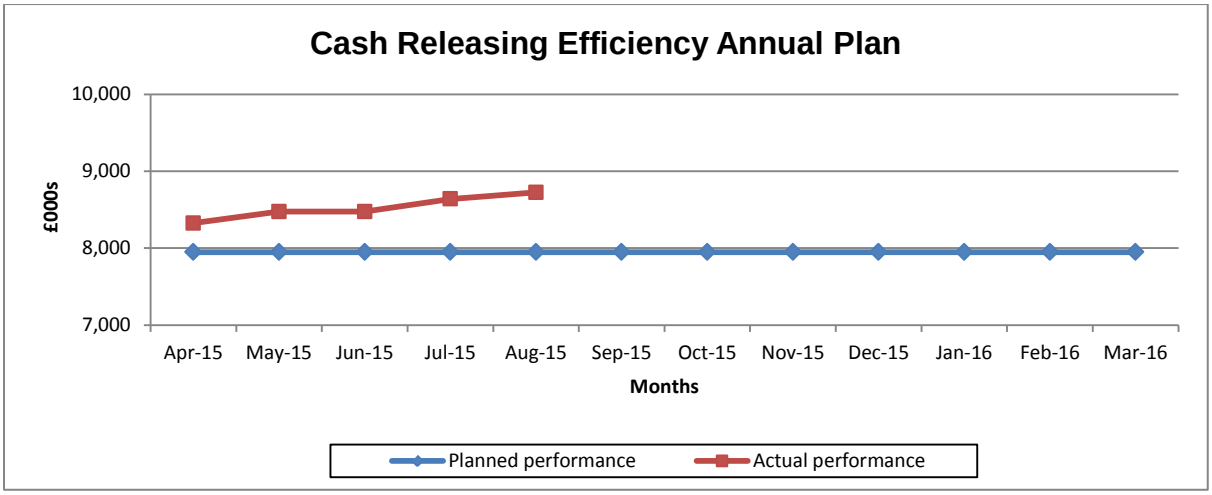
The financial position shows a surplus of £3,611k for the period 1 April 2015 to 31 August 2015, representing 3.0% of the Trust's turnover and is marginally ahead of plan.

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

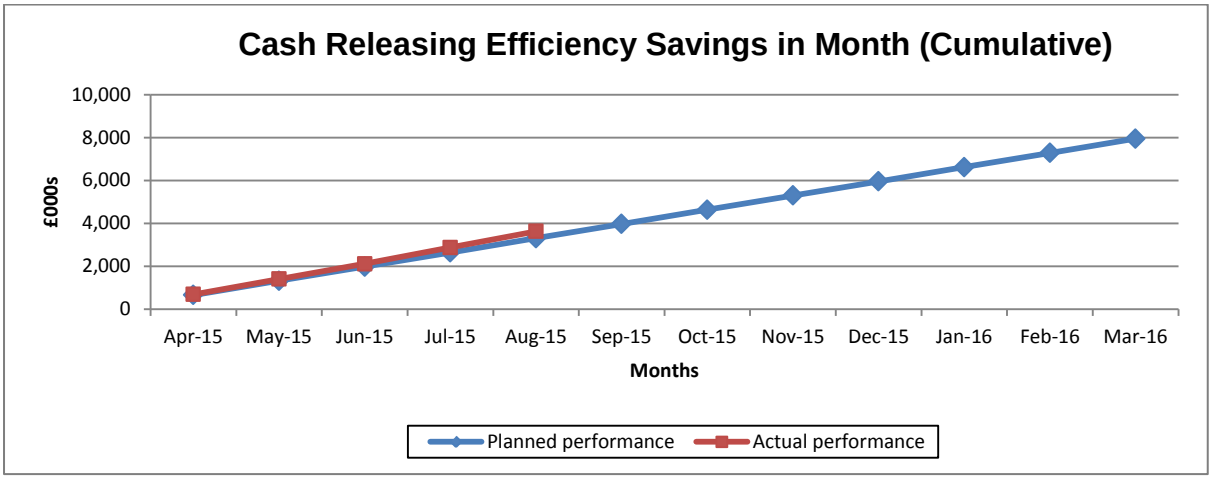


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 August 2015 is £8,741k and is £792k ahead of plan.

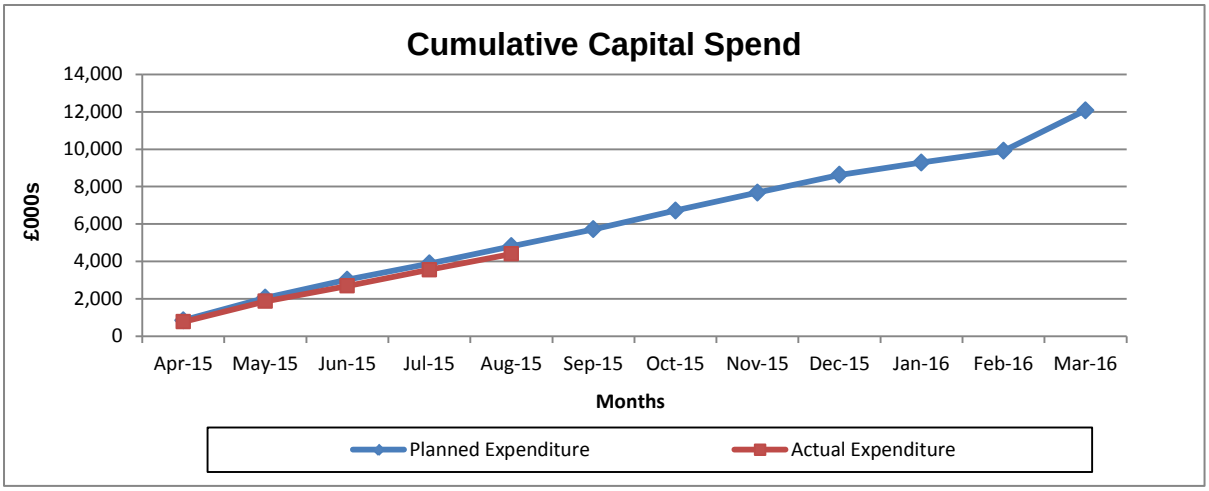


The monthly profile for CRES identified by Localities is shown below.



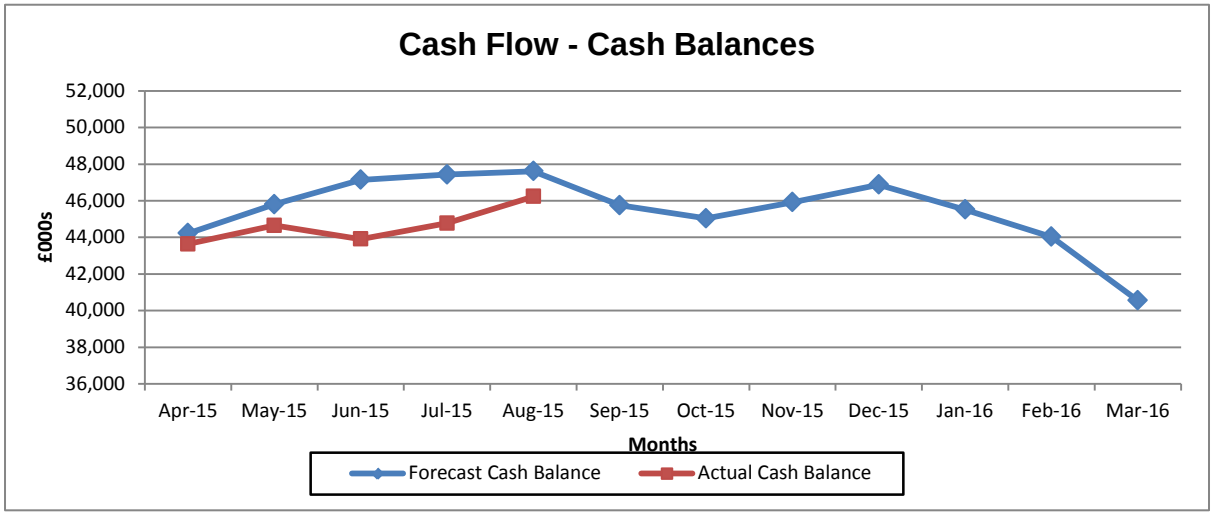
3.3 Capital Programme

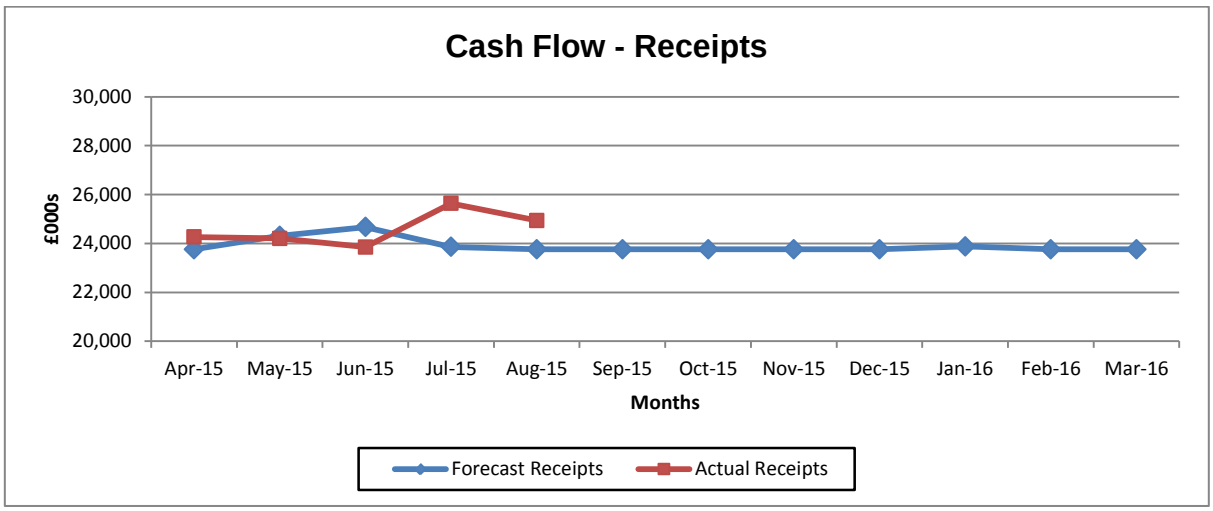
Capital expenditure to 31 August 2015 is £4,396k, which is marginally behind plan.

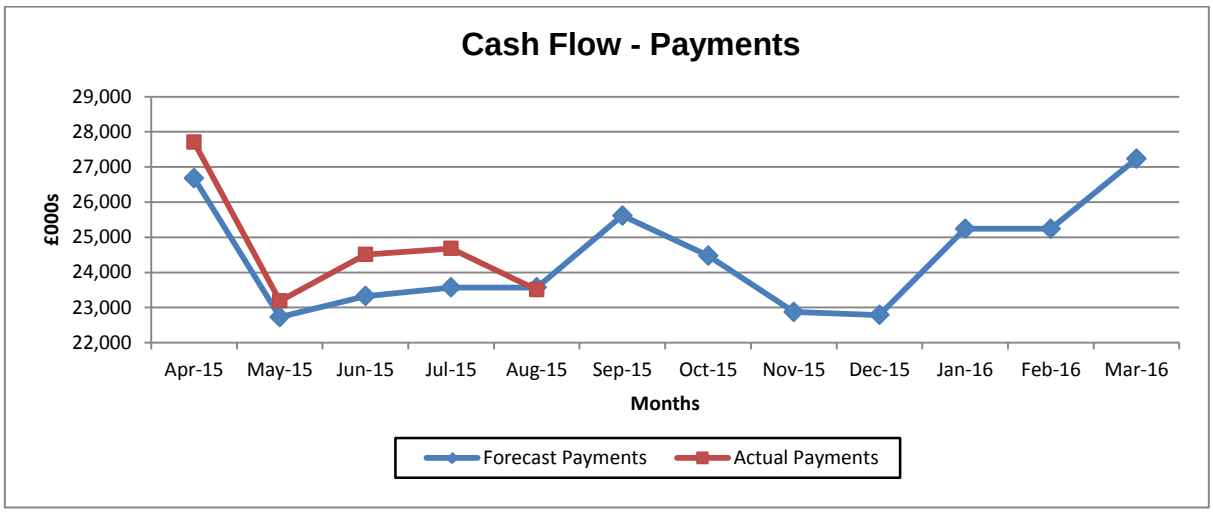


3.4 Cash Flow

Total cash at 31 August 2015 is £46,233k and is behind plan due to a fluctuation in working capital, mainly within creditor payments.



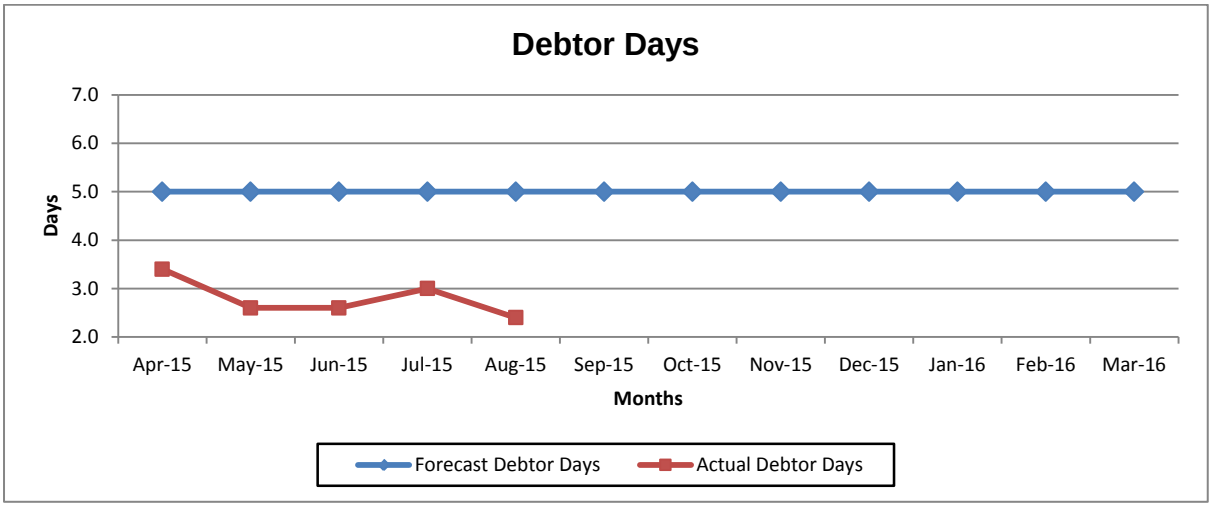




The payments profile fluctuates over the year for PDC dividend payments, financing repayments and payments for capital expenditure.

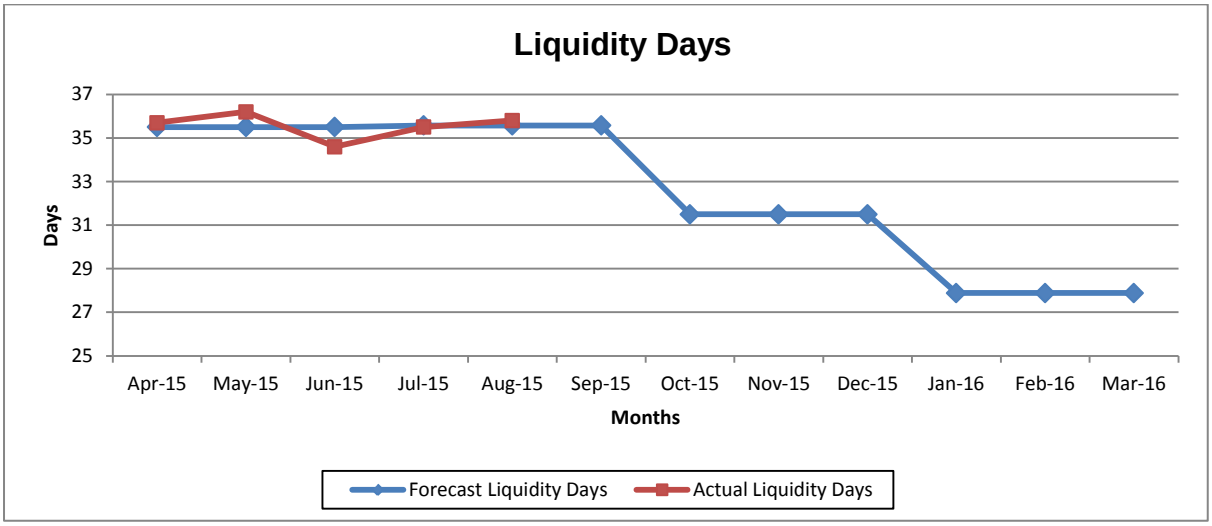
Working Capital ratios for period to 31 August 2015 were:

- Debtor Days of 2.4 days
- Liquidity of 35.8 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 87.41%
  Non NHS 30 Days – 98.57%



The Trust had a debtors' target of 5.0 days and actual performance of 2.4 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 in line with plan.



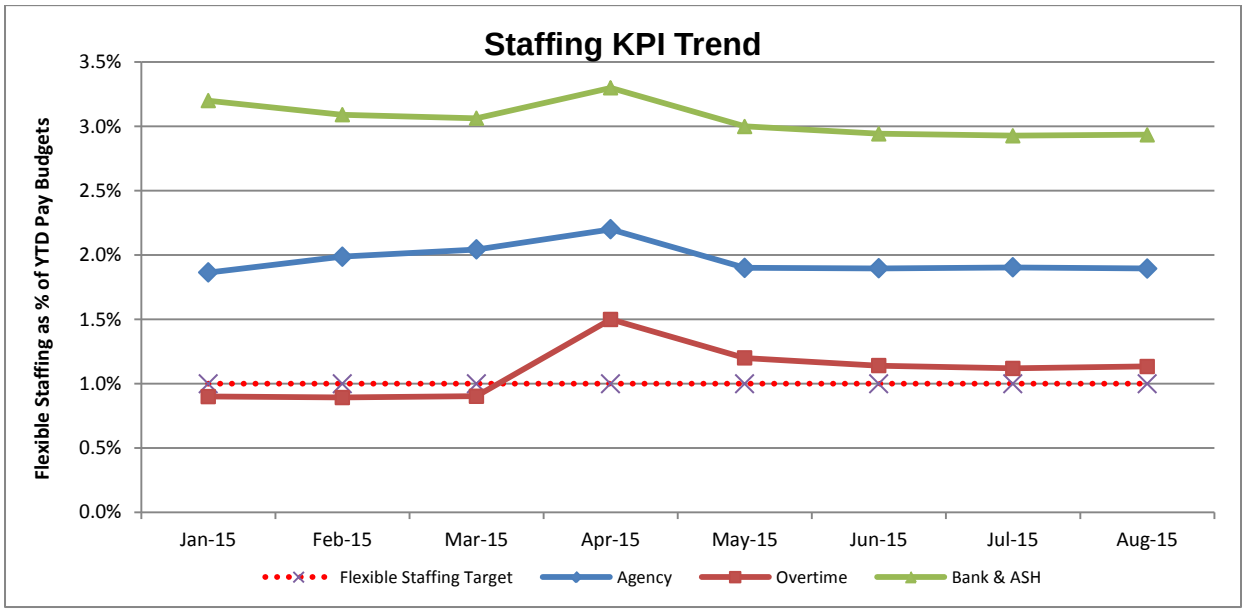
3.5 Financial Drivers

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

Tolerance	Apr	May	Jun	Jul	Aug
Agency (1%)	2.2%	1.9%	1.9%	1.9%	1.9%
Overtime (1%)	1.5%	1.2%	1.1%	1.1%	1.1%
Bank & ASH (flexed against establishment)	3.3%	3.0%	2.9%	2.9%	2.9%
Establishment (90%-95%)	94.0%	94.1%	93.7%	94.0%	94.3%
Total	**101.0%**	**100.2%**	**99.7%**	**100.0%**	**100.3%**

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 August 2015 the tolerance for Bank and ASH is 3.7% of pay budgets.

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



Additional staffing expenditure is 5.92% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (44%), enhanced observations (20%) 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.

For consistency the Trust will continue to report both ratings until September.

The Continuity of Service Risk Rating was assessed as 3 at 31 August 2015 and is in line with plan.

The Financial Sustainability Risk Rating was assessed as 3 at 31 August 2015.

3.6.2 Capital service capacity rating (Debt service cover – CoSRR) 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 1.53x (can cover debt payments due 1.53 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 costs held in cash or cash equivalents. The Trust liquidity metric is 35.8 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 3.59% 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 0.01% behind plan and is rated as a 3.

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 £1,813k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £26,108k is required.
- I&E Margin – to reduce to a 3 a surplus decrease of £3,093k is required.
- Variance from plan – to reduce to a 2 a decrease in surplus of £1,186k 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	1.53x	2	1.58x	2	
Liquidity	35.8 days	4	35.6 days	4	
I&E Margin	3.59%	4	3.60%	4	
Variance from plan	-0.01%	3	0%	4	
Overall Financial Sustainability Risk Rating		**3.00**			

3.6.7 5.8% of total receivables (£131k) 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 2.0% of total payables invoices (£187k) 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 August 2015 is £46,233k and represents 63.8 days of annualised operating expenses.

3.6.10 Actual capital expenditure is 91% 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 August 2015 is a surplus of £3,611k, which is equivalent to 3.0% of turnover and is marginally ahead of plan.

5.2 The Trust is ahead of plan for identified Cash Releasing Efficiency Savings at 31 August 2015. The Trust continues to identify schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for 2017/18.

5.3 The Continuity of Services Risk Rating for the Trust is 3 for the period ending 31 August 2015.

5.4 The Financial Sustainability Risk Rating was assessed as 3 at 31 August 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 10

BOARD OF DIRECTORS

Date of Meeting: **29th September 2015**

Title: **Board Dashboard as at 31st August 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: **29th September 2015**

Title: **Board Dashboard as at 31st August 2015**

1 INTRODUCTION & PURPOSE

1.1 To present to the Board the Trust Dashboard **(Appendix 1)** as at 31st August 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:

- At the Board Seminar on 18th August 2015, it was agreed that the SWEMWBS and HONOS indicators (KPIs 19-22) would be removed from the Trust Dashboard and replaced with more "strategic" indicators once these were available. These indicators have now been removed and the subsequent indicators have been renumbered in the Dashboard.

- 10 of the 24 (42%) indicators are being reported as red in August 2015 compared to 64% in July 2015. Of those 10, 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 August however both are showing an improving trend over the last 3 months. KPI 1(external referrals) has improved considerably compared to the position in July and performance is at the highest point in the year. The action plans developed by the services are continuing to be implemented. Children and Young Peoples' services continue to be the area of most concern although the number of people still waiting over 4 weeks as at the end of August is significantly lower than earlier in the year. In terms of KPI 2 performance in August is also better than July.

- Psychological Therapies Access (KPI 6) has deteriorated further in August and is performance is at the lowest level in the year. However this follows the trend in previous years where the number of people accessing services during the key holiday periods (August and December) reduces due to lower referrals and more people not attending their appointment. Performance in August 2015 remains higher than the same period in 2013 and 2014. In terms of KPI 7 Recovery Rate the Trust has failed to achieve the 50% recovery target; and the position has deteriorated in August to the lowest level of the year to date. Performance varies

across the CCG areas with some areas (South Tees, Harrogate and Vale of York). Action Plans are in place to improve performance.

- Out of Locality Admissions (KPI 12) – There has been a further deterioration in performance during August. Only Teesside is achieving target (4.6%), North Yorkshire has shown a significant deterioration during August with 34% of its admissions being Out of Locality. In addition to the action plan in Richmondshire work is taking place to support the services in the appropriate management of people with personality disorders.

- Percentage of patients readmitted to assessment and treatment beds within 30 days (KPI 13) – This indicator has continued to underperform and has deteriorated further in August. On investigation it is clear that there is no particular hot spots in terms of the wards or community teams who were involved in the care of the patients who were readmitted during August however further work is being undertaken to see if this is the position for the year to date It should be noted that the related indicators, KPI 14 (number of times a patient has had 3 or more admissions in the past year) and KPI 15 (median number of days between admissions, are both achieving the target and show an improving position over the previous 3 months.

- Appraisal (KPI 23) – The 3 monthly trend continues to be one of deterioration with August reporting a deterioration on the July position to the lowest position reported this financial year (84.48%). The event to look at how the IIC can support the proactive management of this indicator was well attended and a one day follow up workshop is planned to take planned to take place in September.

2.2 **Appendix 2** outlines the assessment of the level of data quality of the Board Dashboard Indicators.

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

	August 2015				April 2015 To August 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%	85.31%			98.00%	81.69%		98.00%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	88.44%			98.00%	87.88%		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%	75.61%			50.00%	73.80%		50.00%
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	86.14%			75.00%	80.54%		75.00%
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	94.25%			95.00%	93.94%		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%	11.16%			15.00%	13.37%		15.00%
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	45.92%			50.00%	46.87%		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%	95.74%			95.00%	97.77%		95.00%
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	97.52%			95.00%	97.96%		95.00%
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.52%			98.00%	98.52%		98.00%
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	88.77%			85.00%	89.53%		85.00%

Trust Dashboard Summary for TRUST

Strategic Goal 2: To continuously improve the quality and value of our work

	August 2015				April 2015 To August 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%	19.17%			15.00%	17.64%		15.00%
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	27.03%			15.00%	24.58%		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	18.00			88.00	110.00		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	150.50			146.00	114.00		146.00
16) Percentage of appointments cancelled by the Trust	0.67%	0.95%			0.67%	1.06%		0.67%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.92			5.00	7.68		12.00
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	89.29%			75.00%	71.58%		75.00%

Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce

	August 2015				April 2015 To August 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%	84.48%			95.00%	84.48%		95.00%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	89.96%			95.00%	89.96%		95.00%
21) Percentage Sickness Absence Rate (month behind)	4.50%	4.45%			4.50%	4.56%		4.50%

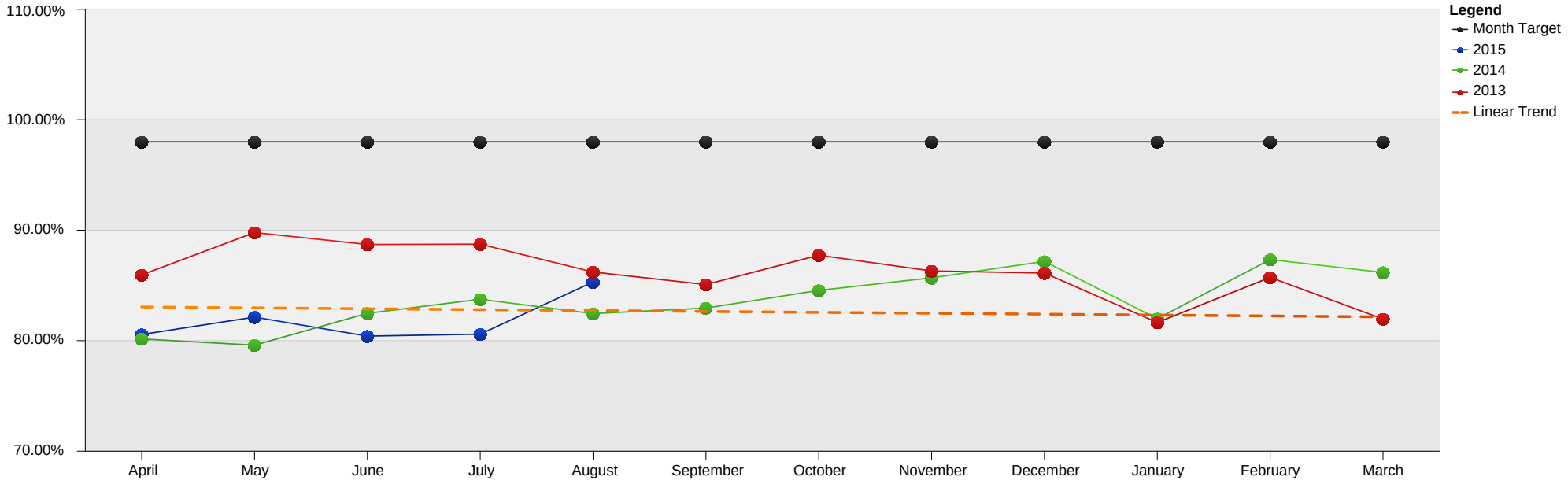
Trust Dashboard Summary for TRUST

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

	August 2015				April 2015 To August 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	5,602.00			29,314.00	30,393.00		69,931.00
24) Delivery of our financial plan (I and E)	-797,000.00	-937,000.00			-3,375,000.00	-3,611,000.00		-4,784,000.00

Trust Dashboard Graphs for TRUST

1) Percentage of patients seen with 4 weeks for a first appointment (external referral)



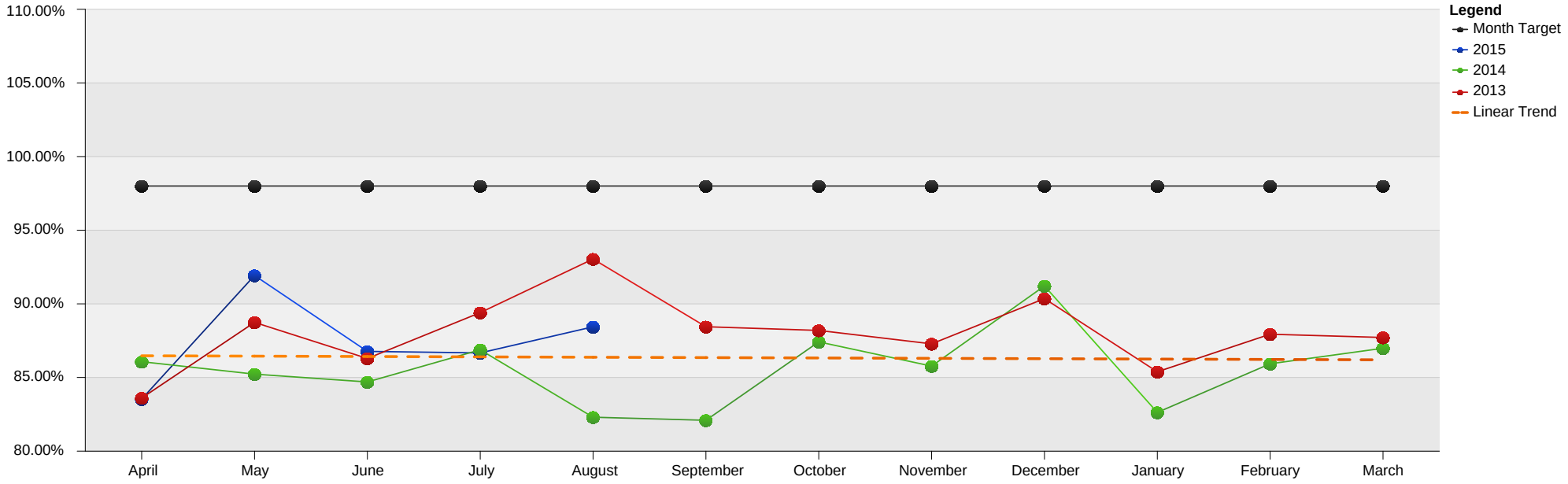
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	85.31%	81.69%	79.59%	77.29%	93.24%	88.71%	77.82%	74.97%	100.00%	99.89%

Narrative

The Trust position for August 2015 is 85.31%, which relates to 499 patients out of 3397 who had waited longer than 4 weeks for a first appointment. This is 12.69% below target, but an improvement on July 2015 performance. The Trust position for the financial year to date is 81.69%, which is 16.31% below target.The specific areas of concern are:• Durham and Darlington CYP at 40.63% (114 patients) and AMH at 81.26% (86 patients). CYP is primarily attributable to large numbers of referrals for the PMHW teams. A 15 point action plan is in place; 12 have been completed. Processes are in place to implement the remaining 3.• Teesside CYP at 72.00% (56 patients). All new patients are being given appointments within 4 weeks. There remains a backlog of patients waiting over 4 weeks, but they are being allocated appointments.• North Yorkshire CYP at 69.14% (25 patients), MHSOP at 74.51% (65 patients) and AMH at 82.34% (74 patients). An action plan scheduled to run for ten weeks within MHSOP commenced in July; improvements are being achieved but remain limited due to staff sickness. The issue within AMH is primarily attributable to Ripon CMHT and Hambleton & Richmondshire CMHT experiencing staffing pressures and Primary Care in Hambleton & Richmondshire.Whilst the Trust reports an improving trend and August the highest position 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)



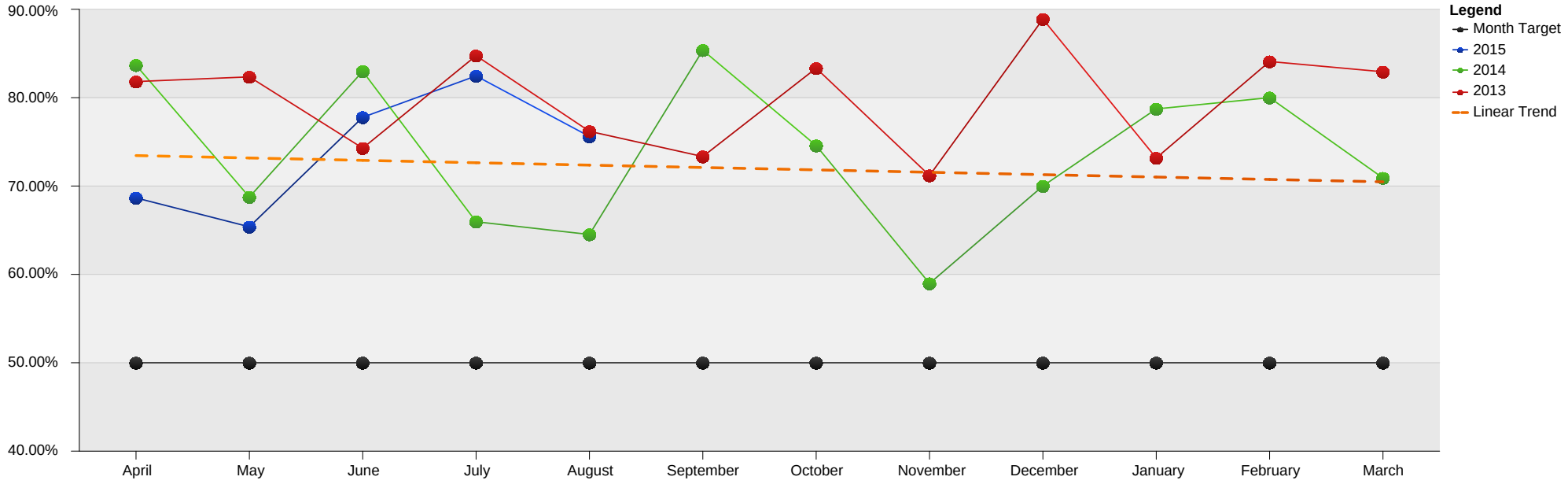
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	88.44%	87.88%	81.24%	84.79%	93.93%	91.79%	92.04%	89.27%	47.62%	60.00%

Narrative

The Trust position for August 2015 is 88.44%, which relates to 235 patients out of 2033 that were not seen within 4 weeks of an internal referral. This is 9.56% below target but a slight improvement on July 2015 performance. The Trust position for the financial year to date is 87.88%, which is 10.12% below target.The specific areas of concern are:• Durham and Darlington Children & Young People's Services at 62.25% (57 patients), Adult Mental Health Services at 85.50% (58 patients)• Teesside Children & Young People's Services at 84.21% (21 patients)• Forensic Services at 47.62% (11 patients), all of which are within Forensic Learning Disability autism services.Based on past performance and August's performance there is 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

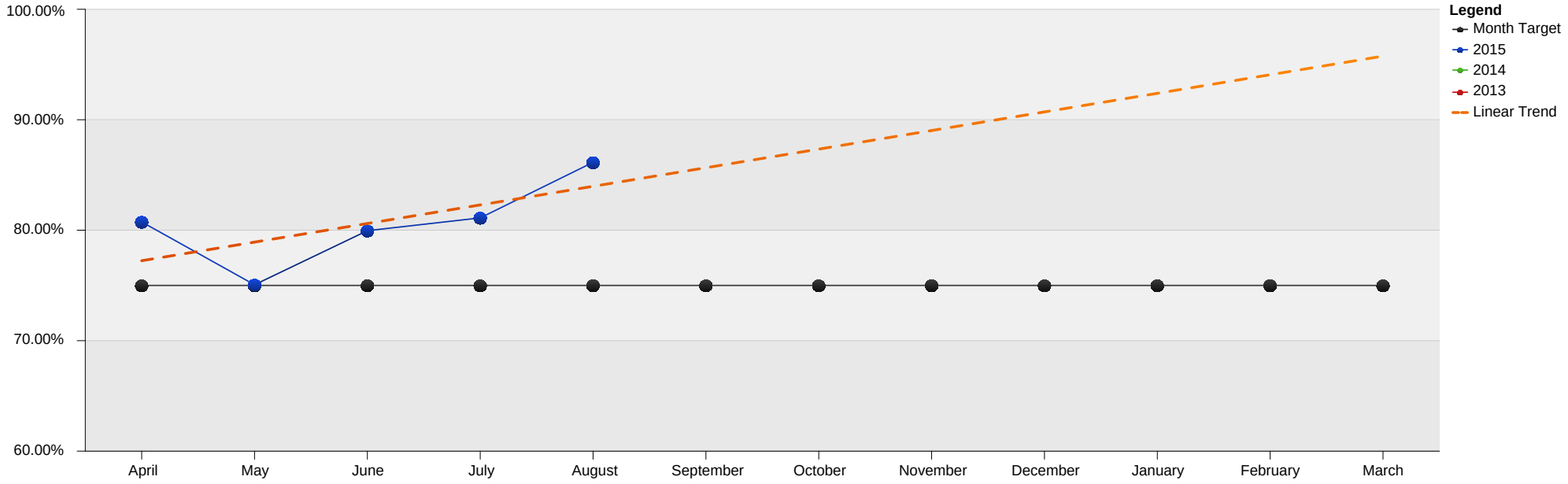


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	75.61%	73.80%	68.75%	61.32%	81.25%	82.05%	77.78%	81.25%	NA	NA

Narrative
The Trust position for August 2015 is 75.61%, which relates to 10 patients out of 41 that were not treated with a NICE approved care package within 2 weeks of referral. This is 25.61% above target but a deterioration on July 2015 performance. All localities are achieving target. The Trust position for the financial year to date is 73.80%, which is 23.80% above target.Based on past performance and August's performance it is anticipated that we will achieve the annual target of 50%. 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.



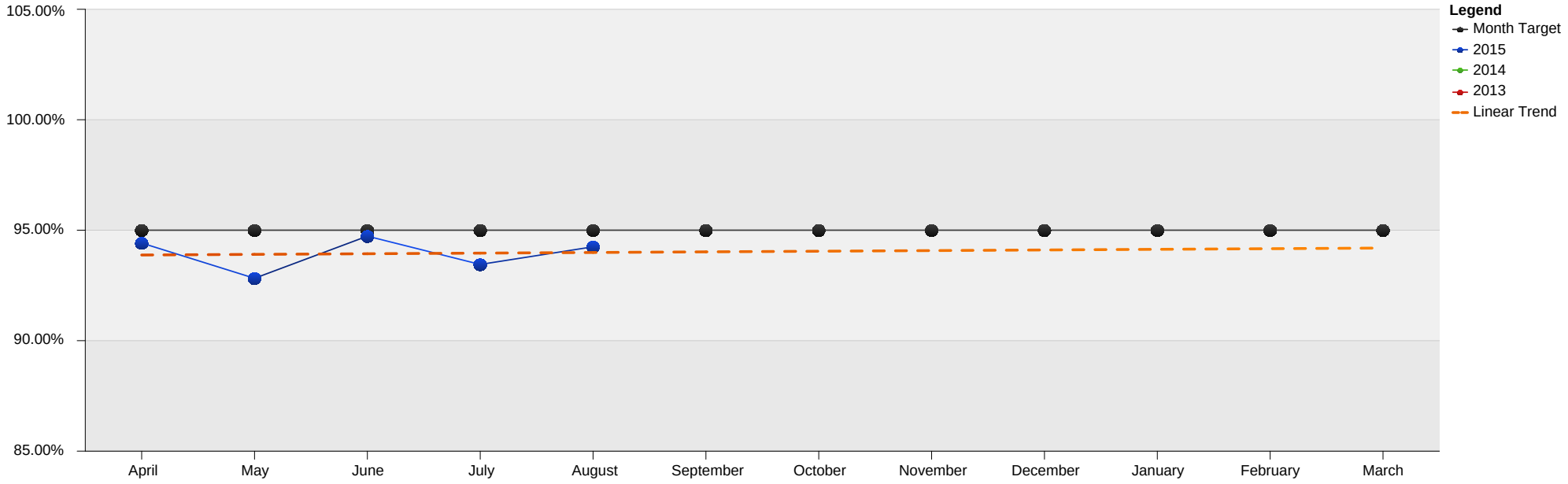
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	86.14%	80.54%	98.16%	98.43%	58.78%	60.23%	77.89%	64.55%	NA	NA

Narrative

The Trust position for August 2015 is 86.14%, which relates to 106 patients out of 765 that were not treated within 6 weeks of referral. This is 11.14% above target and an improvement on July 2015 performance. The Trust position for the financial year to date is 80.54%, which is 5.54% above target.Durham & Darlington (98.16%) and North Yorkshire (77.89%) are both achieving target and showing an improvement on July's performance.Teesside (58.78%) reports below target but has reported a slight improvement on July. The service has an action plan in place to address the areas of underperformance and the number of sessions available has been increased.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

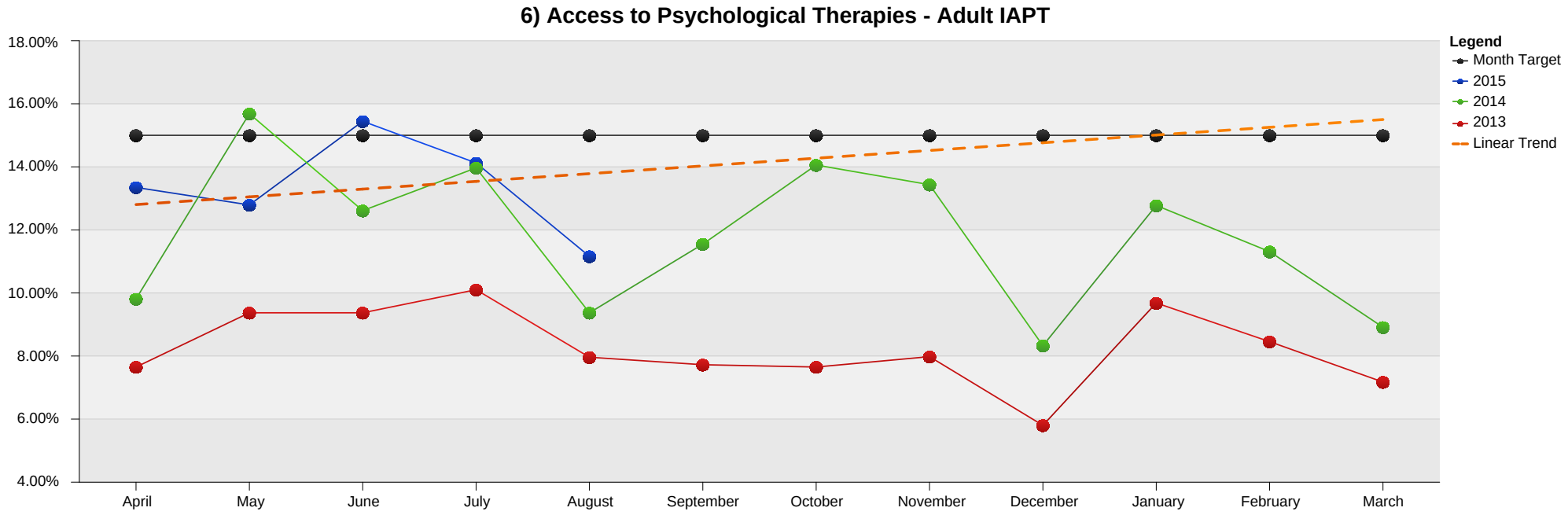
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.



	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.	94.25%	93.94%	100.00%	99.81%	77.86%	79.15%	92.46%	93.29%	NA	NA

Narrative
The Trust position for August 2015 is 94.25%, which relates to 44 patients out of 765 that were not treated within 18 weeks of referral. This is 0.75% below target but a slight improvement on July 2015 performance. Only Durham & Darlington are achieving target, reporting 100% for August. The Trust position for the financial year to date is 93.94%, which is 1.06% below target.Teesside reports 77.86% (29 patients not treated within 18 weeks).North Yorkshire reports 92.46% (15 patients) – this is a significant improvement on July's performance. Based on past performance and August's performance 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.

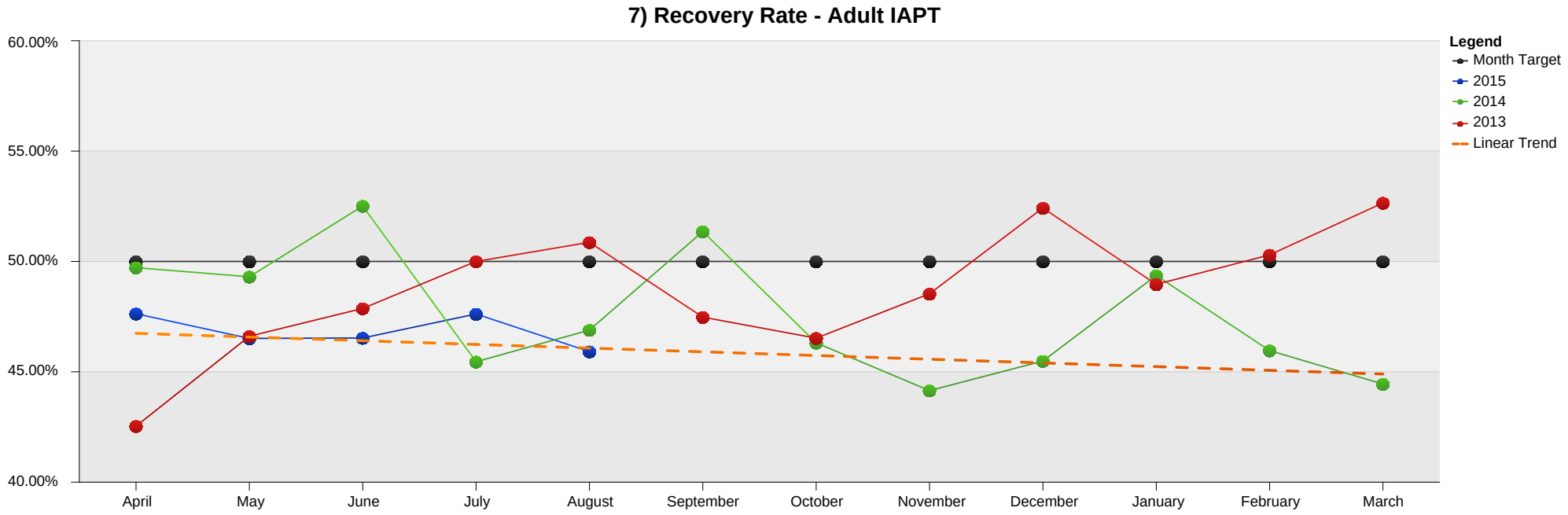
Trust Dashboard Graphs for TRUST



	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)	11.16%	13.37%	11.20%	12.71%	NA	NA	11.10%	14.39%	NA	NA

Narrative
The Trust position for August 2015 is 11.16% which equates to 1005 people entering treatment from 9005 of the general population. This is 3.84% below the target of 15% and is a deterioration on July 2015 performance. The Trust position for the financial year to date is 13.37%, which is 1.63% below target. Historically performance against this indicator dips in key holiday periods when referrals tend to decrease and DNAs increase.North Durham CCG (10.52%) and DDES CCG (11.64%) and Darlington (11.68%) are below target however. Resources are currently being allocated to manage demand with staff focusing on step 2a treatment. Performance also continues to be impacted upon by vacancies, sickness and maternity leave.Scarborough & Ryedale CCG (14.65%), Hambleton, Richmondshire & Whitby CCG (11.46%), Harrogate & Rural CCG (8.88%) and Vale of York CCG (6.54%) are below target. An action plan is in place to address this and recruitment processes within the service continue.August has reported the lowest position to date this year and based on this and past performance, 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

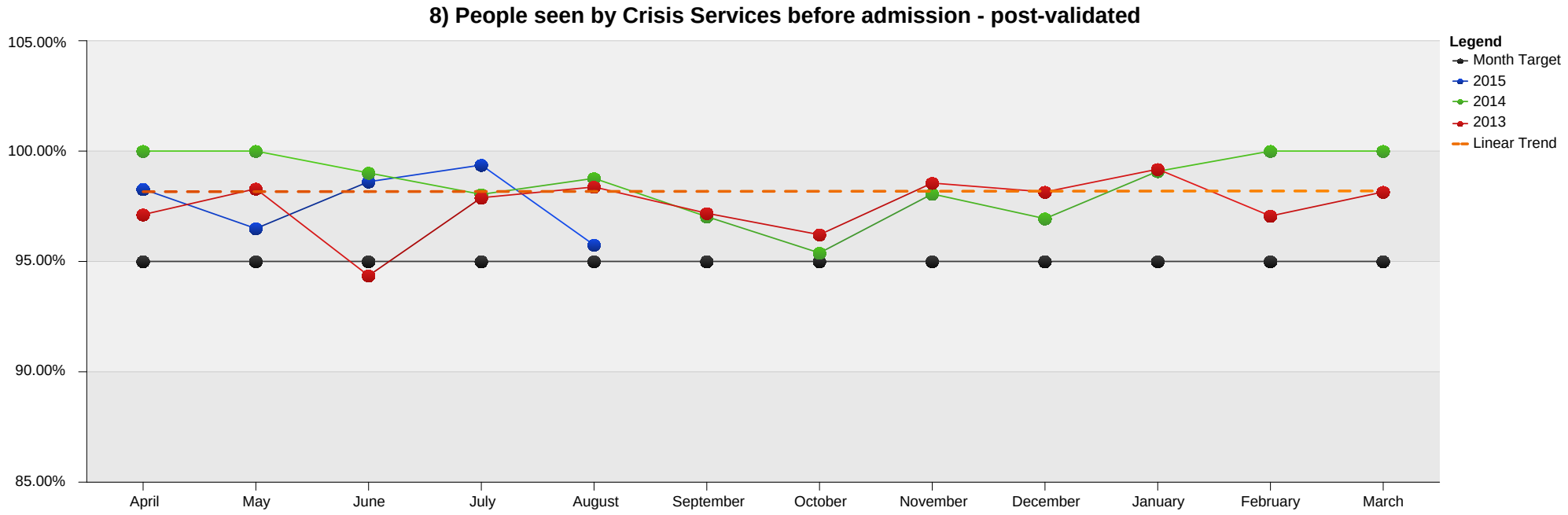


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	45.92%	46.87%	48.12%	44.97%	44.53%	46.88%	42.08%	49.88%	NA	NA

Narrative

The Trust position for August 2015 is 45.92%, with 384 people out of 710 not achieving recovery. This is 4.08% below the target of 50% and a slight deterioration on July performance. All localities are under target. The Trust position for the financial year to date is 46.87%, which is 3.13% below target.All Durham & Darlington CCGs have reported an improvement in performance. Caseload management work is underway to ensure effective discharge management and clinical engagement issues are being discussed with staff. Dropout rates are monitored and investigations continue into patients who did not achieve recovery. Hartlepool & Stockton CCG (32.61%) has reported a deterioration in performance, whereas South Tees CCG (51.22%) have reported an improvement. The action plan and analysis of records for those patients that have not completed treatment are progressing.In Scarborough & Ryedale CCG (28.57%) recruitment for a High Intensity Worker (HIW) is underway and 6 Psychological Wellbeing Practitioners (PWP) have been recruited. Within Hambleton, Richmondshire & Whitby CCG (38.10%) 2 PWP vacancies have been temporarily filled and a HIW vacancy recruited to. Harrogate & Rural CCG (55.22%) have reported a deterioration in performance whereas Vale of York CCG (100%) are achieving target.August reports the lowest position to date this year; based on this and past performance, there is a risk that we will not achieve the annual target of 50%.The annual outturn for 2014/15 was 47.63%.

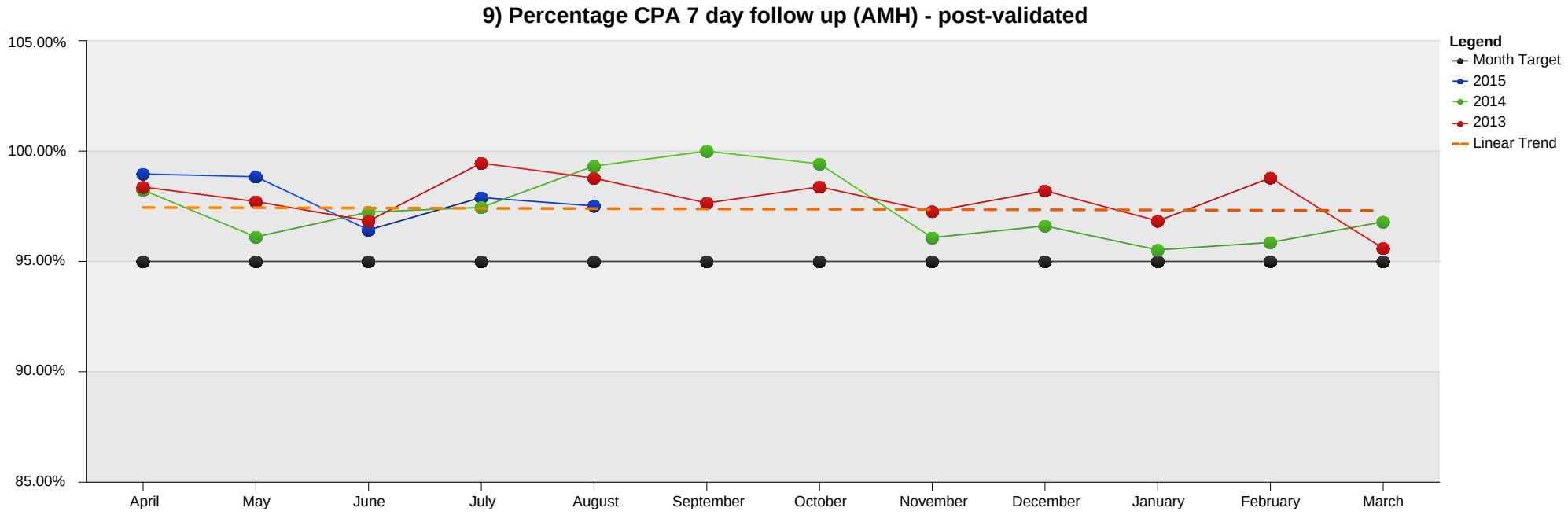
Trust Dashboard Graphs for TRUST



	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	95.74%	97.77%	97.06%	97.45%	94.67%	97.78%	96.88%	98.15%	NA	NA

Narrative
The Trust post validated position for August 2015 is 95.74%, which relates to 6 patients out of 141 that were not seen by a Crisis Home Treatment Team prior to admission. This is 0.74% above the target but a deterioration on July performance. The Trust post validated position for the financial year to date is 97.77%, which is 2.77% above target.August has reported the lowest position to date. The Corporate Performance Team continues to raise awareness of the crisis gatekeeping requirements with wards, crisis teams and Heads of Service.Based on past performance and August's performance, it is anticipated that we will achieve the annual target of 95%.The annual outturn for 2014/15 was 98.42%.

Trust Dashboard Graphs for TRUST

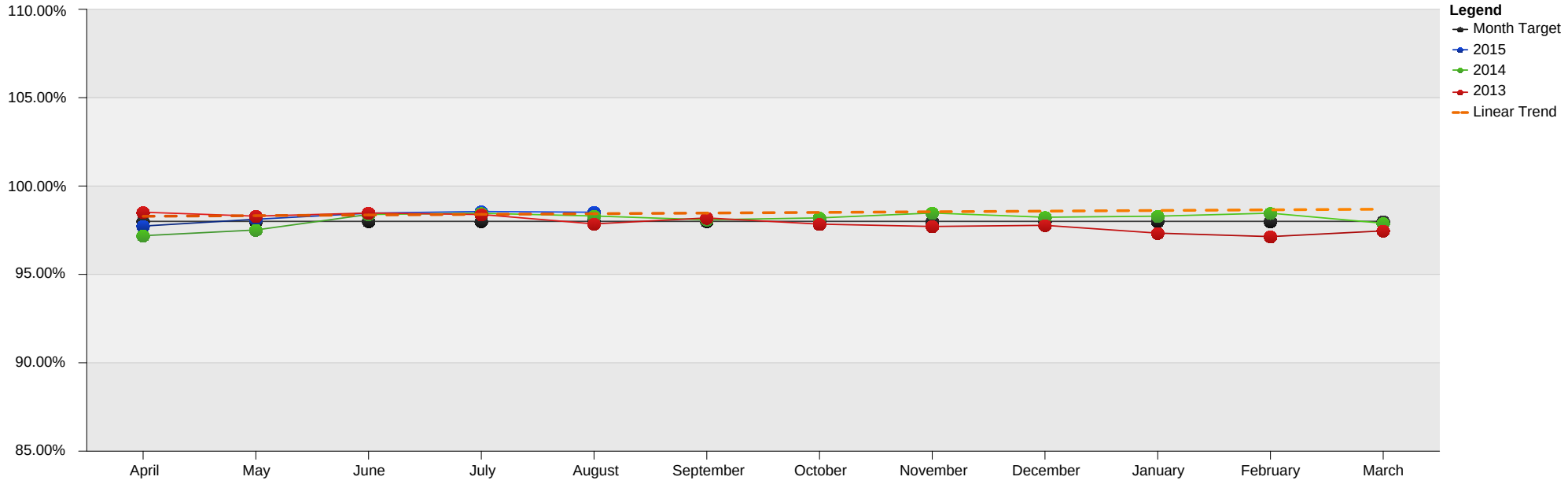


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) Percentage CPA 7 day follow up (AMH) - post-validated	97.52%	97.96%	98.18%	98.53%	96.72%	98.31%	97.78%	96.32%	NA	NA

Narrative
The Trust post validated position for August 2015 is 97.52% which relates to 4 patients out of 161 that were not followed up within 7 days of discharge. This is 2.52% above the target but a slight deterioration on July performance. The Trust post validated position for the financial year to date is 97.96%, which is 2.96% above target.Based on past performance and August'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)



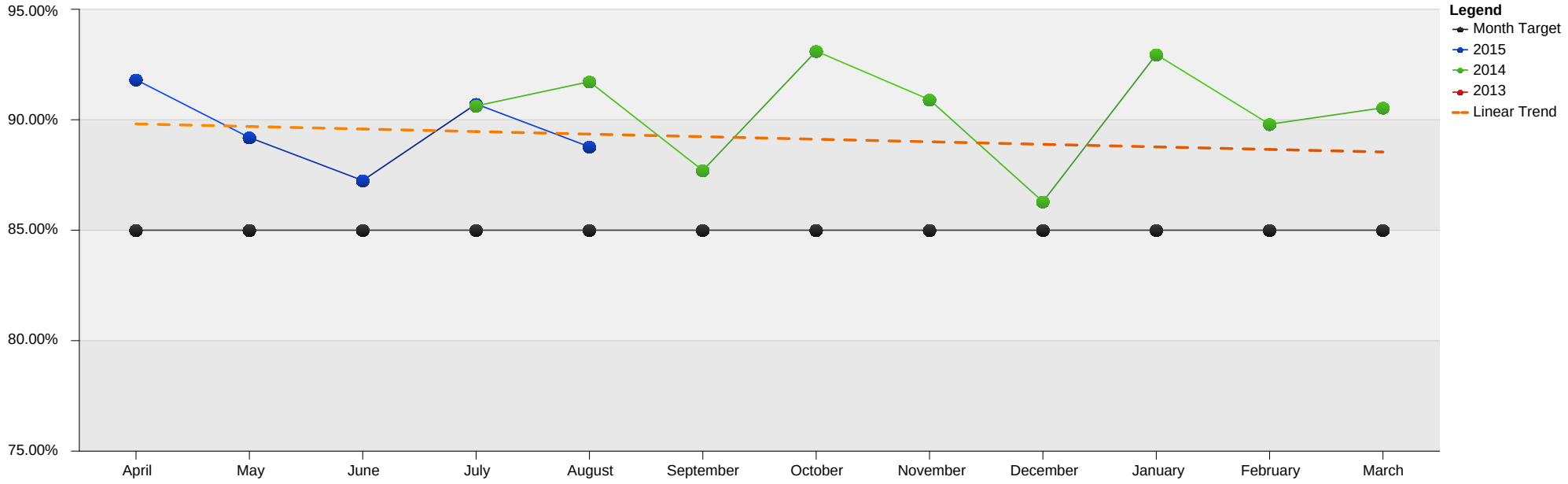
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.52%	98.52%	97.94%	97.94%	99.69%	99.69%	98.05%	98.05%		

Narrative

The Trust position for August 2015 is 98.52% which relates to 62 patients out of 4177 that had not had a formal review documented within 12 months. This is 3.52% above the Monitor target of 95%, 0.52% above the Trust target of 98% and a very slight deterioration on July performance. Only Durham and Darlington has failed to achieve target by 0.06%; this is not attributable to any particular team.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)

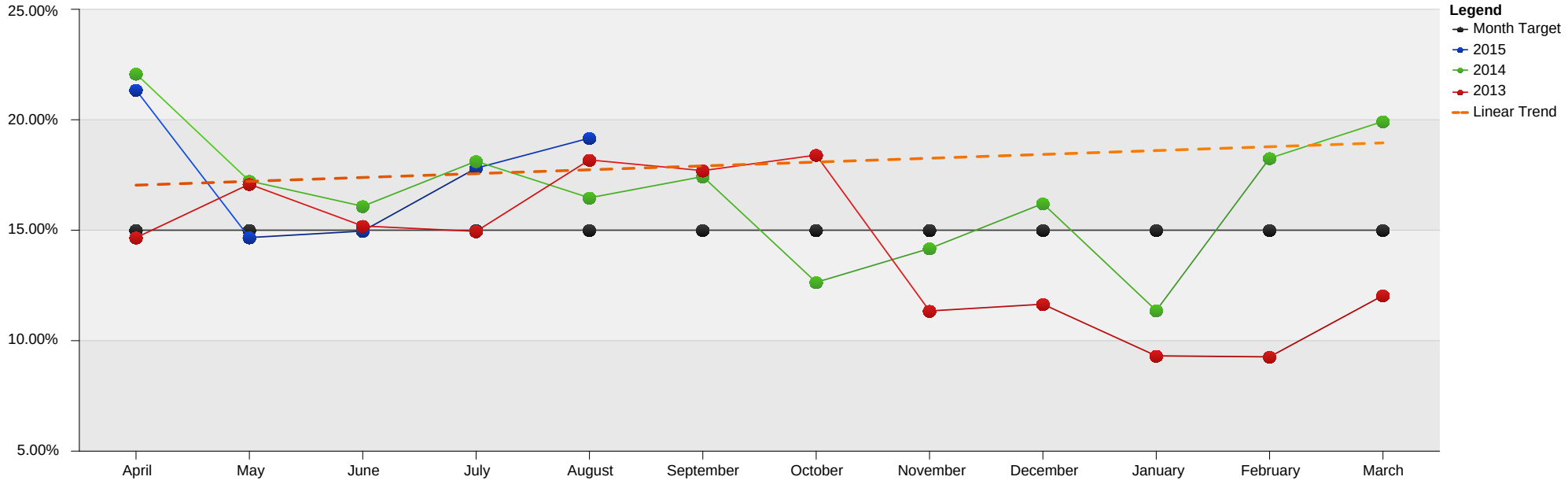


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	88.77%	89.53%	89.24%	89.28%	91.11%	90.09%	82.50%	88.89%	100.00%	94.74%

Narrative
The position reported in August relates to July performance. The Trust position for July 2015 is 88.77%, which relates to 76 patients out of 677 that state they have not been involved in the development of their care plan. This is 3.77% above the target of 85% but a deterioration on the performance reported for June. The Trust position for the financial year to date is 89.53%, which is 4.53% above target.Based on past performance and July'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



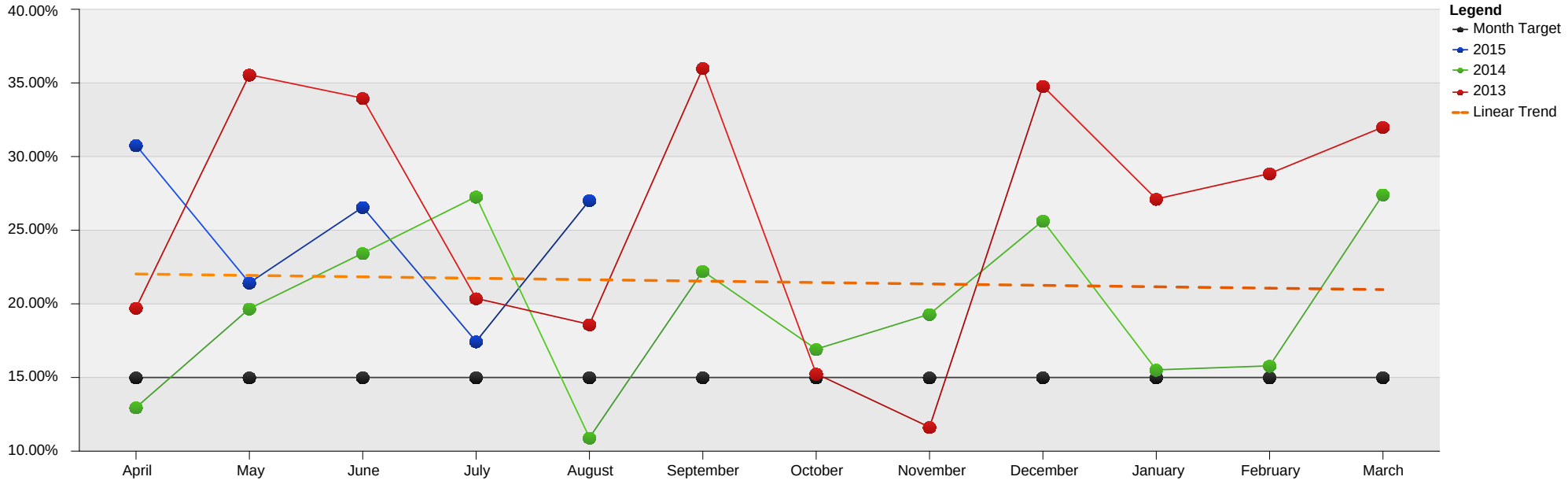
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	19.17%	17.64%	23.47%	19.73%	4.60%	7.09%	34.55%	28.89%	NA	NA

Narrative

The Trust position for August 2015 is 19.17%, which relates to 46 admissions out of 240 that were admitted to out of locality assessment and treatment wards. This is 4.17% above the target of 15% and a deterioration on the position reported in July. Only Teesside Locality is reporting below target; Durham & Darlington reported 8.47% above target and North Yorkshire 19.55% above target. The Trust position for the financial year to date is 17.64%, which is 2.64% above target.Of the 46 patients admitted to an 'out of locality' bed:• 44 (95.62%) were due to no beds being available at their local hospital – AMH 33, MHSOP 11• 2 (4.35%) were due to other breaches The localities continue to investigate ways in which they can improve OOL admissionsFor the first time this financial year, the Trust reports a higher position compared to the same position during 2013 and 2014 and should that trend continue, there is a risk that we would not achieve the annual target. However, this year's performance mirrors that of previous years and should that continue, we could anticipate an improving trend during the last six months of the year and a possibility we will 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)



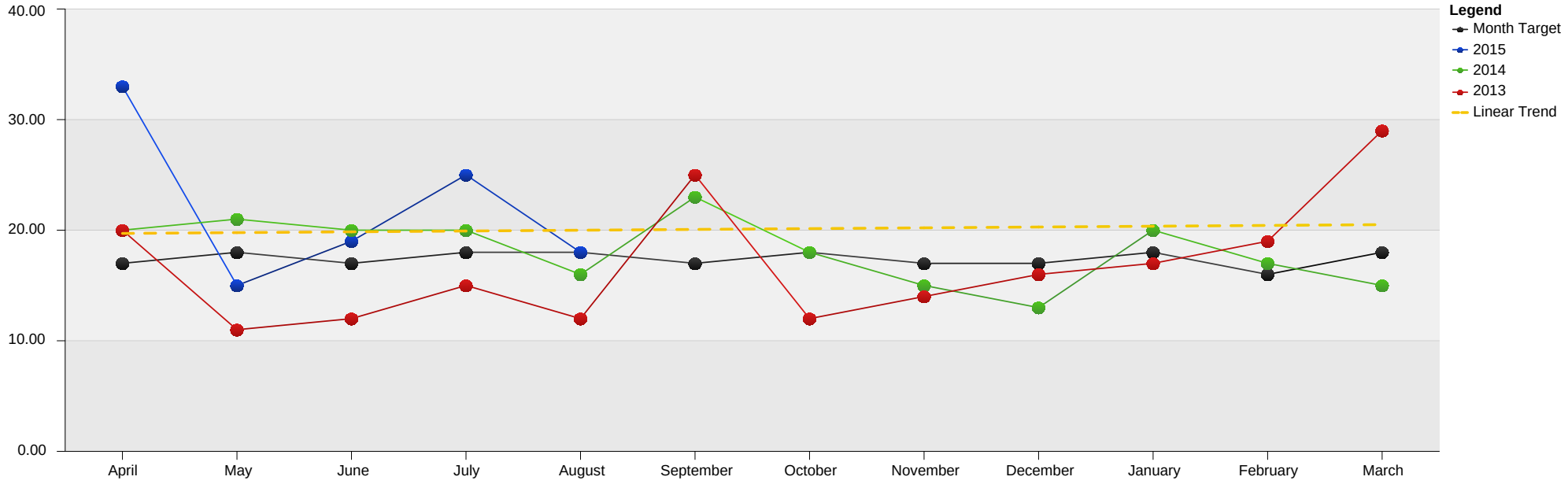
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	27.03%	24.58%	36.84%	25.44%	17.50%	18.94%	40.00%	30.63%	NA	NA

Narrative

The Trust position for August 2015 is 27.03%, which relates to 20 patients out of 74 that were readmitted within 30 days. This is 12.03% above the target of 15% and a significant deterioration on the position reported in July. The Trust position for the financial year to date is 24.58%, which is 9.58% above target.19 of the 20 readmissions were within AMH Services:• 7 (35%) were within Durham & Darlington • 7 (35%) were within Teesside• 5 (25%) were within North Yorkshire No particular patterns or trends in terms of wards or community teams can be identified.1 admission was for MHSOP:• 1 (5%) was within North YorkshireBased on past performance and August's performance, there remains a risk that we will not achieve the annual target of 15%, unless further action is taken.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)

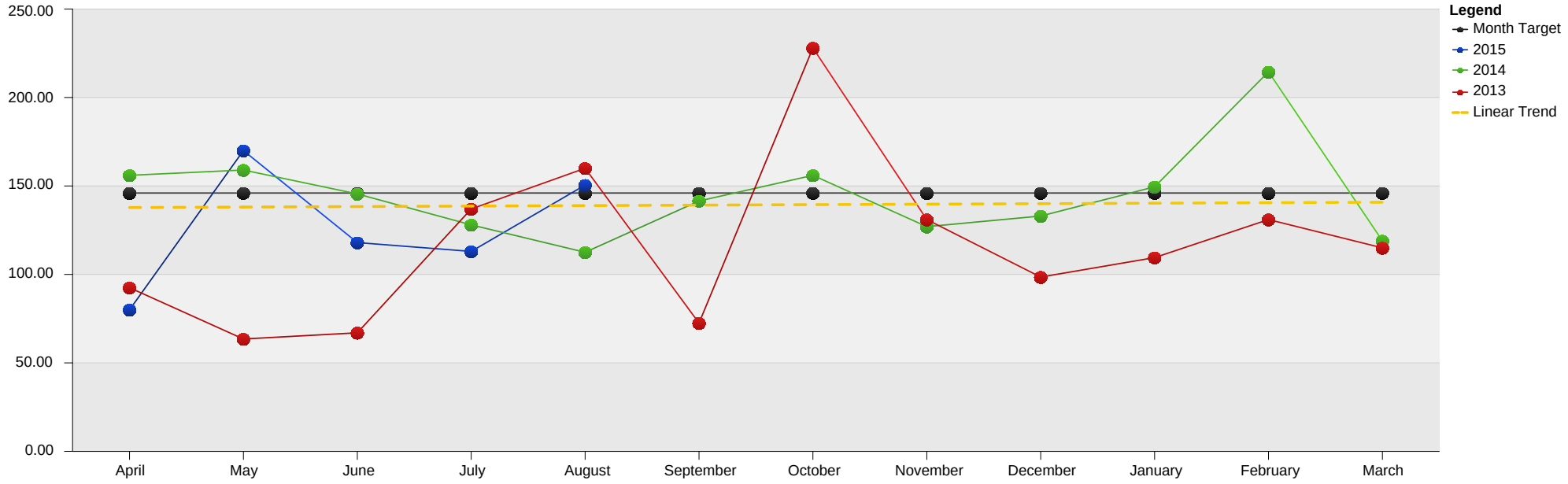


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	18.00	110.00	3.00	41.00	7.00	28.00	8.00	40.00	NA	NA

Narrative
The Trust position for August 2015 is 18, which is achieving the target of 18 and a significant improvement on the position reported in July. The Trust position for the financial year to date is 110, which is 22 above target.Of the 18 readmissions:• 3 (16.67%) were Durham & Darlington Adult Mental Health patients.• 7 (38.89%) were Teesside Adult Mental Health patients.• 8 (44.44%) were North Yorkshire Adult Mental Health patients.Based on past performance and August's performance, there is a risk that we will not achieve the annual target of 209; however, the Trust has reported an improving trend since April and should this continue, the target is achievable.The annual outturn for 2014/15 was 219.

Trust Dashboard Graphs for TRUST

15) Median number of days between admissions (AMH & MHSOP) - Monthly

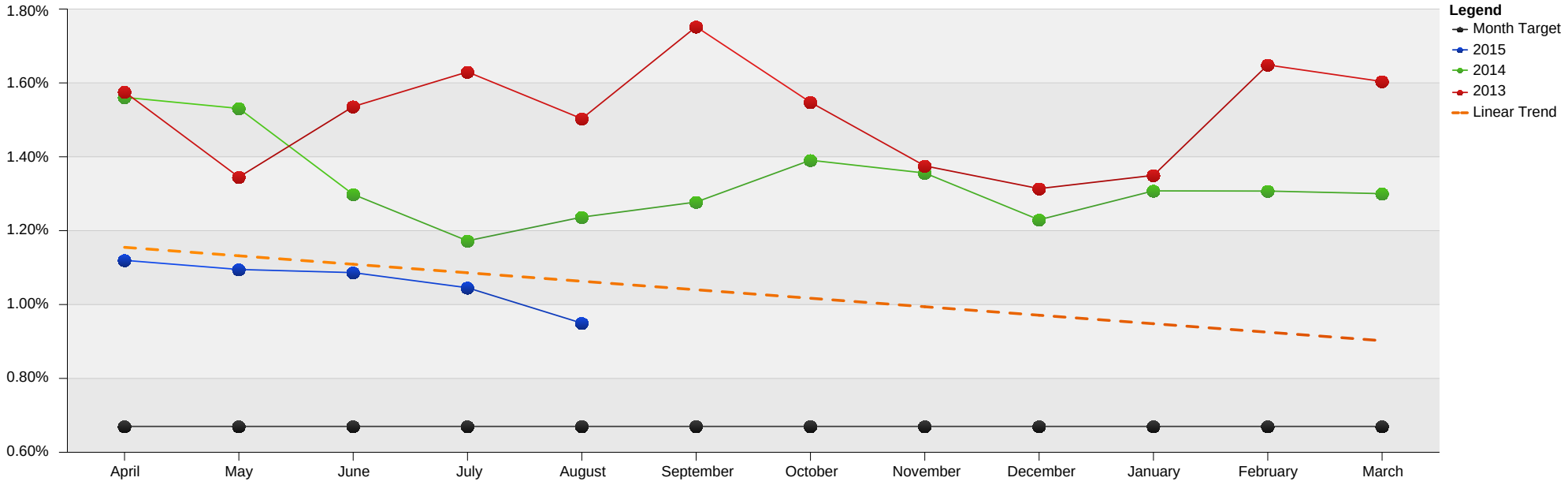


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	150.50	114.00	155.00	125.00	164.00	139.00	111.00	87.00	NA	NA

Narrative
The Trust position for August 2015 is 150.50, which is 4.5 above the target of 146 and a significant improvement on July's performance. The Trust position for the financial year to date is 114, which is 32 below target. Based on past performance and August's performance, there is a risk that we will not achieve the annual target of 146; however should the improving trend continue achievement is attainable. The annual outturn for 2014/15 was 139.
The Trust position for August 2015 is 150.50, which is 4.5 above the target of 146 and a significant improvement on July's performance. The Trust position for the financial year to date is 114, which is 32 below target. Based on past performance and August's performance, there is a risk that we will not achieve the annual target of 146; however should the improving trend continue achievement is attainable. The annual outturn for 2014/15 was 139.

Trust Dashboard Graphs for TRUST

16) Percentage of appointments cancelled by the Trust



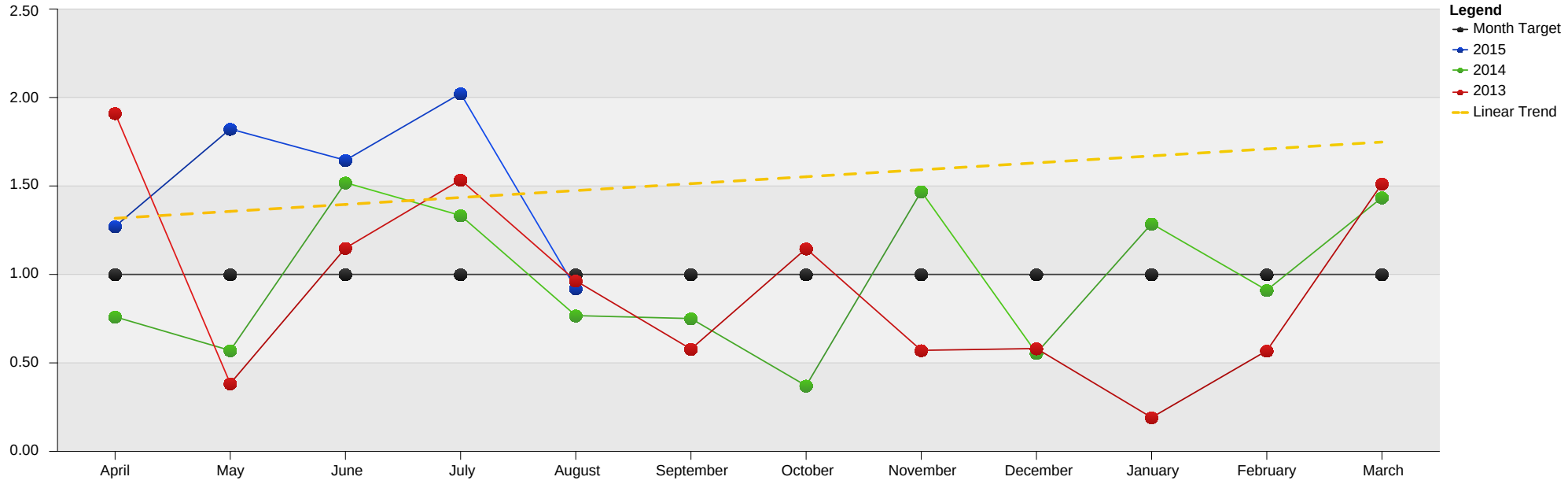
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of appointments cancelled by the Trust	0.95%	1.06%	0.93%	1.09%	0.94%	1.03%	1.16%	1.27%	0.00%	0.05%

Narrative

The Trust position for August 2015 is 0.95%, which relates to 634 appointments out of 66,765 that have been cancelled. This is 0.28% above the target of 0.67% but an improvement compared to July performance. The Trust position for the financial year to date is 1.06%, which is 0.39% above target.Only Forensics are achieving target with no appointments cancelled by the Trust.All 3 geographic 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.Whilst the improving trend continues and August reports the lowest percentage of cancellations over the last two years, 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



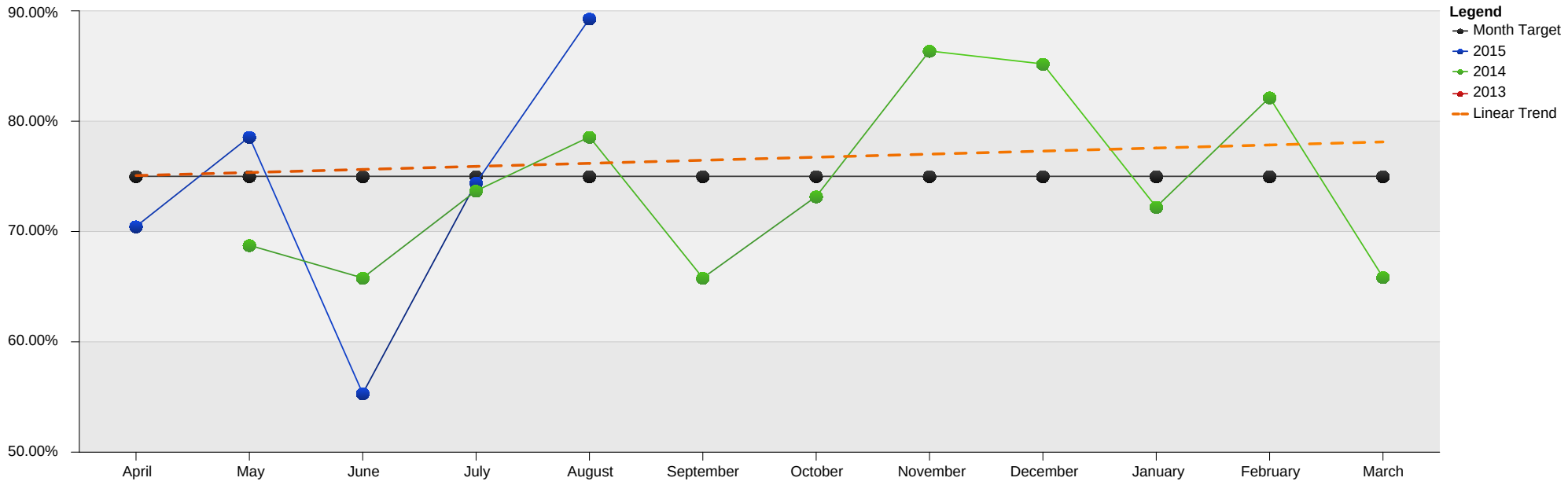
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.92	7.68	0.81	5.97	1.22	6.72	0.83	12.27	0.00	12.91

Narrative

The Trust position for August 2015 is 0.92, which is 0.08 below the target of 1.00 and a significant improvement on July performance. This rate relates to 5 unexpected deaths reported in August; 2 in Durham and Darlington, 1 in North Yorkshire and 2 in Teesside. No patterns or trends have been identified. The Trust position for the financial year to date is 7.68, which is 2.68 above target.The August position is the lowest reported to date; however performance reported for the first five months of this financial year has consistently 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)



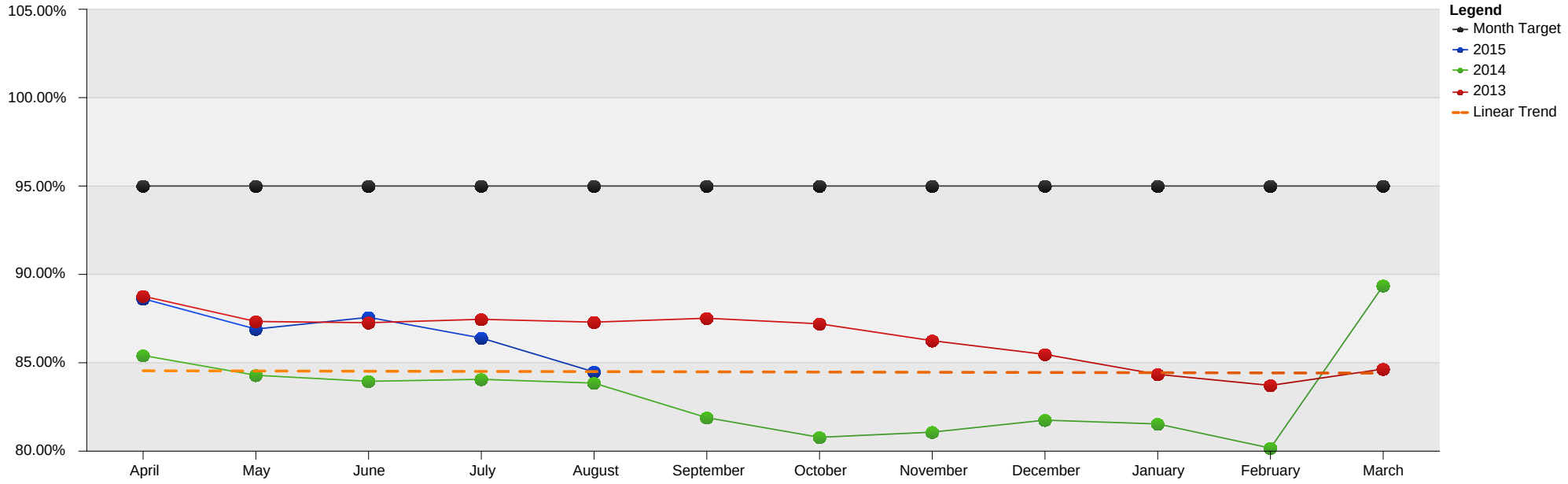
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	89.29%	71.58%	90.00%	84.75%	100.00%	86.27%	83.33%	70.59%	50.00%	28.21%

Narrative

The Trust position reported in August relates to July performance. The Trust position for July 2015 is 89.29% with 3 wards out of 28 wards surveyed in July not scoring higher than 80%. This is 14.29% above the target of 75.00% and a significant improvement on June's position. Only Forensics Services (50.00%) is failing to achieve target, accounting for 1 ward. The Trust position for the financial year to date is 71.58%, which is 3.42% below target.The position within Forensics is largely attributable to the low numbers of surveys that are being returned by patients. This issue with Forensics was discussed at the Performance Improvement Group in August, with a view to taking it to service meetings for further discussions, 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. August has reported the highest performance to date and should the significant improvements in performance during the last two months and the improving trend continue the annual target is attainable.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)



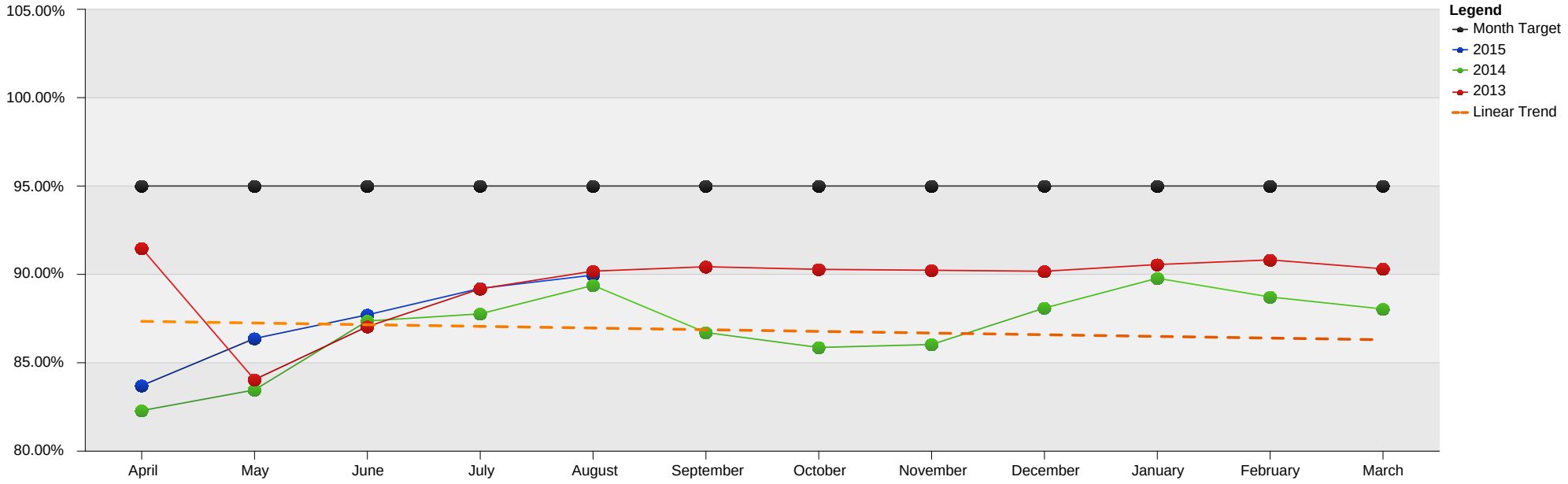
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	84.48%	84.48%	82.79%	82.79%	83.26%	83.26%	83.94%	83.94%	90.92%	90.92%

Narrative

The Trust position for August 2015 is 84.48% which relates to 801 members of staff out of 5162 that do not have a current appraisal. This is 10.52% below the target of 95% and a deterioration on July's position. 20 staff had their pay progression withheld at the end of August due to non-compliance of mandatory training and/or appraisal, this is the same as was reported in July.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. A workshop took place in July to identify how the IIC can be developed further to present HR related information; a follow up workshop is scheduled for early September. Based on the deteriorating trend over the past five months and August's performance, there is 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)

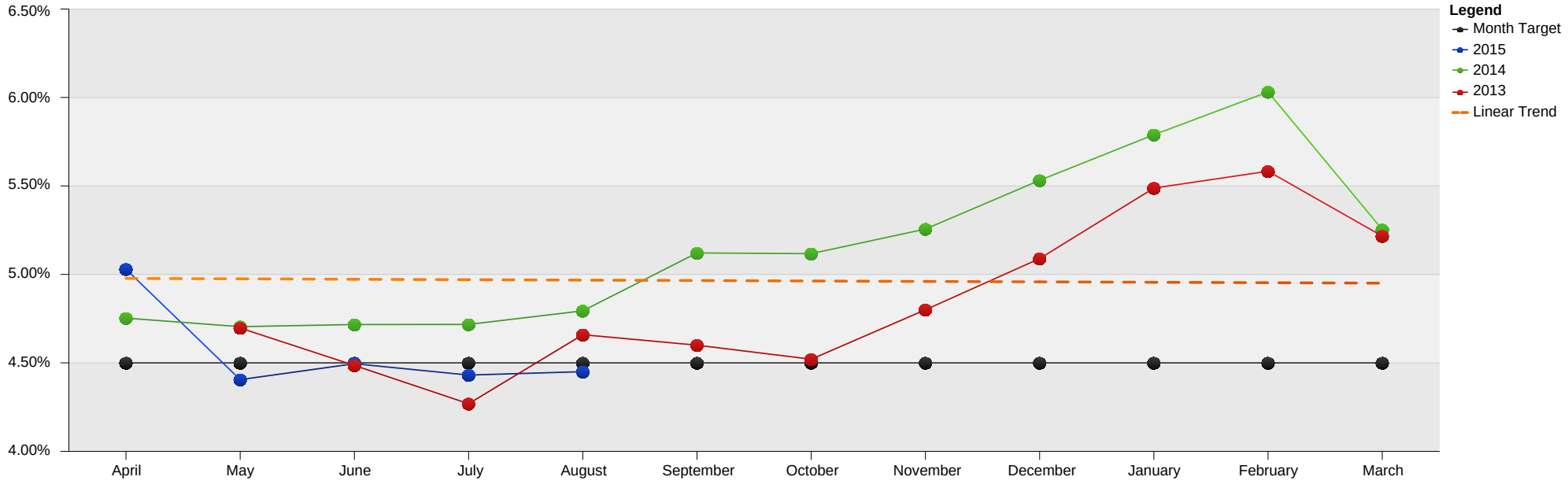


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Percentage compliance with mandatory and statutory training (snapshot)	89.96%	89.96%	88.75%	88.75%	90.78%	90.78%	86.11%	86.11%	89.96%	89.96%

Narrative
The position for August 2015 is 89.96%. This is 5.04% below the target of 95% but a slight improvement on July 2015 performance.Regular monthly reports are produced for Heads of Service and line managers to monitor performance against the target of 95%. The September workshop to identify how the IIC can be developed further to present HR related information will also focus on the mandatory training reports.`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

21) Percentage Sickness Absence Rate (month behind)

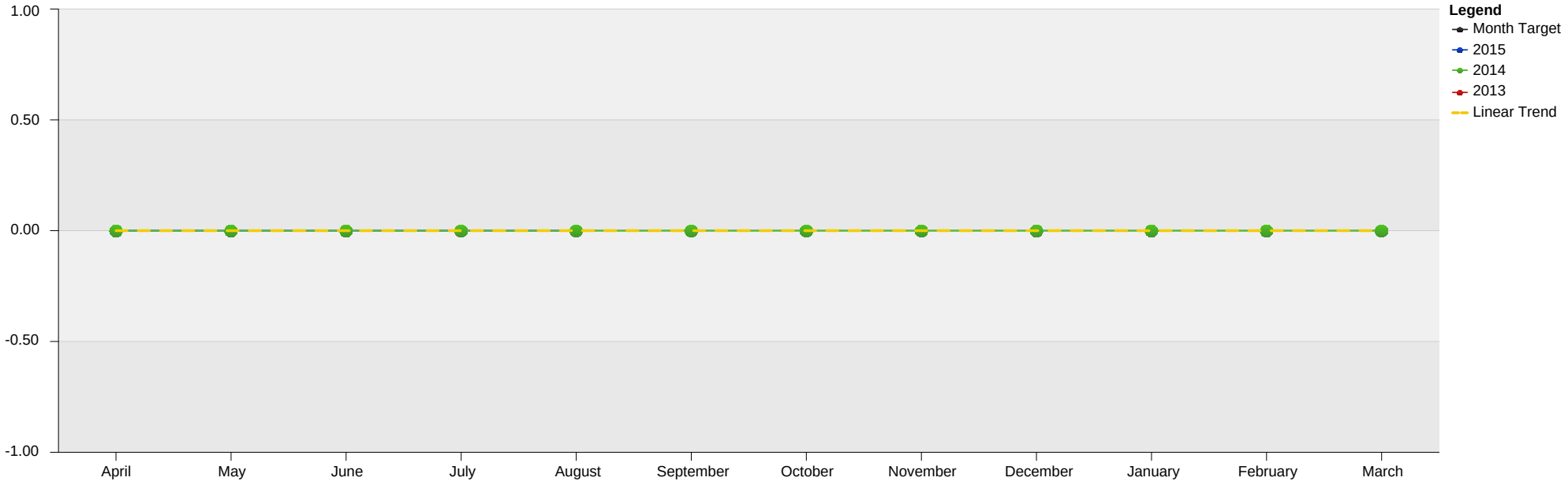


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Percentage Sickness Absence Rate (month behind)	4.45%	4.56%	4.20%	4.45%	4.78%	4.88%	4.20%	4.39%	6.14%	6.26%

Narrative
The Trust position reported in August relates to the July sickness level. The Trust position reported in July 2015 is 4.45%, which is 0.05% below the Trust target of 4.50% but a very slight deterioration on the position reported in June. The Trust position for the financial year to date is 4.56%, which is 0.06% above target.Based on past performance there is a risk that we will not achieve the annual target of 4.50%; however, a decreasing trend has been reported since February and should this improvement continue the target can 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)

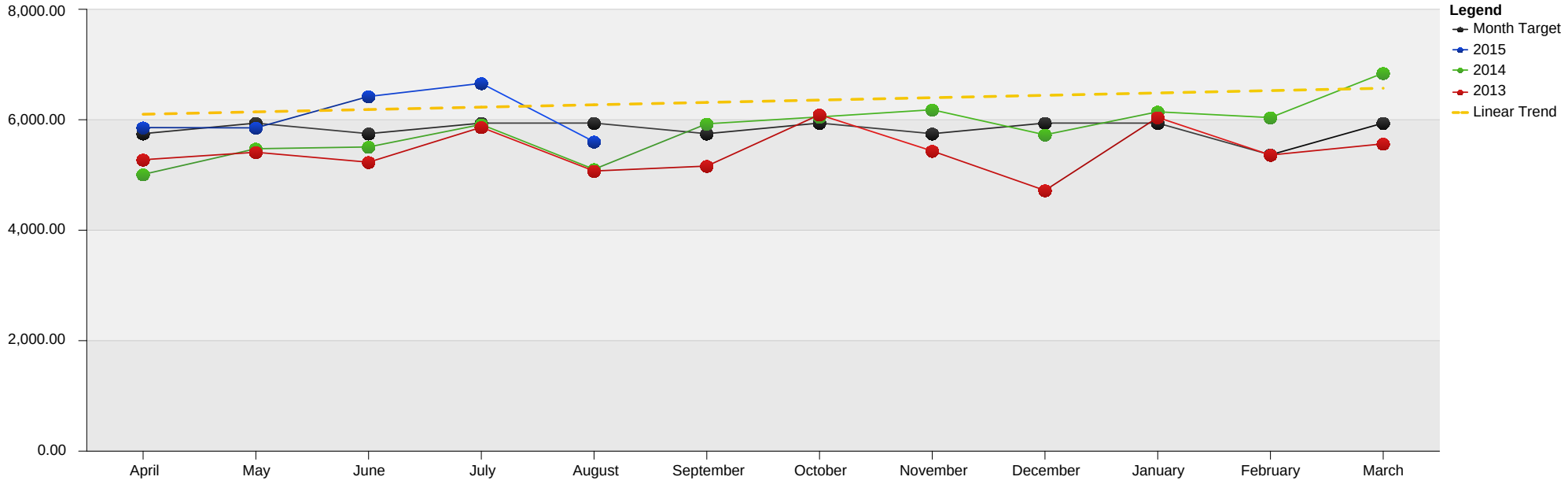


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative
The Trust position for August 2015 is zero, which is consistent with 2014/15 reporting.Based on past performance and August'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

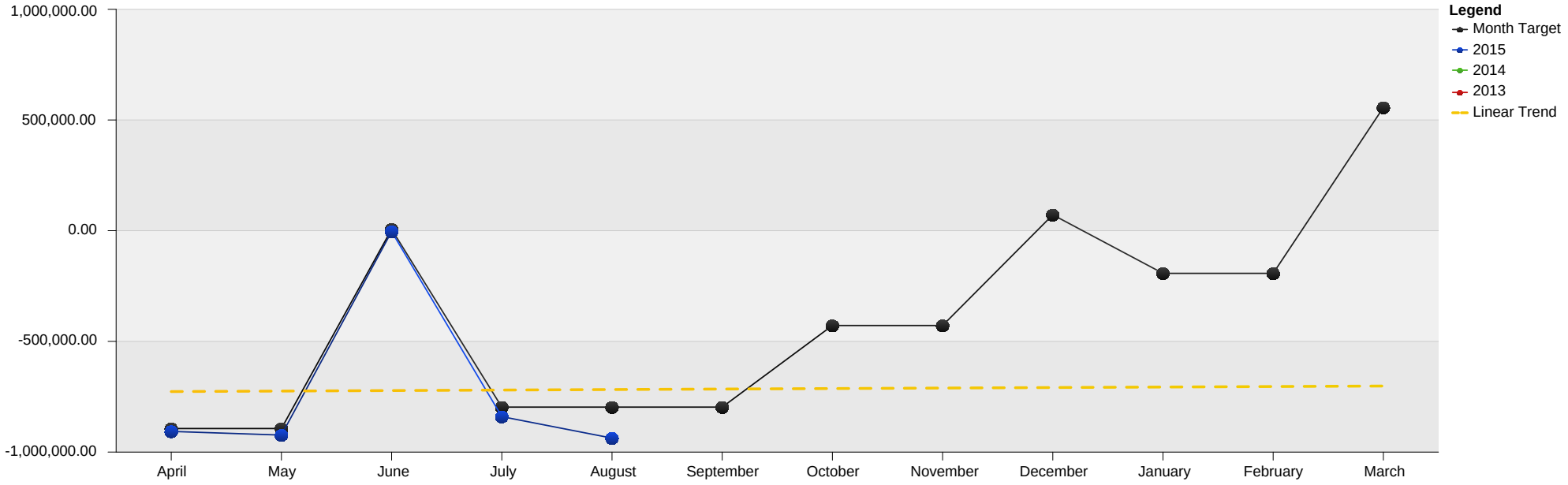


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
23) Total number of External Referrals into the Trust Services	5,602.00	30,393.00	1,638.00	9,397.00	1,821.00	9,983.00	1,650.00	9,071.00	491.00	1,937.00

Narrative
The Trust position for August 2015 is 5602, which is 338 below the Trust target of 5,940 and an decrease on the number received in July. The Trust position for the financial year to date is 30,393, which is 1079 above target. Historically performance against this indicator dips in the key holiday periods of August and December.Whilst the year to date has reported a slightly decreasing trend, this is in line with previous years' performance. Should this pattern 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)	-937,000.00	-3,611,000.00	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The Trust position for August 2015 is a surplus of £937,000 which is £140,000 better that the expected surplus of £797,000. The Trust position for the financial year to date is a surplus of £ 3,611,000, which is £236,000 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

	August 2015										April 2015 To August 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%	85.31%	98.00%	79.59%	98.00%	93.24%	98.00%	77.82%	98.00%	100.00%	98.00%	81.69%	98.00%	77.29%	98.00%	88.71%	98.00%	74.97%	98.00%	99.89%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	88.44%	98.00%	81.24%	98.00%	93.93%	98.00%	92.04%	98.00%	47.62%	98.00%	87.88%	98.00%	84.79%	98.00%	91.79%	98.00%	89.27%	98.00%	60.00%
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%	75.61%	50.00%	68.75%	50.00%	81.25%	50.00%	77.78%	NA	NA	50.00%	73.80%	50.00%	61.32%	50.00%	82.05%	50.00%	81.25%	NA	NA
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	86.14%	75.00%	98.16%	75.00%	58.78%	75.00%	77.89%	NA	NA	75.00%	80.54%	75.00%	98.43%	75.00%	60.23%	75.00%	64.55%	NA	NA
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	94.25%	95.00%	100.00%	95.00%	77.86%	95.00%	92.46%	NA	NA	95.00%	93.94%	95.00%	99.81%	95.00%	79.15%	95.00%	93.29%	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%	11.16%	15.00%	11.20%	NA	NA	15.00%	11.10%	NA	NA	15.00%	13.37%	15.00%	12.71%	NA	NA	15.00%	14.39%	NA	NA
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	45.92%	50.00%	48.12%	50.00%	44.53%	50.00%	42.08%	NA	NA	50.00%	46.87%	50.00%	44.97%	50.00%	46.88%	50.00%	49.88%	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%	95.74%	95.00%	97.06%	95.00%	94.67%	95.00%	96.88%	NA	NA	95.00%	97.77%	95.00%	97.45%	95.00%	97.78%	95.00%	98.15%	NA	NA
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	97.52%	95.00%	98.18%	95.00%	96.72%	95.00%	97.78%	NA	NA	95.00%	97.96%	95.00%	98.53%	95.00%	98.31%	95.00%	96.32%	NA	NA
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.52%	98.00%	97.94%	98.00%	99.69%	98.00%	98.05%	98.00%		98.00%	98.52%	98.00%	97.94%	98.00%	99.69%	98.00%	98.05%	98.00%	
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	88.77%	85.00%	89.24%	85.00%	91.11%	85.00%	82.50%	85.00%	100.00%	85.00%	89.53%	85.00%	89.28%	85.00%	90.09%	85.00%	88.89%	85.00%	94.74%

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 2: To continuously improve the quality and value of our work

	August 2015										April 2015 To August 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%	19.17%	15.00%	23.47%	15.00%	4.60%	15.00%	34.55%	NA	NA	15.00%	17.64%	15.00%	19.73%	15.00%	7.09%	15.00%	28.89%	NA	NA
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	27.03%	15.00%	36.84%	15.00%	17.50%	15.00%	40.00%	NA	NA	15.00%	24.58%	15.00%	25.44%	15.00%	18.94%	15.00%	30.63%	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	18.00	5.00	3.00	5.00	7.00	7.00	8.00	NA	NA	88.00	110.00	27.00	41.00	27.00	28.00	33.00	40.00	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	150.50	146.00	155.00	146.00	164.00	146.00	111.00	NA	NA	146.00	114.00	146.00	125.00	146.00	139.00	146.00	87.00	NA	NA
16) Percentage of appointments cancelled by the Trust	0.67%	0.95%	0.67%	0.93%	0.67%	0.94%	0.67%	1.16%	0.67%	0.00%	0.67%	1.06%	0.67%	1.09%	0.67%	1.03%	0.67%	1.27%	0.67%	0.05%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.92	1.00	0.81	1.00	1.22	1.00	0.83	1.00	0.00	5.00	7.68	5.00	5.97	5.00	6.72	5.00	12.27	5.00	12.91
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	89.29%	75.00%	90.00%	75.00%	100.00%	75.00%	83.33%	75.00%	50.00%	75.00%	71.58%	75.00%	84.75%	75.00%	86.27%	75.00%	70.59%	75.00%	28.21%

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce

	August 2015										April 2015 To August 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%	84.48%	95.00%	82.79%	95.00%	83.26%	95.00%	83.94%	95.00%	90.92%	95.00%	84.48%	95.00%	82.79%	95.00%	83.26%	95.00%	83.94%	95.00%	90.92%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	89.96%	95.00%	88.75%	95.00%	90.78%	95.00%	86.11%	95.00%	89.96%	95.00%	89.96%	95.00%	88.75%	95.00%	90.78%	95.00%	86.11%	95.00%	89.96%
21) Percentage Sickness Absence Rate (month behind)	4.50%	4.45%	4.50%	4.20%	4.50%	4.78%	4.50%	4.20%	4.50%	6.14%	4.50%	4.56%	4.50%	4.45%	4.50%	4.88%	4.50%	4.39%	4.50%	6.26%

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

	August 2015										April 2015 To August 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	5,602.00	1,939.00	1,638.00	1,985.00	1,821.00	1,826.00	1,650.00	190.00	491.00	29,314.00	30,393.00	9,571.00	9,397.00	9,797.00	9,983.00	9,012.00	9,071.00	934.00	1,937.00
24) Delivery of our financial plan (I and E)	-797,000.00	-937,000.00	NA	NA	NA	NA	NA	NA	NA	NA	-3,375,000.00	-3,611,000.00	NA	NA	NA	NA	NA	NA	NA	NA

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at December 2014*	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							3			5					13	n/a	87%	The Trust have 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, this is being looked at through the Data Quality group, but has temporarily been removed from the logic.
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral		4					4				5					13	n/a	87%	
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral		4					4				5					13	n/a	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	80%	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	80%	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	87%	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%	Surveys are manual for community although some hand held for ALD. The surveys are sent to a team in Flatts Lane who input the scores from each paper survey into an excel spreadsheet. They send the spreadsheet to CRT who supply community based reports. The plan is to follow the same process as the ward from this point onwards.
12	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated		4					4				5					13	n/a	87%	
13	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						4				5					14	n/a	93%	
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	n/a	100%	

Appendix 3

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at December 2014*	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				
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	n/a	100%	
16	Percentage of appointments cancelled by the Trust	5							3			5					13	n/a	87%	A number of data quality issues have been identified by the Patient Experience Group and the localities. A paper has been presented to the Data Quality Group and further work is being undertaken on this issue.
17	Number of unexpected deaths classed as a serious incident per 10,000 open cases					1		4				5					10	60%	67%	Different sources in calculation - lower one used which is a manual process including a telephone call and data entered onto a spreadsheet (unexpected deaths)
18	Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)			3				4				5					12	73%	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.
19	Mean level of improvement on SWEMWBS (AMH Only)	5					5					5					15	100%	100%	
20	Mean level of improvement on SWEMWBS (MHSOP Only)	5					5					5					15	100%	100%	
21	Percentage HONOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP)	5						4				5					14	93%	93%	
22	Percentage of HONOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP)	5						4				5					14	93%	93%	
23	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	93%	93%	
24	Percentage compliance with mandatory and statutory training – snapshot	5						4				5					14	93%	93%	
25	Percentage Sickness Absence Rate (month behind)	5							3			5					13	87%	87%	Audit findings have highlighted issues with the accuracy of data: • Discrepancies between ESR and paper records • Sickness periods not being recorded • Sickness episodes not being closed
26	Number of reds on CQC Action Plans (including MHA Action Plans)					1	5					5					11	67%	73%	Static reports are emailed to the Trust. Data is then manually transferred from the reports into an Excel spreadsheet, which is then manually monitored to ensure all actions are green.
27	Total number of External Referrals into the Trust Services	5					5					5					15	100%	100%	
28	Are we delivering our financial plan (I and E)		4				5					5					14	n/a	93%	

* A comparative figure for December 2014 will only be available for those KPIs that were reported during the 2014/15 financial year

Number of unexpected deaths and verdicts from the coroner April 2015-August 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	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	2	0	3	0	0	0	0	0	0	0	0	0	0	1	0	0	**6**
Open	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Abuse of drugs	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
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	9	6	6	0	0	0	0	0	1	1	3	0	0	2	1	1	**30**
Total	**14**	**7**	**11**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**3**	**0**	**0**	**3**	**1**	**1**	**42**

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							

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	5	2	4	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 11

BOARD OF DIRECTORS

Date of Meeting: **29th September 2015**

Title: **Strategic Direction Performance Report Quarter 1 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: **29th September 2015**

Title: **Strategic Direction Performance Report Quarter 1 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 1 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. The Scorecard included from quarter 1 2015/16 reflects all these changes.

3. KEY ISSUES

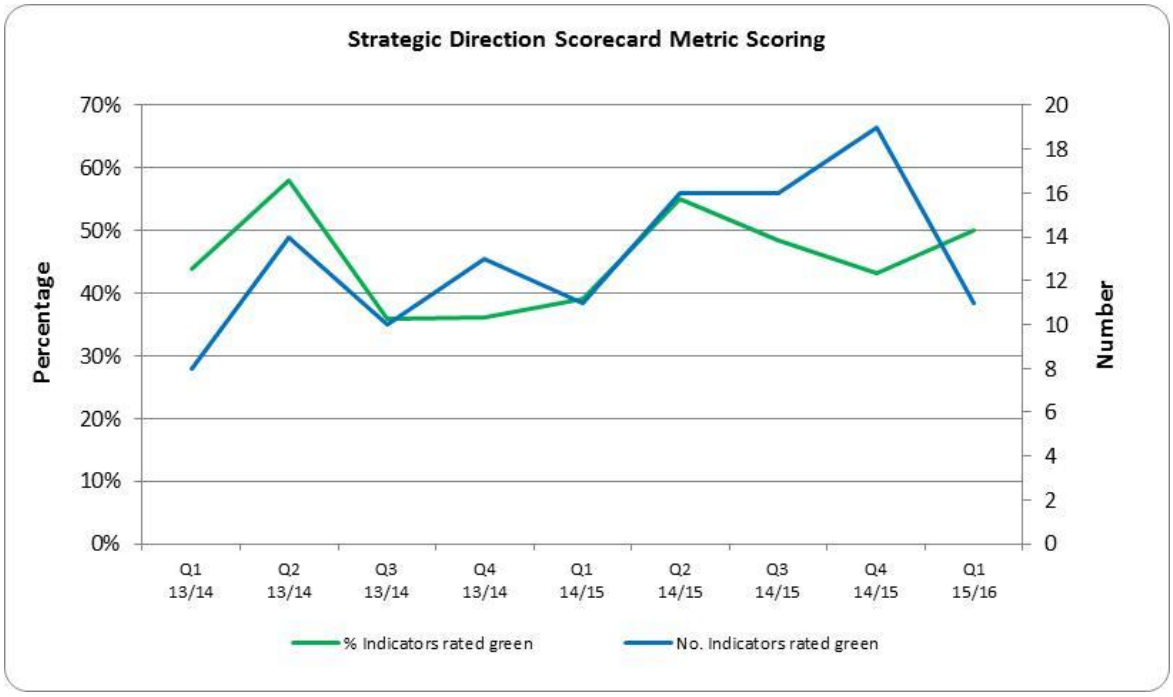
3.1 Trust Strategic Direction Scorecard

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 1 compared to the position in the previous quarter (Q4 2014/15) and the previous financial years 2014/15 and 2013/14:

	2013/14 Actual		2014/15 Actual		Q4 2014/15		Q1 2015/16		2015/16 Actual YTD	
	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	11	31%	18	42%	19	43%	11	50%	11	50%
Indicators rated red	25	69%	25	58%	25	57%	11	50%	11	50%
Indicators with no target	5		2		2		1		1	
Indicators currently under development/being finaliased	1		1		1		3		3	
Indicators where data is not yet available	5		0		0		12		12	

* The percentage is based on the number of indicators that can be RAG rated (22 for quarter 1)



3.2 Strategic Goal 1 - *To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)*

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 4 indicators rated red out of 7 as at quarter 1, and the overall change is less positive than quarter 4 with only 1 indicator improving.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16							
	Indicator	Q1 Target 2015/16	Quarter 4 Actual 2014/15	Quarter 1 Actual 2015/16	Change on previous Qtr	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%	90.14%	89.96%	↓	>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%	85.27%	83.95%	↓	98.00%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	82.38%	78.05%	↓	85.00%	tbc
4	Number of community teams who have implemented the model line way of working	2	2	2	↔	11	tbc
5	The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)	n/a	Surveys: Top 25th %ile of MH Trusts (2014)	Results due in Q3	n/a	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	Surveys: Top 25th %ile of MH Trusts (DEC 2014)	Results due in Q4	n/a	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%	93.16%	93.72%	↑	95.00%	95.00%

Indicators of concern are:

- **KPI 2 - Percentage of patients who have not waited longer than 4 weeks from "referral" to "assessment" for external and internal referrals** – the Trust position for quarter 1 is 83.95% which is 14.05% below the target of 98% and a further reduction on the quarter 4 position. All localities are reporting below target with North Yorkshire the lowest at 78.55%. Reasons for this mainly relate to Adult Mental Health (AMH), Children and Young People (CYP) and Mental Health Services for Older People (MHSOP). There is an action point within the action plan in place for MHSOP Memory service to provide additional support for 10 weeks to improve their position which will commence in July. Action plans are also in place across all 3 for localities for CYP Services, and in Adult Services in Durham and Darlington locality. The Board received a report in May 2015 on progress against the waiting times action plan.

- **KPI 3 - Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"** – the Trust position for quarter 1 is 78.05% which is 6.95% below the target of 85% and relates to 775 patients out of 993 that responded who felt safe on our wards. The main areas of concern are North Yorkshire and Forensic Services.

  Wards within North Yorkshire locality overall are reporting 76.06% (143 patients out of 188) that reported as feeling safe. There are 4 wards of particular concern:
  - Child and Adolescent Mental Health Service (CAMHS) Evergreen Centre is reporting 10 patients out of 17 surveyed in May did not felt safe. However upon review of the 9 comments received from the completed surveys it is clear that some of the data is not valid. The service now has allocated leads for the Patient Experience Device with supervision in place.
  - CAMHS Westwood Centre is reporting 2 patients out of 6 surveyed in May did **not** felt safe. The service is implementing the following measures to facilitate an improvement in this area including:
    - Implemented “Safe Wards” to reduce the number of incidents that occur, some of which can have a detrimental effect on patients that witness disturbances by other patients.
    - Young people are encouraged to seek help and support if an issue arises immediately to address as part of their intervention plan.
    - Patients on Westwood have a Positive Behaviour Support Plan to manage behaviours that can be deemed as challenging or harmful to themselves or those around them.
  - AMH Cedar Ward, Harrogate is reporting 14 patients out of 44 surveyed during quarter 1 did **not** feel safe. The service is implementing the following measures to facilitate an improvement in this area including:
    - Weekly patient meetings to allow them to raise concerns and discuss actions
    - Patients directly involved or witness a violent/aggressive incident are offered a debrief on an individual basis or as a group.
    - Daily safety planning meetings with patients with Borderline Personality Disorder as part of individualised care planning

        - Introduction of Safe Wards and force reduction
        - Team meetings and team supervision
    - MHSOP Rowan Lea, Scarborough is reporting 2 patients out of 5 surveyed in May did **not** feel safe. There are no recurring themes to investigate however the service is implementing the following measures to facilitate an improvement in this area including:
        - Piloting the "Safe Ward" initiative
        - Weekly community meetings where patients can raise concerns and discuss actions for those that have capacity

Of the Forensic Mental Health Service wards below target, there were 10 wards ranging from 36.36% to 62.50% achievement. Wards of particular concern are:

- Fulmar (7 patients out of 11), Kirkdale (10 patients out of 18), Linnet (8 patients out of 15) and Merlin (4 patients out of 7) patients reported they did **not** feel safe. Patients that reported feeling unsafe had witnessed episodes of disturbed behaviour by other patients. The ward staff are implementing the following measures to facilitate an improvement in this area including:
    - The incidents are discussed in community meetings on the wards to debrief all patients and staff, including on an individual basis if required.
    - Rolling out Safe Wards across all inpatient areas when the implementation on the pilot wards is fully embedded. This will address ward atmosphere issues.
    - Reviewing the Essen Climate Evaluation (EssenCED), a rating scale which can be completed by staff and patients which assesses the ward atmosphere. If the score improves then the atmosphere is better which indicates that the patients feel safe.

Of the Forensic Learning Disability Service wards below target, there are 8 wards ranging from 0% to 75% achievement. Wards of particular concern are:

- Rudland - Heron and Robin wards are reporting 0% of patients felt safe. All 8 patients who responded gave a response of "sometimes" they felt safe. The service is implementing the following measures to facilitate an improvement in this area including:
    - Engagement with the Patient Experience team to explore ways of improving the environment for patients. The Patent Experience team have attended the hospital to deliver presentations to the staff, patients and carers in relation to each question and the importance of the surveys.
    - The clinical lead is to ensure there is increased awareness within all Forensic Learning Disability wards. This will include circulating information to staff to increase their understanding of the survey, to enable them to explain its importance and use.
    - Action plans are developed in response to survey feedback to improve the environment for patients. These action plans are reviewed weekly by the clinical business lead, ward manager and staff to ensure any changes identified are implemented to improve the service for patients. They are also discussed in patient meetings.

It should be noted that the survey results reflected in quarter 1 was undertaken in May 2015. Since then the 2 wards have relocated. This facilitated more effective management of the wards. Staff are more visible to provide additional support to patients when required, which the wards believe will reassure the patients to feel safe.

All services regularly review and investigate their information at their Quality Assurance Groups (QuAGs) to identify any issues or trends. This indicator is also discussed at the locality Performance Improvement Groups, LMGBs and Patient Experience Group (PEG).

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 1 were rated green (71.1%). However 9% of the priorities / service developments in the Business Plan are at high risk of failure to deliver on-time or within budget.

The 9% represents 16 priorities / service developments. Of these:

- 3 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 revise actions and timescales for the priority which was agreed by EMT
- 2 required changes to the wording of the actions currently in the Plan which have been agreed by EMT.
- 9 required “in-year” timescale changes which have been agreed by EMT.

There are also 3 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.

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:

- **Hospitality Assured Awards 2015 –** Estates and Facilities Management (EFM) and Hotel Services Operational Team for winning the Institute of Hospitality Team of the Year 2015 award. (This is not just an NHS scheme but a national scheme involving a very wide range of private sector companies, mostly not related to health).
- **Yorkshire and Humber Strategic Clinical Network -** The memory service in Harrogate won the Yorkshire and Humber Strategic Clinical Network Quality Improvement Award 2015 for the joint work with the Harrogate and Rural District CCG on Shared Care Follow up of People on Medication for Alzheimer’s disease.
- **Nursing Times Awards –** The Trust have been shortlisted twice in Child and Adolescent Mental Health Services Award (CAMHS):

- CAMHS Durham and Darlington Crisis Service – for their work on "Person Centred Care Planning for Young People with Emerging Personality Disorders"
- Scarborough Whitby Ryedale CAMHS for work they've done with young people to develop films about services / anti stigma). The outcome of the finalist will be announced at the ceremony in November.

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 with the exception of waiting times. Work is continuing in terms of improving access to services which should improve waiting times in future quarters.

3.3 Strategic Goal 2 - *To continuously improve the quality and value of what we do*

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing 4 indicators rated red out of 8 as at quarter 1, and the overall change is less positive with no actual improvements on the previous quarter.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16							
	Indicator	Q1 Target 2015/16	Quarter 4 Actual 2014/15	Quarter 1 Actual 2015/16	Change on previous Qtr	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 **more than 31 days** for Level 5 SUIs and action points for safeguarding serious case reviews and domestic homicide reviews	0	n/a	3	n/a	0	0
9	Number of action points on action plans for complaints and clinical audit that are outstanding **more than 31 days**	0	8	8	↔	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%	88.96%	86.55%	↓	>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%	37.50%	22.22%	↓	50.00%	>=75%
12	Percentage of staff reporting that they can 'contribute towards improvements at work'*	n/a	77% but in top 20% (DEC 14)	Results due in Q4	n/a	> 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%	n/a	82.87%	n/a	>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 for PLACE (new PEAT) assessments.	n/a	75% (SEPT 2014)	Assessment due in Q2	n/a	80%	80%
15	Hospitality Assured Accreditation score*	n/a	80.5% (Mar 2015)	Assessment due in Q4	n/a	82.00%	86.00%

Indicators of concern are:

- **KPI 8 - Number of outstanding action points 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 1 is 3 against a target of zero but this is the lowest number achieved to date. The 3 outstanding action points are from 1 Serious Incident action plan which is aligned to Tees locality. Assurance

that the outstanding actions were completed was received by the Patient Safety team on 15th July.

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 more than 31 days** – the Trust position for quarter 1 is 8 against a target of zero.

  Complaints – 7 action points from 2 action plans overdue more than one month of the agreed target date. All outstanding action points related to Durham and Darlington Locality: 3 points for MHSOP action plan and 4 points for CAMHS action plan. For all of these outstanding action points, assurance has been given to confirm they have been addressed as at 8th September 2015.

  Any outstanding action points are escalated monthly to EMT and PEG. This is also raised at the specialty QuAGs and LMGBs.

  Clinical Audit – 1 action point - This relates to action point 2 on National Audit of Psychological Therapies to improve clinical practice as identified locally and was applicable to Durham & Darlington and Tees localities. This was 61 days overdue at quarter 1 but assurance evidence has been received to confirm this was completed on 6th July 2015. The delay was due to one team not updating the Clinical Audit team when the action had been completed.

- **KPI 11 - Percentage of NICE Guidance where baseline assessment tool (BAT) signed off by Clinical Effectiveness Group (CEG) within 6 months of publication –** the Trust position at quarter 1 is 22.22% which is 27.78% below the target of 50%.

  There were 7 baseline assessment tools signed off by the CEG in quarter 1 that were after the 6 month time period. The delays were mainly due to the following reasons:
  - NICE BAT for Osteoarthritis (AMH) was delayed by **9 months** due to the topic being complex that needed several specialist staff/advisory groups. There was an added delay due to AMH not having a Physical Healthcare Practitioner in post to review the gap analysis. The Trust has consequently recruited to this post and therefore should not incur a similar delay.
  - NICE BAT for Bipolar (Learning Disability services – LD) was delayed by **1 month** due to the complexity and size of the guidance and the requirement for this to be approved by specialist staff and advisory groups.
  - NICE BAT for Bipolar (Mental Health Services for Older People – MHSOP) and NICE audit for Delirium (Forensic Services) were delayed by **3 months** predominately due to time taken by Services to schedule relevant facilitated events and the requirement to be approved by specialist staff and advisory groups.

- NICE BAT for Drug Allergy (Pharmacy) was delayed **3 months** due to services delay in scheduling a facilitated event and the work being undertaken by the Patient Safety Pharmacist.
- NICE BAT for Obesity (Corporate and Children & Young People Services) was delayed by **3 months** due to being completed by the Head of Dietetics and the requirement to be reviewed by the relevant specialty service development groups.

There were no serious implications identified that resulted from the above delays. Service Development Managers (SMDs)/ Specialties were aware of the delays. Most delays are attributable to BATs now also going to Specialist Advisory Groups/ leads such as QuAGs or Service Development Groups to ensure robust consultation and sign off. Unfortunately due to meeting schedules this also routinely leads to delays.

The Clinical Audit and Effectiveness Team has a 12 month horizon scan of guidance due to be issued by NICE. This is utilised to inform SDMs of when relevant NICE facilitated events should be scheduled. The Clinical Audit & Effectiveness Team is considering how electronic solutions could be further utilised by services to support assessment processes.

3.3.2 Trust Business Plan

A significant number of business plan actions due to be completed by the end of quarter 1 were rated green (96.4%) and there are no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.3.3 Other Qualitative Intelligence

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

- **Academic Health Science Network for North East & North Cumbria (AHSN NENC) –** The Trust received a letter from AHSN NENC to confirm we have been successful with our application to become one of the 10 founding cohort members to help steer a national initiative, referred to as “The Q Initiative”, to improve the quality of patient care in the NHS.
- **Patient Safety Awards** – The Trust was shortlisted for 2 Patient Safety Awards and the event was held 6th & 7th July 2015:
    1. Clinical Leadership - Karen Atkinson, Head of Patient Safety, was awarded "highly commended" for improving quality and efficiency in the Patient Safety department.
    2. Mental Health – two teams were shortlisted for this category – CAMHS Durham and Darlington Crisis Service and Adult Eating Disorder Service.
- **British Institute of Learning Disability 2015 Positive Behaviour Support (PBS) Leadership Awards -** our children and young people’s service in Teesside were “highly commended” in the British Institute of Learning Disability 2015 PBS Leadership Awards for Innovative Practice in supporting people with intellectual disabilities through positive behaviour support.
- **NHS England - Northern Region Specialist Commissioning Team** - Adult Eating Disorders (Durham & Darlington and Tees patients) – the commissioning

team undertook a 2nd quality visit to our Adult Eating Disorder Day Service at Imperial Avenue. Overall the visit acknowledged issues from their 1st visit had been addressed and the positive impact is apparent, with no further areas for consideration at this point.

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 identifying ways we can increase the pace with which NICE guideline baseline assessments are completed without detracting from the thoroughness of these assessments.

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 1 indicator rated red out of 11 as at quarter 1, with two indicators showing an improvement on the quarter 4 position.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16							
	Indicator	Q1 Target 2015/16	Quarter 4 Actual 2014/15	Quarter 1 Actual 2015/16	Change on previous Qtr	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%	n/a	71.04%	n/a	>66.57%	> previous year out-turn
17	Percentage of medical students and junior doctors reporting satisfaction with their placement	87.00%	87.25%	91.03%	↑	87.00%	90.00%
18	Percentage of positive nursing placement evaluations received	95.00%	89.68%	96.86%	↑	95.00%	95.00%
19	Excess cost of employing agency versus substantive	tbc	n/a	KPI under development	n/a	tbc	tbc
20	NHS Employers Assessment of Wellbeing	n/a	100.00%	due in Q3	n/a	100%	100%
21	Percentage of Culture Metrics showing improvement at year end*	n/a	16.67%	due in Q4	n/a	100%	100%
22	Percentage of positive staff responses for training/development evaluations received	n/a	deferred	72.04%	n/a	Collect Baseline	tbc
23	Percentage of staff reporting that they have had a 'well-structured appraisal in last 12 months'*	n/a	49% but in top 20%	Results due in Q4	n/a	>= 2014/15 & in top 20%	>= 2018/19 & in top 20%
24	Percentage of medical staff successfully revalidated	100%	100.00%	100.00%	↔	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	81% points (DEC 14)	Results due in Q4	n/a	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	40.00%	23.53%	21.74%	↓	40.00%	80.00%
27	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	n/a	38% but in top 20% (DEC 14)	Results due in Q4	n/a	< previous year out-turn: <38%	< previous year out-turn

Indicators of concern are:

- **KPI 26 - Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above** – the Trust position for quarter 1 is 21.74% which is 18.26% below the target of 40%.

  Variance has been discussed at the Talent Management Forum and a further meeting will take place in August with the Operational Management Team. The talent management project is progressing with training of band 6 staff and it is expected that once the talent management is expanded to include band 6 staff this will in the longer term have a positive impact on this target. The talent management lead is proactively discussing recruitment and succession planning with any recruiting managers where there appears to be difficulties in recruitment. The current level of the metric is further evidence of the importance of our Talent Management programme which over the next two of years should make a positive change to this metric.

3.4.2 Trust Business Plan

This strategic goal has a small number of actions however only 40% are rated green as at quarter 1. There are also 2 priorities / service developments in the Business Plan that are at high risk of not being delivered.

Of the 2 priorities / service developments at risk:

- 1 required changes to the wording of the actions currently in the Plan which has been agreed by EMT.
- 1 requires "in-year" timescale changes which has been agreed by EMT

Neither of the 2 priorities / service developments at risk are a significant concern to the overall achievement of the strategic goal.

3.4.3 Other Qualitative Intelligence

- **NHS England - STAFF Friends and Family Test (FFT) - Q4 2014/15 results -** TEWV scored well in comparison against other Trusts. The results of the 2014/15 FFT show that TEWV has the joint highest % (83%) of staff (of comparable Mental Health Trusts) who would recommend their Trust as a place to receive treatment. Our results for percentage who would recommend working in the Trust was also one of the highest at 72%. Our results were notably better than Leeds Partnership NHS Foundation Trust (FT), Humber NHS FT and Northumberland, Tyne & Wear NHS FT but comparable with Cumbria Partnership NHS FT. TEWV is also notable for the number of staff who took part (2,822) which compares very well against some other trusts such as Bradford District Care Trust, Lancashire Care NHS FT, Oxleas NHS FT and East London NHS FT where fewer than 100 staff submitted their views
- **Nursing and Midwifery Council (NMC) report on education -** TEWV received very positive feedback from the NMC in their recent review of nursing and midwifery education at Teesside University. Students gave positive feedback about their placements with the Trust and the report noted good partnership working between the university and the Trusts.

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.

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 1, with one indicator showing an improvement on the quarter 4 position.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16							
	Indicator	Q1 Target 2015/16	Quarter 4 Actual 2014/15	Quarter 1 Actual 2015/16	Change on previous Qtr	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	98%	88.89%	83.33%	↓	98%	98%
29	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100%	100.00%	↔	98%	98%
30	Proportion of student nursing placements provided as a % of placements requested	90.00%	99.38%	100.00%	↑	90.00%	90.00%
31	Research and Development Outcomes (to be developed)	tbc	n/a	KPI under development	n/a	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 & 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 1 is 83.33% which is 14.67% below the target of 98%.
  The Trust was represented at 5 out of 6 Health and Well Being Boards. There was one board meeting held in Hartlepool in June 2015 that was not attended with apologies given as a suitable deputy was not available. On reflection the target is not realistic and should be reduced to 90% i.e. the Trust attends 9 out of 10 Board meetings of the 50+ that are held each year.

  A Board decision is required to change the target for the above indicator.

3.5.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 1 were rated green (100.0%) and there is a no risk of failure to deliver the priorities/development in the Business Plan.

3.5.3 Other Qualitative Intelligence

- The Chief Executive has now completed meetings with the 7 emerging GP Federations in Durham and Darlington locality.
- The Trust has become an active member of the Harrogate Vanguard work and has been asked to lead the Care Planning work stream.
- The Trust is engaged with the recently announced North East Urgent and Emergency Care Vanguard and has been asked to lead the Mental Health work stream.

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.

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 1, with no improvements on the quarter 4 position.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16							
	Indicator	Q1 Target 2015/16	Quarter 4 Actual 2014/15	Quarter 1 Actual 2015/16	Change on previous Qtr	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%	75.00%	**81.25%**	↓	<=56.25%	<=6.25%
34	Percentage of Information Strategy outcomes achieved that are reported on Information Strategy Metrics Scorecard	n/a	n/a	due in Q3	n/a	Collect Baseline	tbc
35	Percentage change in income for Trust contracted services compared to previous year	-1.30%	**0.90%**	**-0.01%**	↓	-1.30%	Better than deflator
36	Productivity Metric (to be developed)	tbc	n/a	KPI under development	n/a	tbc	tbc
37	EBITDA **	8.39%	**10.80%**	**8.41%**	↓	7.01%	8.00%
38	Good Corporate Citizenship audit scores*	n/a	**51% (March 15)**	due in Q4	n/a	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 1 is 81.25% which is 25% 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. Directors are confident that performance against this metric will improve.

3.6.2 Trust Business Plan

This strategic goal has a small number of actions and whilst only 40% are rated green as at quarter 1, there is no identified risk of failure to deliver the priorities/development in the Business Plan.

3.6.3 Other Qualitative Intelligence

- **Care Quality Commission -** TEWV received an extremely positive report from the CQC and they have given an overall rating of 'GOOD'. CQC rated services for being well-led as "outstanding". The category relating to our services being "safe" required some improvement. The inspectors found lots of good evidence of how we keep patients safe but unfortunately because of four minor breaches we were rated as requiring improvement. Overall, the inspector's highlighted six issues that we needed to address, four of which have now been completed as at 29th July.

- **Q1 Contract Round -** information on the current position with 15/16 contracts for provision of services is as follows:

  - NHS England Specialised Services – the contract has been agreed and signed. An additional investment in CYP Eating Disorder beds and CYP Eating Disorder Intensive Home Support Service has been agreed. In addition reconfiguration of Forensic Learning Disability services agreed with Commissioners will result in additional investment.

  - Durham and Darlington CCGs – a 2 year contract has been agreed and signed. We have received additional investment in Early Intervention Psychosis (EIP) and MHSOP services. The CCGs have agreed to ring fence current mental health spend and increase it annually in line with CCG allocation uplifts. The Trust will work with the CCG to minimise pressures on the ring fence budget

  - Tees CCGs – the contracts are agreed and signed. We have received additional investment in EIP and to continue to provide the Crisis Assessment Centre at Roseberry Park Hospital. Hartlepool and Stockton CCG (HaST) has agreed to continue with the ring fence of the mental health budget which has been in place for 4 years. HaST has also identified a number of investments which will be supported within the ring fence. South Tees CCG has decided to cease the ring fenced approach but will continue to increase investment in mental health in line with CCG allocation uplifts.

  - North Yorkshire CCGs – contract discussions are ongoing but we expect to sign the contract. We have received additional investment in EIP services and the Scarborough Street Triage service.

  - Durham and Darlington IAPT – contract discussions are ongoing but we expect to gain agreement.

  - Vale of York Contract - The contract is for 5 years from 1st October 2015. The contract has not been signed yet but a process is in place to negotiate the detail within the contract.

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. However further work is needed in terms of improving data quality and the finalisation of the remaining contracts.

4.0 IMPLICATIONS & RISKS

4.1 **Quality**: The report highlights that four 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 This is the first 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. 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 change in target referenced in section 3.5.1

Sharon Pickering
Director of Planning & Performance & Communications

Request for changes to the Business Plan

Appendix 1

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Current Status	Future Risk Status	Comment and requests for decisions
1.5.130	Develop and implement plans to deliver significant service changes/developments required for each service - **Development of service for Medically Unexplained Systems**	Tees	MHSOP	Undertake 3P event to develop model and support future bids for funding	3P event completed	15/16 Q2	Lorraine Ferrier	**N/A**		This is not identified within current commissioning intentions and further clarity of intent will be sought. **Rec: removal.**
1.5.133	Develop and implement plans to deliver significant service changes/developments required for each service - **Improve efficiency of AMH Community Teams**	Tees	AMH	Review service provision following the implementation of Model Lines, Affective Collaborative work and PBR benchmarking to assess community staff differences and the impact on teams	Community Review Group established and baseline data established	15/16 Q1	AMH Head of Service			It is now not intended to establish a Community Review Group in AMH as work being taken forward Tees wide. Model lines currently being rolled out across South Tees. PBR Benchmarking has been carried out and work to compare teams e.g. Affective, Psychosis, Crisis, is being done across Teesside. **Rec: removal.**
1.5.136	Develop and implement plans to deliver significant service changes/developments required for each service - **Anti-psychotic monitoring in Care Homes**	Tees	MHSOP	Anti-psychotic monitoring in Care Homes - completion of evaluation report to support recurrent income	Evaluation completed	15/16 Q4	Emma Thompson	**N/A**		This bid was not approved by commissioners and therefore the evaluation is no longer needed. **Rec: removal.**
1.5.144	Develop and implement plans to deliver significant service changes/developments required for each service - **Development of Crisis Service for LD**	Tees	LD	In response to issues highlighted from National Benchmarking Project, consider further extending community services to provide dedicated Crisis Services	Scope the need for dedicated crisis provision post implementation of the enhanced community infrastructure	15/16 Q2	Chris Graham	**N/A**		Following input from AMH Services it has been agreed that a dedicated LD Crisis Team would not be appropriate. This will now be considered in terms of Green Light and reasonable adjustments. **Rec: removal.**

Request for changes to the Business Plan

Appendix 1

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Current Status	Future Risk Status	Comment and requests for decisions
1.5.107	Develop and implement plans to deliver significant service changes/developments required for each service - **Bid for Autism Spectrum Disorder diagnosis service in North Yorkshire**	North Yorkshire	All	Respond to ASD/ADHD ITT once published by Partnership Commissioning Unit	ITT submitted in line with timescales as set out by PCU	15/16 Q4	Paul Hyde / Bridget Lentell / Jackie Ennis	**N/A**		EMT, at its meeting on 17 June 2015, agreed not so submit a bid due to concerns around resources available to deliver the service. **Rec: removal.**
1.5.057	Complete the implementation of existing service development/changes identified for 2014/15 and 2015/16 **- Implement the invest to save - renewable energy programme service developments**	EFM	NA	Invest to save, investigate the use of renewable energy	Implementation commenced at Roseberry Park, subject to approval by EMT	15/16 Q3	Dave Turner	**N/A**		Following a change in PFI provider - the provider is no longer able to deliver this action. **Rec: removal.**
1.5.064	Develop and implement plans to deliver significant service changes/developments required for each service - **Retender Domestic services contract**	EFM	NA	Re tender domestic services contract of non patient facilities	Trust's standards/ frequency for office cleaning agreed. Contract/ specification defined and properties established.	15/16 Q1	Caroline Siddall			York tender outcome has impacted upon this work, requiring the process to be delayed by 12 months. The current contract will therefore be extended. The contract will be re-tendered from April 2016. **Rec: All timescales associated with this priority to be extended by 1 year.**

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **29th September 2015**

Title: **Register of Interests of the Board of Directors**

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

Date of Meeting: **29th September 2015**

Title: **Register of Interests of the Board of Directors**

1. INTRODUCTION & PURPOSE

1.1 To present the revised Register of Interests of the Board of Directors.

2. BACKGROUND INFORMATION

2.1 The National Health Service Act 2006 and the Constitution require the Trust to maintain a Register of Interests of Members of the Board of Directors.

2.2 In accordance with the Constitution, Members of the Board of Directors are required to declare details of all directorships and other relevant and material interests including any business interests, positions of authority in a charity or voluntary body in the field of health and social care and any connection with a body contracting for NHS services.

2.3 The Register is formally reviewed, at least, on an annual basis.

3. KEY ISSUES:

3.1 The updated Register of Interests of Members of the Board of Directors of Tees, Esk and Wear Valleys NHS Foundation Trust is attached as Annex 1 to this report based on a review undertaken in July - September 2015.

3.2 The Board is asked to note that the Register of Interests is a public document which is published on the Trust's website and publicised in the Annual Report.

3.3 The next annual review of the Register of Interests will commence in August 2016.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** None identified.

4.2 **Financial:** None identified.

4.3 **Legal and Constitutional:** The Trust is required to maintain and publish a Register of Interests of the Board of Directors under the National Health Service Act 2006 and the Constitution.

4.4 **Equality and Diversity:** There are no equality and diversity implications arising from this report.

4.5 **Other Risks:** None identified.

5. CONCLUSIONS

5.1 The report supports compliance with the Trust's Constitution.

6. RECOMMENDATIONS

6.1 The Board is asked to receive and note the revised Register of Interests of the Board of Directors.

Phil Bellas,
Trust Secretary

Background Papers: *The Constitution of Tees, Esk and Wear Valleys NHS Foundation Trust*

Tees, Esk and Wear Valleys NHS Foundation Trust

Register of Interests of Members of the Board of Directors

Note: 1 - The full description of each interest type is given in the Declaration of Personal Interests form
Note: 2 - (B) denotes that the Director is a voting member of the Board of Directors
Note: 3 - Details of interests must be entered as submitted on the Declaration form including 'NIL RETURNS'
Note: 4 - Changes of interest should be recorded as notified
Note: 5 - The Register should be refreshed annually
Note: 6 - The Register should be a record of interests over time and additional lines should be inserted as required

Name	Position	Directorships or Position of Authority	Employment and Consultancy	Commercial Interests	Membership of public body, charity or pressure group whose work is related to the business of the Trust	Donations and Sponsorship	Other Interests
Lesley Bessant	Chairman **(B)**	No	**Yes** Husband employed by Northumbria University	No	No	No	No
Marcus Hawthorn	Non-Executive Director **(B)**	No	**Yes** Area Manager, Northern for the Royal British Legion	No	**Yes** Volunteer with the Great North Air Ambulance Service	No	No
Barbara Matthews	Non-Executive Director **(B)**	No	**Yes** Political Assistant, City of York Council	No	No	No	No
David Jennings	Non-Executive Director **(B)**	**Yes** Financial Services Manager at Redcar and Cleveland Borough Council	No	No	**Yes** Member of Chartered Institute of Public Finance and Accountancy	No	**Yes** Pensioner Audit Commission Membership of Local Government Pension Scheme Independent Appointed Member: Northumbria University Audit Committee
Dr Hugh Griffiths	Non-Executive Director **(B)**	**Yes** Non-Executive Director North of England Mental Health Development Unit Wife is Director of Planning and Strategy at Mid-Yorkshire Hospitals NHS Trust	**Yes** Director of Hugh Griffiths Associate Ltd Associate contract with GE Finnamore Healthcare	No	**Yes** Fellow of the Royal College of Psychiatrists Member of the British Medical Association	No	No
Richard Simpson	Non-Executive Director **(B)**	**Yes** Gateshead Health NHS Foundation Trust - Non-Executive Director (2006-2013)	**Yes** Northumbria University - Associate	No	No	No	No
Jim Tucker	Deputy Chairman **(B)**	No	No	No	No	No	No

Name	Position	Directorships or Position of Authority	Employment and Consultancy	Commercial Interests	Membership of public body, charity or pressure group whose work is related to the business of the Trust	Donations and Sponsorship	Other Interests
Martin Barkley	Chief Executive **(B)**	**Yes** Vice-Chairman of the North East NHS Local Education and Training Board Member of the National Leadership Academy Board Member of the Board of the North East & North Cumbria Academic Science Network	No	No	No	No	No
Brent Kilmurray	Chief Operating Officer **(B)**	**Yes** Vice-Chairman of Achieving Real Change in Communities (ARCC) CIC Ltd	**Yes** Wife employed as a Clinical Psychologist by Northumberland, Tyne and Wear NHS Foundation Trust.	No	No	No	No
Nick Land	Medical Director **(B)**	**Yes** Member of the Archbishop of York's Council Director York Diocesan Board of Finance	No	No	**Yes** Member of the Mental Health Network Board (NHS Confederation) Chairman of the Psychiatric Workforce Planning Group (a sub-committee of the School of Psychiatry of the Northern Deanery) Member of the British Medical Association Member of the Royal College of Psychiatrists	No	**Yes** Non-Executive for Areté multi-school academy
Colin Martin	Director of Finance and Information and Deputy Chief Executive **(B)**	**Yes** Chairman of Audit North which is an NHS Internal Audit Consortium operating in the North of England	No	No	**Yes** Member of HFMA Policy and Research Committee	No	No
Elizabeth Moody	Director of Nursing and Governance **(B)**	No	No	No	No	No	No
David Levy	Director of Human Resources and Organisational Development	No	No	No	No	No	No
Sharon Pickering	Director of Planning, Performance and Communications	**Yes** Husband, Mark Pickering employed by Durham Dales Easington and Sedgefield CCG as Chief Finance Officer	No	No	No	No	No

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **29th September 2015**

Title: **Terms of Reference of the Board's Committees**

Lead: **Phil Bellas, Trust Secretary**

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 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: **29th September 2015**

Title: **Terms of Reference of the Board's Committees**

1. INTRODUCTION & PURPOSE

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

2. BACKGROUND INFORMATION

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

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

2.2 The terms of reference of the above committees (attached as annexes 1 to 6, respectively, to this report) were reviewed in 2014 in consultation with the Chairman of the Trust, the Chief Executive, the Chairmen of the Committees and Lead Directors.

2.3 The terms of reference of most of the Board's committees are subject to an annual review.

3. KEY ISSUES:

3.1 A review of the terms of reference has been undertaken in consultation with the Chairmen and Lead Directors of each committee.

3.2 The outcome of the review is that no changes to the terms of reference are proposed at the present time.

3.3 Board Members will be aware that the terms of reference of the Quality Assurance Committee were subject to significant changes in 2014. In view of this the Chairman of the Trust will be hosting a meeting in December 2015, involving the Chairman of the Committee and Lead Officers, to consider the operation of the Committee after its first year under these revised arrangements. Any proposed changes to the terms of reference arising from this meeting will be presented to the Board for consideration in due course.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** None identified.

4.2 **Financial:** None identified.

4.3 **Legal and Constitutional:** The report supports compliance with the Constitution and the terms of reference of the Board's committees.

4.4 **Equality and Diversity:** None identified.

4.5 **Other Risks:** None identified.

5. CONCLUSIONS

5.1 It is considered that the terms of reference of the Board's committees remain fit for purpose; however, changes might be required to those of the Quality Assurance Committee in the light of discussions on the operation of the Committee at the meeting to be hosted by the Chairman which is due to be held in December 2015.

6. RECOMMENDATIONS

6.1 The Board is asked to confirm the terms of reference of the Board's committees noting that a review of the operation of the Quality Assurance Committee is due to be held in December 2015.

Phil Bellas,
Trust Secretary

Background Papers:

The Standing Orders of the Board of Directors (Annex 8 to the Constitution).

Annex 1

AUDIT COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION AND PURPOSE

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

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

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

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

2 FUNCTIONS

Governance, Risk Management and Internal Control

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

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

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

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

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

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

Internal Audit

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

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

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

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

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

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

External Audit

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

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

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

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

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

- consideration of the appointment and performance of the External Auditor ;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; and
- reviewing all External Audit reports, including agreement of the annual audit letter (if required) before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses.

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

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

Annual Accounts Review

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

2.14 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes.
- Areas where judgment has been exercised.
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having a material effect
- The schedule of losses and special payments
- Any adjusted misstatements
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved

2.15 To review the Annual Report and Annual Governance Statement prior to submission to the Board of Directors to determine their completeness, objectivity, integrity, accuracy and compliance with directions received from Monitor.

2.16 To review the Trust's Quality Account/Report prior to inclusion in the Annual Report and submission to the Board of Directors to determine its completeness, integrity and accuracy. This review will include but is not limited to:

- Compliance with directions received from the Department of Health and Monitor.
- The accuracy of mandatory and local performance indicators
- Any issues raised by stakeholders

2.17 To review all systems of accounting and financial reporting, including those of budgetary control, in order to provide assurance on the completeness and accuracy of information provided to the Board.

Other

2.18 To review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Monitor, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

2.19 To review the work of other committees within the organisation and the Executive Management Team (*including recommendations from EMT and the other Committees)* whose work can provide relevant assurance to the Committee's own scope of work. This will particularly include the Quality Assurance Committee.

In reviewing the work of the Quality Assurance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

2.20 To review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ("The Whistle Blowing Policy").

In undertaking the review the Committee's objective will be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

2.21 To review the Trust's systems and processes for the prevention of bribery and receive reports on non-compliance.

2.22 To request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

2.23 To request and review specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

2.24 To commission and review value for money studies of the Trust's services and functions and to make recommendations to the Board accordingly.

3 MEMBERSHIP

3.1 The Committee shall be appointed by the Board from amongst the Non - Executive Directors of the Trust and shall consist of not less than four members. At least one Member of the Committee shall have recent and relevant financial experience.

3.2 The Chairman of the Committee shall be appointed by the Board of Directors.

3.3 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman. Nominated deputies may be appointed when appropriate.

4 ATTENDANCE

4.1. The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. .

4.2 The Chairman of the Trust shall not be a member of the Committee but may attend as an observer at the invitation of the Committee.

4.3 Any Non-Executive Director of the Trust may attend meetings should they wish and participate in discussions on all matters before the Committee. All Non-Executive Directors will receive Audit Committee agendas and papers.

4.4. The Chief Executive and other Executive Directors **may** be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

4.5 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

4.6 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary of the Committee.

5 QUORUM

5.1 A quorum shall not be less than three members of the Committee.

6 FREQUENCY

6.1. Meetings shall be held not less than three times a year.

6.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

6.3 The Committee shall meet privately at least once a year with the Internal and External Auditors.

7 DELEGATED AUTHORITY

7.1 Authority to investigate any activity within its terms of reference.

7.2 Authority to seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee.

7.3 Authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise at its meetings if it considers this necessary.

7.4 Authority to commission value for money and other studies.

7.5 Approval of the Internal Audit Strategy and Operational Plan.

7.6 Appointment and dismissal of the Internal Audit provider.

7.7 Approval of the External Audit Strategy.

8 REPORTING

8.1. The minutes of Audit Committee meetings shall be formally recorded by the Trust Secretary and submitted to the Board. The Chairman of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action, including any risks which the Committee considers should be included in the Board's Chapter of the Integrated Assurance Framework and Risk Register.

8.2. The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessments as required by Monitor and/or the Care Quality Commission.

8.4 The Audit Committee may also make recommendations directly to the Council of Governors on any matters it deems appropriate within the Council of Governors roles and responsibilities.

9 REVIEW

9.1. The terms of reference of the Committee shall be reviewed, at least, annually.

Annex 2

COMMERCIAL OVERSIGHT COMMITTEE

TERMS OF REFERENCE

CONSTITUTION

The Commercial Oversight Committee is established under Standing Order 6 of the Board of Directors.

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

For the purposes of these Terms of Reference the term "Subsidiary" shall include any company, limited liability partnership, joint venture or other trading initiative which the Committee is designated as overseeing.

FUNCTIONS

1 To oversee and provide assurance to the Board on the performance of the Trust's Subsidiaries.

2 To ensure that all the Trust's Subsidiaries:

- (a) Are and remain established in accordance with the Companies Act 2006 and / or other relevant legislative requirements;
- (b) Have no functions other than those agreed by the Board of Directors of the Trust;
- (c) Adhere to all applicable laws and statutory guidance;
- (d) Ensure appropriate insurance is in place, in particular:
  - i. Employer Liability
  - ii. Public Liability
  - iii. If relevant, Directors and Officers insurance
  - iv. All other relevant insurance
- (e) Apply the proceeds of any trading activity to the benefit of the Trust.

3 To provide input on any matter related to the Trust's interest in a Subsidiary to:

- (i) The nominee(s) on the board or equivalent of that Subsidiary.
- (ii) If relevant, a person or persons appointed under Section 323 of the Companies Act 2006 to act as the Trust's representative or representatives at any meeting of the Subsidiary.

4 To receive and review the annual reports and accounts of Trust Subsidiaries.

5 To notify any material risks with regard to the operation of the Trust Subsidiaries to the Board of Directors.

6 To investigate any concerns it may have in relation to any Subsidiary and to report the outcome of any investigations, if it considers it appropriate, together with suggested recommendations to the relevant Subsidiary and the Board.

7 To take appropriate steps to ensure the Subsidiaries remain financially solvent and provide a positive financial return to the Trust.

DELEGATED AUTHORITY

1 In carrying out its duties the Committee may do anything which appears to it to be reasonably necessary or expedient for the purposes of or in connection with the functions set out above. In particular it may agree its requirements as to the information it requires from Trust Subsidiaries in order to maintain proper oversight of their activities.

MEMBERSHIP

The Committee shall comprise:

- The Chairman of the Trust*.
- The Chairman of the Investment Committee*
- The Chairman of the Audit Committee*
- An Executive Director*

(* subject to them also not being a director or senior post holder of any Subsidiary).

The Chairman of the Committee shall be appointed by the Board from amongst the Committee's membership.

The Committee may require:

- Directors or senior post holders of Subsidiaries;
- Internal or external auditors;
- Any other relevant third parties

to attend its meetings, as it considers appropriate, for maintaining an oversight of Subsidiary business planning, performance and activities.

The Trust Secretary, or a member of his/her staff, shall be the Secretary to the Committee.

QUORUM

A quorum shall be not less than two members of the Committee of which one shall be a Non-Executive Director and one shall be an Executive Director.

FREQUENCY OF MEETINGS

The Committee shall meet at least once each quarter.

MINUTES AND REPORTING PROCEDURES

1 Reports on the material issues considered by the Committee shall be submitted, together with formal minutes of its meetings, to the Board.

2 Any issues or risks to the Trust's reputation and/or sustainability arising from the performance of Subsidiaries shall be escalated to the Board for its attention in accordance with the Trust's integrated governance arrangements.

3 Any reports provided to the Board on matters which have been subject to consideration by the Committee shall disclose this fact together with details of any views expressed or recommendations made by the Committee.

REVIEW

The terms of reference of the Commercial Oversight Committee shall be reviewed at least annually.

Annex 3

INVESTMENT COMMITTEE (INCLUDING CHARITABLE FUNDS)

TERMS OF REFERENCE

1 CONSTITUTION

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

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

2 FUNCTIONS

2.1 To establish the overall methodology, processes and controls which govern investments.

2.2 To keep the Trust's investment strategy and policy under review and to ensure they are aligned to the Business Development Strategy.

2.3 To consider and provide assurance to the Board on the appropriateness and robustness of:

(a) The medium-term financial strategy, in relation to both revenue and capital.
(b) The Estates and Facilities Management Framework.
(c) The Information Strategy.

2.4 To review the Capital Plan prior to its incorporation in the Business Plan.

2.5 To undertake in-year monitoring of capital expenditure.

2.6 To monitor the implementation of the Business Development Strategy.

2.7 To review proposals (including evaluating risks) for major business cases and their respective funding sources.

2.8 To review the management and administration of Charitable Funds held by the Trust.

2.9 To review progress towards the achievement of the "upside" scenarios included in the Business Plan.

3 DELEGATED AUTHORITY

3.1 The investigation of any activity within its terms of reference.

(Note: All employees are directed to cooperate with any request made by the Committee)

3.2 Approval of outline business cases for projects included in the Business Plan to progress to full business case stage subject to their financial consequences (both capital and revenue) remaining within estimate.

3.3 Approval of full business cases for:
- High risk investments valued under £250,000.
- Low risk investments valued between £250,000 and £1 million.

3.4 Approval of the submission of reference cost information to the Department of Health.

3.5 Approval of applications for financial assistance from the Trust's Charitable Trust Funds.

3.6 The commissioning of any outside legal or other independent professional advice and expertise if it considers this necessary.

4 MEMBERSHIP

4.1 The Committee shall comprise:
- A Non-Executive Director as the Chairman of the Committee
- Two other Non-Executive Directors
- The Chairman of the Trust
- The Chief Executive
- The Director of Finance and Deputy Chief Executive
- The Chief Operating Officer
- The Director of Planning, Performance and Communications

4.2 The Chairman of the Committee shall be appointed by the Board of Directors.

4.3 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman.

4.4 Any Non-Executive Director of the Trust may attend meetings should they wish and participate in discussions on all matters before the Committee. All Non-Executive Directors will receive agendas and papers.

4.5 The Committee may invite other directors and other Trust staff to attend its meetings as appropriate. It will also invite the attendance of independent external advisors as required subject to the size and complexity of the investment.

4.6 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary of the Committee.

5 QUORUM

5.1 A quorum shall be not less than two Non-Executive Directors, one of which will chair the meeting and one Executive Director.

6 DECISION MAKING

6.1 Normal practice will be to reach decisions through consensus; however, where this is not possible the chairman of the Committee will refer the matter to the Board for decision together with briefing papers.

7 FREQUENCY OF MEETINGS

7.1 The Committee shall meet at least once each quarter.

8 MINUTES AND REPORTING PROCEDURES

8.1 Reports on the material issues considered by the Committee shall be submitted, together with formal minutes of its meetings, to the Board of Directors.

8.2 Any risks to the Trust's sustainability shall be escalated to the Board for its attention in accordance with the Trust's integrated governance arrangements.

8.3 Any reports provided to the Board on matters which have been subject to consideration by the Committee shall disclose this fact together with details of any views expressed or recommendations made by the Committee.

9 REVIEW

9.1 The terms of reference of the Investment Committee shall be reviewed at least annually.

Annex 4

MENTAL HEALTH LEGISLATION COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Mental Health Legislation Committee is established under Standing Order 6 of the Board of Directors

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

1.3 All meetings of the Committee will be held in public.

2 FUNCTIONS

2.1 To provide assurance to the Board on the Trust's compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005, including any statutory Codes of Practice relating thereto, by:

(a) reviewing activity and performance with appropriate comparisons and trends; and

(b) identifying common themes arising from the findings of the Care Quality Commission following visits to the Trust's services

and to escalate risk and propose mitigating actions to the Board where assurance is lacking.

(NOTE: Oversight and monitoring of actions in response to recommendations received from the Care Quality Commission falls within the remit of the Quality Assurance Committee).

2.2 To consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to make recommendations, as required, for changes to the Trust's policies, procedures and practice.

2.3 To ensure appropriate arrangements are in place for the appointment and appraisal of associate managers and oversee managers' hearings.

2.4 To consider other matters at the request of the Board of Directors.

3 MEMBERSHIP

3.1 The Committee will comprise:

- A Non-Executive Director as the Chairman of the Committee
- One other Non-Executive Director
- The Chairman of the Trust
- The Director of Nursing and Governance
- The Medical Director

- The Chief Operating Officer
- Two Public Governors (as representatives of service user/carers)

3.2 The Chairman of the Committee shall be appointed by the Board.

3.3 The Executive Director Members of the Committee may nominate deputies (with voting rights) to attend meetings on their behalf.

3.4 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman.

3.5 Any Non-Executive Director of the Trust may attend meetings should they wish and all Non-Executive Directors will receive agendas and papers.

3.6 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary to the Committee.

3.7 Other officers of the Trust may attend meetings on the invitation of the Committee.

4 QUORUM

4.1 A quorum shall be three members of whom at least one must be a Non-Executive Director and one must be an Executive Director (or nominated Deputy).

5 FREQUENCY OF MEETINGS

5.1 Meetings will be held at least every quarter.

6 RELATIONSHIP WITH THE BOARD AND OTHER COMMITTEES

6.1 In the course of fulfilling its functions and duties if the Committee becomes aware of any risk which could impact on the Trust's ability to deliver its Strategic Goals it shall seek assurances from the appropriate Director that the risk is being managed effectively. On considering the Director's report it shall:

- When necessary (in conjunction with the Quality Assurance Committee) assure itself that appropriate controls are in place to manage the risk or specify the controls it considers should be established to mitigate the risk.
- Report to the Audit Committee if the risk raises concerns regarding the effectiveness of the Trust's governance arrangements; risk management and assurance arrangements or system of internal control.
- Make a recommendation to the Board that the risk be included in the Board's Chapter of the Integrated Assurance Framework and Risk Register if it believes the risk could have a significant impact on the sustainability/viability of the Trust or on its ability to deliver the Strategic Direction.

7 DELEGATED AUTHORITY

7.1 The Committee is authorised to seek any information it requires through the Executive Directors and Chief Executive.

7.2 All executive action arising from the work of the Committee shall be taken forward either by way of a recommendation to the Board of Directors or by agreement of the relevant Executive Director under their delegated powers.

8 REPORTING ARRANGEMENTS

8.1 Following every meeting the Chairman of the Committee shall report to the next ordinary meeting of the Board of Directors:

- To provide assurance to the Board on the matters considered and to highlight any risks and mitigating actions identified by the Committee at its meeting.
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

9 REVIEW

9.1 The terms of reference of the Committee will be reviewed, at least, annually.

Annex 5

NOMINATION AND REMUNERATION COMMITTEE OF THE BOARD OF DIRECTORS

TERMS OF REFERENCE

CONSTITUTION

The Nomination and Remuneration Committee is established under Standing Order 6 of the Board of Directors.

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

FUNCTIONS

Nominations

1 To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and to make recommendations to the Board with regard to any changes.

2 To be assured that arrangements are in place to support succession planning for Executive Director roles.

3 To be responsible for appointing Executive Directors and other Directors reporting directly to the Chief Executive.

4 To be responsible for appointing the Chief Executive subject to the approval of the Council of Governors.

5 To confirm any matter relating to the continuation in office of any Executive Director (including the Chief Executive) or other Director reporting directly to the Chief Executive at any time including suspension or termination of an individual as an employee of the Trust.

Remuneration

1 To be responsible for reviewing and deciding the terms and conditions of office of the Trust's Executive Directors and other Directors (where these are not determined nationally) including:

- Salary including any performance related pay or bonus
- Provisions for other benefits including pensions
- Allowances

2 To be assured, through the consideration of benchmarking information, that the terms and conditions of employment, including levels of remuneration are sufficient to attract, retain and motivate the Executive Directors and other Directors (where these are not determined nationally).

3 To receive reports on the performance of the Chief Executive and individual Directors who report to the Chief Executive (and other Directors if relevant), as required, to support the consideration of any decisions affecting their remuneration.

4 To advise upon and oversee contractual arrangements for Executive Directors and other Directors (where these are not determined nationally) including but not limited to termination payments.

Miscellaneous

1 To be responsible for authorising applications to Monitor and HM Treasury for permission to make a special severance payment to an employee or former employee.

2 To consider the engagement or involvement or any suitably qualified adviser to assist with any aspect of its responsibilities.

DELEGATED AUTHORITY

1 The agreement of all matters relating to the appointment of Executive Directors and other Directors (who report directly to the Chief Executive) including the role description and person specification for the position subject to:

- All appointments being advertised externally to the Trust.
- Suitable controls being established to ensure all candidates are considered on merit against objective criteria.
- Suitable controls being established to ensure candidates meet all statutory and regulatory requirements for appointment as directors of the Trust.
- Due regard being given to equality and diversity.

2 The appointment Executive Directors and other Directors (who report directly to the Chief Executive) subject to the Committee being assured that the appointee is a “fit and proper person” as defined in the Licence and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

(Note: the appointment of the Chief Executive requires the approval of the Council of Governors)

3 The approval of the remuneration and terms and conditions of service of the Executive Directors and other Directors (where these are not determined nationally).

4 The approval of any annual uplifts in Trust determined pay structures.

5 The approval of any termination payments to the Executive Directors and other Directors (where these are not determined nationally), ensuring they are properly calculated and are reasonable with regard to their probity and value for money.

6 The approval of applications to Monitor and HM Treasury for permission to make a special severance payment to an employee or former employee.

MEMBERSHIP

The Committee shall comprise the Chairman of the Trust and all Non-Executive Directors.

The Chief Executive shall be an ex officio member of the Committee for all matters pertaining to the appointment of Executive Directors (excluding to the office of Chief Executive) and other Directors who report directly to the Chief Executive.

The Chairman of the Trust shall be the Chairman of the Committee.

A quorum shall be at least three Members of the Committee.

The number of Non-Executive Directors and their individual attendance at meetings held for the purpose of conducting interviews and appointing Executive Directors or other Directors reporting to the Chief Executive shall be determined by the Chairman in consultation with the Chief Executive.

ATTENDANCE AT MEETINGS

With the agreement of the Chairman meetings of the Nomination and Remuneration Committee may be attended by:

- *The Chief Executive*
- *The Director of Human Resources and Organisational Development*
- *any other person on the invitation of the Committee so as to assist in its deliberations*

The Trust Secretary shall be the secretary of the Committee.

FREQUENCY OF MEETINGS

Meetings shall be held as and when required on dates and at times agreed by the Chairman.

MINUTES AND REPORTING PROCEDURES

1 The minutes of all meetings of the Nomination and Remuneration Committee shall be formerly recorded. These will be retained by the Secretary and not shared with any person who is not a member of the Committee without the permission of the Chairman.

2 The Nomination and Remuneration Committee will report to the Board of Directors after each meeting.

3 Matters pertaining to the work of the Nomination and Remuneration shall be reported, as required by Monitor, in the Annual Report.

REVIEW

The terms of reference of the Nomination and Remuneration Committee shall be reviewed by the Board of Directors as an when it is considered necessary and expedient to do so.

Annex 6

QUALITY ASSURANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Quality Assurance Committee is established under Standing Order 6 of the Board of Directors.

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

The Committee exists to provide assurance to the Board to enable it ("the Board") to fulfil its responsibilities.

2 FUNCTIONS

2.1 To provide assurance to the Board that the Trust is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008 ("the Act").

2.2 To gain and provide assurance to the Board on:

a. The Trust's compliance with regulation requirements enabling it to maintain registration with the Care Quality Commission to undertake regulated activities at each location;

b. The Trust is compliant with the Regulator's standards of quality and safety as set out in the Health and Social Care Act 2008 (Registration requirements) Regulations 2009 and the fundamental standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014 (from 1st April 2015);

c. The delivery of the strategic quality objectives in the Trust's Quality Strategy and its supporting Frameworks;

d. The delivery of the Quality Account priorities and escalate risks of achievement to the Board;

e. That effective processes are in place in the Trust to ensure that lessons are learned and that good practice is shared and implemented across the Trust.

And to escalate risk to the Board where assurance is lacking.

2.3 To make recommendations about priorities in the Trust's Annual Quality Account for the following year.

2.4 To commission and monitor projects/programmes of work to assist the Trust to maintain CQC registration and/or discharge its duty of quality and safety.

2.5 To co-operate fully with all Board Committees and to support those Committees achieving their objectives.

2.6 To develop an annual programme of work to ensure the functions of the Committee are achieved.

2.7 To agree in consultation with the Audit Committee, an annual Clinical Audit programme (aligned to the key clinical risks of the Trust); and to monitor that programme and liaise with the Audit Committee as appropriate.

2.8 To monitor that the risks relevant to the Committee within the Risk Register are regularly reviewed to reflect the dynamic nature of risk.

2.9 To agree the information requirements of the Committee which will assist it to fulfil its functions, identify any risk to the Trust and allow improvement to be monitored. The information will be provided to the Committee through regular reports which meet the requirements of Monitor's Quality Governance Framework.

2.10 To obtain assurance from service users and carers on the quality and safety of service provision through an Essential Standards Group.

2.11 To undertake an annual review of each working group that reports to the Committee.

2.12 To provide the Board of Directors with a monthly report on the quality, assurance and governance activities of the Committee and to escalate any risk to quality to the Board for its attention in accordance with the Trust's integrated governance arrangements.

3 MEMBERSHIP

Voting Members
Chairman of the Committee (a Non-Executive Director)
4 Non-Executive Directors / Associate Non-Executive Directors
Director of Nursing and Governance
Medical Director
Chief Operating Officer
Trust Chairman
Chief Executive

IN ATTENDANCE (Whole meeting)

- The 2 Deputy Medical Directors and Directors of Operations whose LMGB reports are being considered.
- Deputy Director of Nursing
- Associate Directors of Nursing

The Trust Secretary shall be the secretary of the Committee.

NB other staff will attend for the relevant specific agenda item only

4 QUORUM

4.1 A quorum should be not less than two Non-Executive Directors, one of which will chair the meeting and two Executive Directors.

5 FREQUENCY OF MEETINGS

The Committee will meet monthly, usually from 14:00 – 17.00 on the 1st Thursday of the month.

6 RELATIONSHIP WITH THE BOARD AND OTHER COMMITTEES

In the course of fulfilling its duties if the Committee becomes aware of any risk which could impact on the Trust's ability to deliver its Strategic Goals it shall seek assurances from the appropriate Director whether the risk is being managed effectively.

On considering the Director's report it shall:

- Assure itself that appropriate controls are in place to manage that risk or specify the controls it considers should be established to mitigate the risk.
- Report to the Audit Committee if the risk raises concerns regarding the effectiveness of the Trust's governance arrangements; risk management and assurance arrangements; or system of internal control.
- Make a recommendation to the Board that the risk be included in the Board's Chapter of the Integrated Assurance framework and Risk Register if it believes the risk could have significant impact on the sustainability/viability of the Trust or its ability to deliver the Strategic Direction.

7 DELEGATED AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee has delegated authority, subject to consultation with the Audit Committee, to approve an annual programme of clinical audit.

8 REVIEW

The Committee will be reviewed at least annually – within 12 months following approval by the Board of Directors or earlier if required by national guidance or legislation.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **29th September 2015**

Title: **Board Business Cycle**

Lead: **Phil Bellas, Trust Secretary**

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 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: **29th September 2015**

Title: **Board Business Cycle**

1. INTRODUCTION & PURPOSE

1.1 To enable the Board to consider its meeting arrangements and business cycle for the period October 2015 to December 2016.

2. BACKGROUND INFORMATION

2.1 The Business Cycle sets out the matters to be considered by the Board at its formal meetings and seminars.

2.2 It takes into account:

- The recommendations of "The Intelligent Board".
- The recommendations arising from the governance reviews undertaken by Deloitte LLP in 2014/15.
- The need for the provision of timely assurance to the Board to support achievement of the Trust's strategic goals and regulatory compliance.
- The delivery of key corporate processes.
- The reporting requirements of the Board's committees as set out in their terms of reference.

2.3 The Board's present meeting arrangements are based on the following approach:

- All formal meetings being held in public as required by the Health and Social Care Act 2012.
- Formal Board meetings being held usually on the last Tuesday of each month (except in July, August and December).
- The Board meeting in July being held on the Thursday of the penultimate week of the month. to enable Board members greater flexibility in taking holidays during the summer period.
- Special Board meetings being held in conjunction with Board seminars on the third Tuesdays of August and December.
- All formal meetings being held at West Park Hospital, Darlington except for the end of Quarter meetings which are held in one of the Trust's geographic Localities.
- 10 private Board seminars being held each year. These are usually held on the second Tuesday of each month apart from October (the annual Board Business Planning event) and August and December (where they are held in conjunction with the Special Board meetings).

2.4 The Business Cycle is only indicative and the matters to be included on the agenda for each Board meeting are agreed by the Chairman.

3. KEY ISSUES:

Formal Board Meetings:

3.1 The proposed arrangements for formal Board meetings for the period October 2015 to December 2016 are set out in Annex 1 to this report.

3.2 The Board is asked to note the following proposed changes to the Board's usual meeting arrangements during the period:

(a) To hold a meeting on 22nd March 2016 (rather than 29th March) to support the preparation of the business plan and to avoid school holidays.

(b) To hold a meeting on 21st June 2016 (rather than 28th June) at the request of the Chairman.

(c) The inclusion of a provisional Board meeting to held on 24th May 2016.

The reason for this is that the usual meeting date falls on the last day of the month and difficulties could arise if any statutory submissions are required on that date.

Board members are asked to hold this date in their diaries pending confirmation of the arrangements for the meeting following the publication of Monitor's Annual Reporting Manual 2016 later in the year.

(d) The proposal to reduce the number of Board meetings held in the North Yorkshire Locality to enable a meeting to be held in the York and Selby Locality.

Board Members will be aware that, in previous years, the Trust has held two meetings the North Yorkshire Locality: an April meeting in Harrogate and an October meeting in Scarborough.

It is now proposed that the Board should meet only once each year in the North Yorkshire Locality (in April) and that the venue for this meeting should alternate between the two towns.

This approach will enable the October meeting to be held in York.

3.3 Board Members will note that the usual date of the Board meeting to be held in December 2016 falls on the 20th of the month.

The Board is asked to confirm that this is acceptable, in view of its proximity to Christmas, or to agree a different date for the meeting.

Board Seminars

3.4 Annex 2 to this report sets out the proposed dates for Board Seminars and includes the usual items considered by the Board on an annual basis.

3.5 Board Members are asked to:

(a) Note that the following topics have also been proposed for inclusion in the programme:

- The Trust's position against Monitor's Quality Governance Framework
- Mental health payment mechanisms (to be reviewed after Christmas 2015)
- Service analyses and NHS benchmarking
- Purposeful and productive community teams

(b) Suggest any further topics they would like to be discussed at Board Seminars during the period.

3.6 The Board is asked to note that the final annual programme for Board Seminars will be agreed by the Chairman and Chief Executive.

4.0. IMPLICATIONS / RISKS:

4.1 **Quality:** No risks have been identified.

4.2 **Financial:** No risks have been identified.

4.3 **Legal and Constitutional:** No risks have been identified.

4.4 **Equality and Diversity:** No risks have been identified.

4.5 **Other Risks:** No risks have been identified.

5. CONCLUSIONS

5.1 The report supports compliance with the Integrated Governance Framework.

6. RECOMMENDATIONS

6.1 The Board is asked to:

(a) Approve arrangements for formal Board meetings to be held during the period October 2015 to December 2016 (as set out in Annex 1 to this report) including confirming the date for the Board meeting in December 2016.

(b) Approve the draft programme of Board Seminars as set out in Annex 2 to this report.

(c) Suggest any further topics for discussions at Board Seminars during the period.

(d) Note that the final programme of Board Seminars will be agreed by the Chairman and Chief Executive.

Phil Bellas,
Trust Secretary

Tees, Esk and Wear Valleys NHS Foundation Trust

Schedule of Board Business (Oct 2015 - December 2016)

			2015			2016											
	Meeting Date	**Lead**	**27.10**	**24.11**	**15.12 Special**	**26-Jan**	**23-Feb**	**22-Mar**	**26-Apr**	**31 May (24 May Provisional)**	**21-Jun**	**21-Jul**	**16-Aug Special**	**27-Sep**	**25-Oct**	**29-Nov**	**20-Dec Special**
	Venue		**Scarborough**	**WP**	**WP**	**Durham**	**WP**	**WP**	**Harrogate**	**WP**	**WP**	**Middlesbrough**	**WP**	**WP**	**York**	**WP**	**WP**
1	**Standard Items**																
	Apologies for Absence		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Minutes		√	√		√	√	√	√	√	√	√		√	√	√	
	Board Action Logs (Public and Confidential)	PB	√	√		√	√	√	√	√	√	√		√	√	√	
	Declarations of Interest		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Chairman's Report	Chair	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Chief Executive's Report	MB	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Governor Issues	Board	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Reportable Issues Log	MB	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2	**Quality**																
	Locality Briefings	DoOps		**NY**		**CD&D**		**Forensic**				**Tees**			**Y&S**	**NY**	
	Quality Assurance Committee Report	MH/EM	√	√	√		√	√	√	√	√	√		√	√	√	√
	Francis 2 Action Plan Progress Report	MB				√						√					
	"Hard Truths" Nurse Staffing Report	EM	√	√	√	6 monthly	√	√	√	√	√	6 monthly	√	√	√	√	√
	MHLC Report	RS/EM		√			√			√				√		√	
	Governance Action Plans	MB	√			√			√			√			√		
	Progress Report on the "Out of Locality" Admissions Action Plan	BK	√								√						
	Progress reports on service support plans	SP			√			√			√			√			√
	Progress Report on the Waiting Times Action Plan	BK		√						√							
	Updates on Clinical Supervision & CRHM workstreams	EM	√			√			√			√			√		
	Briefing of C&YP Services	BK	√														
	Update on the Smoking Cessation Project	NL				√											
3	**Strategic**																
	Budget/Capital Programme	CM						√									
	Business/Monitor Plan	SP	√				√	√							√		
	Generating Income from the TEWV QIS	BK								√							
	Integrated Governance Framework	PB			√												√
	Report on Culture Metrics	DL		√					√							√	
	Local pay and conditions of service for senior staff	DL			√												
	Staffing Recruitment/Retention at Springwood	DL	√														
	Introduction of a MARS scheme	DL		√													
	"Freedom to speak up" review	DL						√									
4	**Services Developments/Investments**																
	Tender submission approvals (as and when required)	MB															
	Business Cases (as and when required)	CM															
5	**Performance**																
	Performance Dashboard (Reports poss. to be tabled in August and December)	SP	√	√		√	√	√	√	√	√	√		√	√	√	
	Workforce Reports (inc six monthly updates from the E&D Steering Group)	DL	√			√			√			√			√		
	Finance Report	CM	√ (x2)	√		√ (x2)	√	√	√ (x2)	√	√	√ (x2)		√	√ (x2)	√	
	Strategic Direction Performance Report	SP		√			√			√				√		√	
	Staff Survey	DL	6 month update				Results			Action Plan							
	Structured Board Visits Annual Progress Report	BK									√						
6	**Governance**																
	Register of Directors' Interests	PB												√			
	Board Business Cycle	PB												√			
	Annual Review of Board Committee's terms of reference	PB												√			
	Monitor Governance Certificates	PB								√							
	Annual Accounts	CM								√							
	Annual Governance Statement	CM								√							
	Annual Report	PB								√							
	Quality Account/Report	SP								√							
	External Auditors' Report to those charged with Governance (ISA 260)	CM								√							

Tees, Esk and Wear Valleys NHS Foundation Trust

Schedule of Board Business (Oct 2015 - December 2016)

			2015			2016											
	Meeting Date	**Lead**	**27.10**	**24.11**	**15.12 Special**	**26-Jan**	**23-Feb**	**22-Mar**	**26-Apr**	**31 May (24 May Provisional)**	**21-Jun**	**21-Jul**	**16-Aug Special**	**27-Sep**	**25-Oct**	**29-Nov**	**20-Dec Special**
	External Auditors' Report on the Quality Report	CM								√							
	Charitable Funds Annual Report and Accounts	CM								√							
	Integrated Assurance Framework and Risk Register	PB	Summary	Summary	Full	Summary	Summary	Summary	Summary	Summary	Review	Full		Summary	Summary	Summary	Full
	Quarterly Monitor Risk Assessment Framework Report	PB	√			√			√			√			√		
	Information Strategy and Governance Report (ink the IG Toolkit submission)	CM		√				√ (inc toolkit)		√				√		√	
	Annual Report on Research and Development	NL		√												√	
	Annual Report of the Responsible Officer for Medical Revalidation	NL												√			
	Medical Education Annual Report	NL	√												√		
	Annual Claims Report	EM									√						
	Audit Committee Report	MH	√			√			√	Verbal					√		
	Investment Committee Report (additional reports dependent on provisional meetings)	JT/CM			Verbal	√		√			√			√		√	
	Commercial Oversight Committee (to be determined)	Chair		√													
	Board Nomination and Remuneration Committee Report (as and when required)	Chair															
	Equality Act Data Publication	DL				√											
7	**For Information**																
	Register of Seals (as and when required)	MB	√	√		√	√	√	√	√	√	√		√	√	√	
	Policies agreed by EMT	MB	√	√		√	√	√	√	√	√	√		√	√	√	

Draft Board Seminar Programme

Annex 2

October 2015 - December 2016

Month	Topic	Lead
6.10.15 - 7.10.15	Business Planning Event	MB/SP/CM
10.11.15	Board Development Workshop (see Governance Action Plan)	Herman Gilligan
15.12.2015 (with Board Meeting)	Briefing on Equality and Diversity	DL
	Briefing from the LD Speciality Development Group	Dr. Passmore
	Key factors influencing trends on unexpected deaths	MB
12.01.2016	Business Planning Event	MB/CM/SP
08.03.2016	To be determined	
12.04.2016	SDG Briefing	TBD
	Briefing on the "Working Longer" review	DL
10.05.2016	SDG Briefing	TBD
	BPES Results	PB
12.07.2016	SDG Briefing	TBD
16.08.2016 with BoD meeting	To be determined	
13.09.2016	SDG Briefing	TBD
4 & 5.10.2016	Business Planning Event	MB/CM/SP
08.11.2016	To be determined	
20.12.2016 with BoD meeting	To be determined	

ITEM 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **29th September 2015**

Title: **Report on the Register of Sealing**

Lead: **Phil Bellas, Trust Secretary**

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: **29th September 2015**

Title: **Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to inform the Board of Directors of the use of the Trust's Seal in accordance with Standing Orders.

2. BACKGROUND INFORMATION

2.1 An entry of every sealing is made and numbered consecutively in a Register specifically provided for the purpose. It is signed by the persons who have approved and authorised the document and those who attested the seal.

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
250	15/7/15	Deed of surrender relating to premises knows as part of Easington Medical Centre, School Street, Easington	Mr. B. Kilmurray, Chief Operating Officer Mrs. C. Stanbury, Director of Nursing and Governance
251	15/7/15	Contract documents for West Lane Hospital Phase 3 (incorporating Phases 4 and 5)	Mr. B. Kilmurray, Chief Operating Officer Mrs. C. Stanbury, Director of Nursing and Governance
252	8/9/15	Contract documents relating to The Rowan Building, Darlington	Mr. B. Kilmurray, Chief Operating Officer Mr. C. Martin Director of Finance and Deputy Chief Executive
253	14/9/15	TR1 Form relating to Abdale House, 49-51 Trewit Well Road, Harrogate	Mrs. E. Moody, Director of Nursing and Governance Mr. C. Martin Director of Finance and Deputy Chief Executive

4. IMPLICATIONS / RISKS:

4.1 **Quality:** None identified.

4.2 **Financial:** None identified.

4.3 **Legal and Constitutional:** The report supports compliance with Standing Orders.

4.4 **Equality and Diversity:** None identified.

4.5 **Other Risks:** None identified.

5. CONCLUSIONS

5.1 This report supports compliance with Standing Orders.

6. RECOMMENDATIONS

6.1 The Board is asked to receive and note this report.

Phil Bellas,
Trust Secretary

Background Papers:

The Standing Orders of the Board of Directors (Annex 8 to the Constitution).
Seals Register.

ITEM 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **29th September 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: **29th September 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 new policy required ratification:

CLIN-0084-v1 Physical Healthcare (inpatients) policy

Following the comments from EMT on 5 August 2015, the section on community patients has been removed and the policy focusses solely on inpatients.

However community patients cannot be dismissed, as their ongoing physical health monitoring is essential, particularly SMI/Psychosis patients. Therefore, the Physical Health Project Team will develop guidance around community patients to be included within the Physical Healthcare Policy at a later date.

3.2 The following had undergone significant review and required ratification

CLIN-0001-v4 Consent to examination and treatment policy

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 2 September 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