

**AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS  
TUESDAY 24<sup>TH</sup> SEPTEMBER 2019  
VENUE: THE BOARDROOM, WEST PARK HOSPITAL,  
DARLINGTON  
AT 9.30 A.M.**

Apologies for Absence

Standard Items (9.30 am)

<b>Item 1</b>	To approve the public minutes of the last ordinary meeting held on <b>18<sup>th</sup> July 2019</b> .		<b>Attached</b>
<b>Item 2</b>	Matters Arising.		-
<b>Item 3</b>	Public Board Action Log.		<b>Attached</b>
<b>Item 4</b>	Declarations of Interest.		-
<b>Item 5</b>	Chairman's Report.	<b>Chairman</b>	<b>Verbal</b>
<b>Item 6</b>	Chief Executive's Report.	<b>CM</b>	<b>Attached</b>
<b>Item 7</b>	To consider any issues raised by Governors.	<b>Board</b>	<b>Verbal</b>

Quality Items (9.50 am)

<b>Item 8</b>	To consider the report of the Quality Assurance Committee.	<b>HG/EM</b>	<b>Attached</b>
<b>Item 9</b>	To consider the monthly Nurse Staffing Report.	<b>EM</b>	<b>Attached</b>
<b>Item 10</b>	To receive and note the Annual Report on Patient Safety.	<b>EM</b>	<b>Attached</b>
<b>Item 11</b>	To consider a report on waiting times.	<b>RH</b>	<b>Attached</b>
<b>Item 12</b>	To receive and note the Annual Report on Directors' visits.	<b>RH</b>	<b>Attached</b>
<b>Item 13</b>	To consider the report of the Mental Health Legislation Committee.	<b>EM</b>	<b>Attached</b>

Strategic Items (11.00 am)

- |                |   |           |                 |
|----------------|---|-----------|-----------------|
| <b>Item 14</b> | To approve the draft Memorandum of Understanding for the North East and North Cumbria Integrated Care System. | <b>CM</b> | <b>Attached</b> |
|----------------|---|-----------|-----------------|

Performance (11.10 am)

- |                |   |                   |                 |
|----------------|---|-------------------|-----------------|
| <b>Item 15</b> | To consider the Trust Performance Dashboard as at 31 <sup>st</sup> August 2019. | Sarah<br>Theobald | <b>Attached</b> |
| <b>Item 16</b> | To consider the Strategic Direction Performance Report for Quarter 1, 2019/20.  | Sarah<br>Theobald | <b>Attached</b> |

Governance (11.25 am)

- |                |   |                 |                 |
|----------------|---|-----------------|-----------------|
| <b>Item 17</b> | To approve changes to the Board's Committee arrangements.                         | <b>Chairman</b> | <b>Attached</b> |
| <b>Item 18</b> | To appoint Non-Executive Director chairmen and members of the Board's Committees. | <b>Chairman</b> | <b>Attached</b> |
| <b>Item 19</b> | To approve the indicative Board Business Cycle for 2020.                          | <b>PB</b>       | <b>Attached</b> |
| <b>Item 20</b> | To receive and note the Register of Interests of the Board of Directors.          | <b>PB</b>       | <b>Attached</b> |

Items for Information (11.45 am)

- |                |  |           |                 |
|----------------|--|-----------|-----------------|
| <b>Item 21</b> | Policies and Procedures ratified by the Executive Management Team.   | <b>CM</b> | <b>Attached</b> |
| <b>Item 22</b> | To note that the next meeting of the Board of Directors will be held on <b>Tuesday 29<sup>th</sup> October 2019</b> in the Hilton York, 1 Tower Street , York, YO1 9WD at 9.30 am. |           |                 |

Confidential Motion (11.50 am)

**Item 23 The Chairman to move:**

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

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

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

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

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

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

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

***The meeting will adjourn for a refreshment break***

**Miriam Harte**  
**Chairman**  
**18<sup>th</sup> September 2019**

**Contact:** Phil Bellas, Trust Secretary Tel: 01325 552312/Email: [p.bellas@nhs.net](mailto:p.bellas@nhs.net)

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**MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 18<sup>TH</sup> JULY 2019 AT MIDDLESBROUGH FOOTBALL CLUB, RIVERSIDE STADIUM, MIDDLESBROUGH, COMMENCING AT 9.30 AM**

**Present:**

Ms. M. Harte, Chairman  
Mrs. E. Moody, Director of Nursing and Governance and Deputy Chief Executive  
Dr. H. Griffiths, Deputy Chairman  
Mr. M. Hawthorn, Senior Independent Director  
Mr. P. Murphy, Non-Executive Director  
Mrs. S. Richardson, Non-Executive Director  
Mr. R. Simpson, Non-Executive Director  
Mrs. R. Hill, Chief Operating Officer  
Mr. P. McGahon, Director of Finance and Information  
Mr. D. Levy, Director of HR and Organisational Development (non-voting)  
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

**In Attendance:**

Mr. M. Eltringham, Public Governor for Stockton-on-Tees  
Mr. A. Williams, Public Governor for Redcar and Cleveland  
Mr. M. Williams, Public Governor for Durham  
Mrs. L. Robertson, Care Group Director (Responsive Care), North Tees and Hartlepool NHS Foundation Trust (observing the meeting as part of the Nye Bevan Leadership Programme)  
Mr. P. Bellas, Trust Secretary  
Mrs. S. Paxton, Head of Communications  
Mr. D. Gardner, Director of Operations for Teesside (minute 19/183 refers)  
Dr. J. Whaley, Guardian of Safe Working (minute 19/184 refers)

**19/176 APOLOGIES**

Apologies for absence were received from Mr. C. Martin (Chief Executive), Mr. D. Jennings (Non-Executive Director) and Dr. A. Khouja (Medical Director).

**19/177 MINUTES**

*Agreed – that the minutes of the last meeting held on 25<sup>th</sup> June 2019 be approved as a correct record and signed by the Chairman.*

**19/178 PUBLIC BOARD ACTION LOG**

The Board received and noted the Public Board Action Log.

Arising from the report:

- (1) Further to minute 19/129 (21/5/19) Mrs. Moody confirmed that each instance of use of tear resistant clothing was recorded.

It was noted that:

- (a) Tear resistant clothing was only used infrequently.

- (b) A procedure had been prepared which would provide clarity on the recording of its use.
- (2) At the request of Mrs. Hill, it was agreed to defer the action under minute 19/103 (30/4/19), to include the shortage of SOADS, and its impact on operational services, in the corporate risk register, until September 2019.
- (3) Further to minute 19/160 (25/6/19) Mrs. Moody reported that a number of staff at Westerdale South had been placed on alternative (non-clinical) duties following an incident.

#### **19/179 DECLARATIONS OF INTEREST**

There were no declarations of interest.

#### **19/180 CHAIRMAN'S REPORT**

The Chairman:

- (1) Expressed her gratitude to all staff involved in:
  - (a) Arranging the Annual General Meeting held on 17<sup>th</sup> July 2019 and particularly to Mrs. Moody for her support during the event.  
  
It was noted that the event had been successful and had provided a great opportunity for people to meet staff and to find out more about services.
  - (b) Addressing the challenges at West Lane Hospital for their work.
- (2) Reported that the Council of Governors had approved:
  - (a) The appointment of two new Non-Executive Directors.
  - (b) The re-appointment of Mrs. Richardson and Mr. Murphy for their second terms of office.
  - (c) The re-appointment of Mr. Hawthorn, for a short period, to support her during her early period in office and to mitigate potential risks arising from significant changes in the Non-Executive membership of the Board during 2019/20.
- (3) Noting that this was his last Board meeting, thanked Mr. Simpson for his tremendous work for the Trust particularly on the development of the Mental Health Legislation Committee.

The Chairman's sentiments were echoed by Board Members.

- (4) Reported that the next regional meeting of Trust Chairmen was due to be held on 26<sup>th</sup> July 2019.

It was noted that further discussions on the ongoing development of the ICS were due to be held at the meeting.

#### **19/181 CHIEF EXECUTIVE'S REPORT**

The Board received and noted the Chief Executive's Report.

Mrs. Moody highlighted the following matters:

- (1) The review of capital spending plans for 2019/20, by each ICS in England, to ensure that the national Capital Delegated Expenditure Limit could be delivered.

It was noted that the ICS had agreed the Trust's proposed reduction of 9%. This was based on slippage on parts of the capital programme and would not impact on the development of Foss Park or the rectification of defects at Roseberry Park.

- (2) The publication of the "NHS Patient Safety Strategy: Safer Culture, Safer Systems, Safer Patients" in July 2019.

Mrs. Moody advised that the implications of the strategy would be reviewed by the Patient Safety Group.

- (3) The Trust being recognised by the National Freedom to Speak Up Guardian for having recorded the equal highest score for combined mental health and learning disability trusts on the relevant results of the most recent staff survey; a proxy measure for the Freedom to Speak Up culture in trusts.

It was noted that the Trust had been asked to support the roll out of the index; to provide details of the actions it was taking; and for its views on how other trusts could be supported to develop their own Freedom to Speak Up cultures.

- (4) The publication of the implementation framework for the NHS Long Term Plan by NHS England and NHS Improvement.

## **19/182 GOVERNOR ISSUES**

It was noted that the last meeting of the Council of Governors had been held during the previous week and there were no issues, raised by Governors, to be brought to the Board's attention.

## **19/183 LOCALITY BRIEFING – TEES**

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

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

The following matters were raised in the discussions:

- (1) The inclusion of Tier 4 CAMHS in the New Care Model (NCM) for C&YPS and whether this had led to a reduction in funding for services at West Lane Hospital.

It was noted that the Trust, through the NCM programme, had been able to reduce bed usage by other providers and to release funding to develop services. An example of this was the establishment of the children's crisis services in North Yorkshire and York which would further contribute to reducing inpatient admissions.

Assurance was provided that, as a result of the programme, funding to services at West Lane Hospital had increased and had been used to provide additional staffing.

- (2) Further to discussions at the Board Seminar held on 12<sup>th</sup> March 2019, whether benchmarking of restrictive interventions would now be possible through the RRP Collaborative.

It was noted that:

- (a) Applications to join the RRP Collaborative had been oversubscribed.
- (b) Whilst the Trust had put forward its CAMHS inpatient services, a range of types of ward had been nominated by other providers.
- (c) The new national definition of restrictive interventions (minute 19/129 - 21/5/19 refers) should support benchmarking in the future but it was not practicable at present.

- (3) The support, both initially and continuing, provided to newly qualified nurses given the very high proportion of them in the Locality.

Mr. Gardner explained that:

- (a) Nursing Development Groups had been established to offer support to newly qualified nurses.
- (b) The introduction of duty nurse co-ordinators had been beneficial as support could be sought on live issues on wards from these senior nurses.
- (c) The impact of coaching was also having an impact with leaders now more likely to step back and support staff rather than stepping in to deal with issues themselves.

In addition it was noted that:

- (a) The Heads of Nursing had developed a competency based preceptorship package, including an action plan, to support newly qualified nurses.
- (b) The provision of support was keeping pace with recruitment and good feedback was being received.
- (c) As retirement was the most common reason for staff leaving the Trust, the focus on retire and return needed to be continued in order to maintain the balance of experienced and newly qualified nurses.

- (4) The experience, in the Locality, of introducing peer support workers and the potential to expand these roles.

Mr. Gardner advised that:

- (a) The Locality had taken a careful approach to the introduction of peer support workers for the benefit of both parties.
- (b) Significant work had been undertaken to ensure services understood their role and were ready to receive them.
- (c) Since their introduction, the experience of the peer support workers had been positive.
- (d) Support for them was provided through regular meetings with the Senior Peer Support Worker.

- (e) The further roll out of the roles was planned for the coming months, for example, opportunities had been identified in recovery services and CRHTs.
- (5) The importance of ensuring the engagement of junior doctors in the preparation of the rectification plans for Roseberry Park as changes, for example the proposal to move AMH inpatient services to Sandwell Park, might impact on the rotas and there was a time lag before they could be changed.

Assurance was provided that all specialties were involved in the planning of the rectification works, including the planned transition to Sandwell Park, through the locality project group.

The Chairman thanked Mr. Gardner for his presentation.

### **19/184 REPORT OF THE GUARDIAN OF SAFE WORKING**

The Board received and noted the Report of the Guardian of Safe Working (GoSW).

In his report Dr. Whaley concluded that “The organisation continues to fulfil requirements of the new 2016 Junior Doctor Contract and junior doctors are appropriately submitting exception reports which are being handled appropriately. I am satisfied that processes are in place to identify and rectify issues of safety.”

The report also included, as Appendix 3, the views of junior doctors on the Guardian’s performance. The Board considered that the positive feedback was of personal credit to Dr. Whaley.

The following matters were raised:

- (1) The request that consideration should be given to providing laptops to Trust doctors in order for them to be able to complete on-call tasks remotely where appropriate.

Dr. Whaley provided clarity that all junior doctors in training had a laptop but Trust doctors, who worked with them on the rota, did not.

Mr. McGahon undertook to look into this matter.

**Action: Mr. McGahon**

- (2) The feedback from junior doctors that approximately 49% of them did not see or have access to the reports produced for the Board by the GoSW.

The Board noted that junior doctors were now sent copies of the reports; however, it was hoped to further improve access by publishing them on the Trust’s intranet site.

- (3) Further to minute 18/310 (27/11/18) the progress being made on the development of the “hospital at night” system and whether it could be extended to cover all working hours.



The Board noted that:

- (a) It was hoped to trial the system during August 2019.
  - (b) A training package had been developed to support its introduction.
  - (c) Discussions were being held on the transition to the new system as there were risks to its implementation if existing arrangements were retained for a lengthy period.
  - (d) Initially the system would be used out of hours but there were no reasons why the timeframe could not be extended in due course.
- (4) Further to discussions under minute 19/98 (30/4/19) whether a process was in place to assess and manage environmental improvements in line with the fatigue and facilities charter.

Dr. Whaley advised that:

- (a) There were significant concerns about compliance with the fatigue and facilities charter in each rota area; however, these varied in terms of the feasibility of addressing them.
  - (b) He was due to meet with the Director of Estates and Facilities to discuss the use of the funding, received by all trusts, to improve working conditions.
  - (c) Discussions were also being undertaken to ensure the requirements of the charter were reflected in new builds.
- (5) Whether the concerns that lone working procedures were rarely followed were being followed up.

Dr. Whaley considered that a systematic solution was required for all staff, which was responsive to changes to team working, rather than piecemeal approaches.

In response to a question, it was noted that, unlike some other trusts, the Trust did not use lone working devices.

The Chairman considered that the Board should hold further in-depth discussions on the above matters.

**Action: Mr. Martin**

At the conclusion of the discussions, the Chairman:

- (1) Highlighted the importance of encouraging junior doctors, as the workforce of the future, to remain with the Trust.
- (2) Thanked Dr. Whaley for his report.

## **19/185 NURSE STAFFING REPORT**

The Board received and noted the six monthly review report, for the period 1<sup>st</sup> December 2018 to 31<sup>st</sup> May 2019, in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire NHS Foundation Trust ("Francis Review") and in line with National Quality Board (NQB) guidance.

The discussions focused on the following matters:

- (1) The level of confidence that the different approaches being taken to training healthcare professionals would support the Trust meet its workforce needs in the future.

Mrs. Moody explained that:

- (a) For nurses, the work with the universities would not provide a quick remedy to the staffing challenges being faced by the Trust as there would be a two to three year gap before students became qualified including nursing associates seeking full qualification.
- (b) Whilst, in due course, the number of nurses would increase, a gap had been identified in regard to post graduate training for experienced nurses.
- (c) The Trust was less well sighted on the training of AHPs; however:
  - A local course for dieticians had now been established.
  - Work was being undertaken on supporting the training of psychologists and social workers with funding being recently approved by the EMT for a new role in the latter case.
  - Whilst there were no concerns, at present, about the provision of Occupational Therapists (OTs), discussions were being held on how they could be used in the organisation in the future.

It was noted that a review to support this was being undertaken in forensic services.

- (2) The position on nursing associates.

It was noted that:

- (a) Both registered and non-registered nursing associates were now included in the Model Hospital and the care hours per patient day (CHPPD) metric; however, this was a manual process.
- (b) There were few of these staff at present.

- (3) Whether the Mental Health Optimal Staffing (MHOST) tool included OTs.

It was noted that:

- (a) OTs would be counted in the CHPPD metric if they were included on the roster; however, as previously discussed, these staff tended to work across wards so the metric did not provide an accurate reflection of the national picture at present.
- (b) The work of the OTs would be covered by the MHOST tool, irrespective of whether or not they were included on the roster, as it focused on the activity provided to a patient.

- (4) The extent to which the piloting of zonal care was being reflected in the establishment reviews.

Mrs. Moody advised that:

- (a) A cautious approach was being taken to the introduction of zonal care due to the significant changes and investment which would be required and as its impact was not fully understood.
  - (b) It had been planned, originally, to pilot zonal care in Westerdale South and Acomb Garth; however, it had not been considered appropriate to proceed with the pilot in the latter case due to the ward's move to Foss Park and its merger with Meadowfields.
  - (c) The zonal care pilot was now, therefore, only taking place on one ward.
- (5) The Trust's position on enhanced observations and rostering.

The Chairman considered that, if the level of enhanced observations was consistently above that provided for in the staffing roster, it suggested that the ward establishment needed to be changed to reflect the actual position.

Mrs. Moody explained that:

- (a) A staffing requirement to provide enhanced observations to one patient was built into the rosters.
- (b) If there was a need for the enhanced observation of more than one patient, additional staffing resources were made available, for example through the use of bank and agency staff.
- (c) It was recognised that ward establishments might need to be increased if staffing requirements were consistently above those provided in the rosters, for example, in March 2018, the Board had agreed to increase the establishments of adult wards in the County Durham and Darlington Locality (minute 18/73 – 27/3/18 refers).

In addition, in response to questions on this matter, it was noted that:

- (a) Enhanced observations were included in the MHOST tool as part of a range of indicators to monitor the "temperature" on wards.
- (b) The Trust's stance was that there were no financial barriers to the provision of additional staff; however, the preference was to employ them substantively as this delivered higher levels of quality and consistency of care.
- (c) Significant work had been undertaken on improving rostering and the EMT had recently agreed to fund the fixed term appointment of a senior nurse to further support this going forward.

At the conclusion of the debate, the Chairman considered that it would be beneficial for further discussions to be held on AHPs and their potential future role in delivering care.

Mrs. Moody undertook to include information on this matter in a future nurse staffing report or in the update on the Right Staffing Programme to a Board Seminar.

**Action: Mrs. Moody**

## **19/186 REPORT OF THE QUALITY ASSURANCE COMMITTEE**

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

- (1) The confirmed minutes of its meeting held on 6<sup>th</sup> June 2019 (Annex 1 to the report).
- (2) The key issues considered by the Committee at its meeting held on 4<sup>th</sup> July 2019.

Dr. Griffiths, the Chairman of the Committee, drew attention to the following matters:

- (1) The intention to hold a special meeting of the Committee, in late August 2019, to further discuss the issues at West Lane Hospital.
- (2) The review of the first iteration of the positive and safe dashboard; a weekly snapshot providing information on a number of key indicators relating to the use of restrictive interventions.

Dr. Griffiths:

- (a) Welcomed the use of SPC charts, in the dashboard, which provided greater focus on areas for attention.
- (b) Advised that the Committee had requested that the locality versions of the dashboard should be included in the LMGB reports to the QuAC from September 2019.

Echoing the above comments, Mrs. Moody explained that:

- (a) The dashboards were available at ward and team level enabling managers and clinicians to investigate issues in their services.
- (b) As the data was drawn from the Datix system, the charts could mirror any information held in that system.
- (c) Feedback received was that the dashboard was visual, easy to work with and appreciated by teams.

## **19/187 WORKFORCE RACE EQUALITY STANDARD AND WORKFORCE DISABILITY EQUALITY STANDARD 2019 SUBMISSIONS AND ASSOCIATED ACTION PLANS**

Further to discussions at the meeting of the Resources Committee held on 15<sup>th</sup> July 2019, consideration was given to a report on the Trust's latest information sets and associated action plans for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

Mr. Hawthorn, the Chairman of the Resources Committee, reported that the Committee's discussions had focussed on:

- (1) The importance of focussing on fewer actions and those which provided the greatest impact.
- (2) The significant time lag between actions being taken and their effect being apparent.
- (3) Data quality and the importance of benchmarking.

The Non-Executive Directors, taking into account discussions under minute 19/139 (21/5/19), considered that the Trust should continue to focus on the key indicator on the relative likelihood of staff being appointed from shortlisting across all posts.

In response to questions, Mr. Levy advised that:

- (1) As previously discussed, candidates who had been shortlisted but who withdrew before interview were now excluded from the data.
- (2) The data included medical staff but they only represented a small proportion of the appointments made by the Trust.
- (3) There was no quick solution to addressing the issues relating to why candidates from BAME backgrounds were more likely to withdraw from the recruitment process, and less likely to be appointed, but the Trust would need to examine its recruitment policy and practices together with associated training.

**Agreed -**

- (1) *that the completion of the 2017/18 WRES action plan, apart from action 4 for indicator 1 which was due for completion in September 2019, be noted; and*
- (2) *that the 2018/19 WRES and WDES action plans be endorsed.*

**Action: Mr. Levy**

## **19/188 COMMUNITY SAFE STAFFING DASHBOARD**

Further to minute 18/311 (28/11/18), the Board received and noted a report which presented a set of metrics to be considered in the development of a community safe staffing dashboard which would serve as an early warning score or “team temperature” gauge, thus supporting managers with monitoring and oversight of community teams and enabling timely and proactive interventions and support.

Board Members considered that the dashboard would be beneficial but recognised that it was, at present, at an early stage of development.

The Board discussed:

- (1) The potential burden of data collection which was recognised in the report.

The following matters were raised:

- (a) The need to ensure that teams were engaged in the development of the approach in order for the data collection to be seen by them as worthwhile.
- (b) Whether any data collection could be ceased in order to lessen the impact of that arising from the introduction of the dashboard.
- (c) Whether weighting could be applied to the proposed data elements as they varied in terms of the burden of collection.

Mrs. Moody considered that this could be piloted.

- (2) The alignment between the approach and the intensive team support programme.
- (3) How the purpose of the approach would be communicated and understood as the dashboard, which focussed on identifying how to support teams, was different to others which focussed on performance.

Mrs. Moody advised that the key message was that the dashboard drew together a number of issues to support triangulation and review by teams.

- (4) The variation in the caseloads of community teams and whether cases were allocated to care co-ordinators weighted by complexity.

Mrs. Hill advised that a caseload tool had been developed under the PPCS programme but its use had been subject to variation and modification. Whilst still used by teams, the consistency of its application would need to be reviewed.

- (5) How concerns about teams would be drawn out from the six themes, for example, through the use of an algorithm.

Mrs. Moody explained that it was not proposed to score the themes but to consider trends as the purpose of the dashboard was to gauge and understand the “temperature” in teams and the potential impact on quality.

- (6) Whether the dashboard, when completed, would be reported to the Board.

It was noted that there was the potential for reporting the information contained in the dashboard, by exception, and for including any concerns identified in the nurse staffing reports.

The Non-Executive Directors considered that, as an early warning system, the collation of information was, principally, for the benefit of the teams, rather than the Board, and the focus of the pilot should be to test out whether it provided the information they required.

## **19/189 TRIANGLE OF CARE STAGE 2 SUBMISSION**

Consideration was given to a report which provided assurance that the aims and objectives of the Triangle of Care (ToC) stage 2 had been met prior to submission of a report to the Carers Trust.

The Board welcomed the report and the excellent results from the self-assessment.

The Non-Executive Directors raised the following matters:

- (1) The potential contradiction between staff being encouraged to be honest when RAG rating their service, as part of the self-assessment, and the expectation that action plans would be put in place and monitored where teams scored ‘amber’ or ‘red’ which appeared to represent performance management.

Mrs. Moody explained that where services identified issues (i.e. those areas not rated ‘green’) the approach should not be seen as performance management and, if these related to the concerns of carers, the Trust would want to ensure they were examined and respond to.

- (2) The importance of:
- (a) Sharing the results with carer organisations to counter any misunderstandings and to give them confidence to seek support.
  - (b) Involving carers as they provided a very well informed resource.

- (c) Considering how to hold conversations with families, as promoted by the Meriden Programme at the AGM,

Mrs. Moody advised that a working group had been established to take forward issues raised at the Carers Conference and to link with the Triangle of Care.

***Agreed** – that the submission of the community team self-assessments and report to the Carers Trust, and the continuation of the Triangle of Care across services, be approved.*

**Action: Mrs. Moody**

#### **19/190 SUMMARY FINANCE REPORT AS AT 30<sup>TH</sup> JUNE 2019**

The Board received and noted the summary Finance Report as at 30<sup>th</sup> June 2019.

#### **19/191 SINGLE OVERSIGHT FRAMEWORK**

The Board received and noted a report on the Trust's indicative position against the requirements of NHS Improvement's Single Oversight Framework for Quarter 1, 2019/20.

#### **19/192 USE OF THE TRUST SEAL**

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

#### **19/193 DATE OF NEXT MEETING**

It was noted that the next meeting of the Board of Directors was due to be held at 9.30 am on 24<sup>th</sup> September 2019 in the Boardroom, West Park Hospital Darlington.

#### **19/194 CONFIDENTIAL MOTION**

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

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

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

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

*Information which, if published would, or be likely to, inhibit -*  
(a) *the free and frank provision of advice, or*

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

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

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




Tees, Esk and Wear Valleys   
NHS Foundation Trust



## Tees Locality Board Presentation 18th July 2019

Dominic Gardner  
Director of Operations

making a difference together

Tees, Esk and Wear Valleys   
NHS Foundation Trust



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

- Previously
  - Support to independent providers
  - Urgent Care Centre, Street Triage and Police Force Control Room Pilot, Perinatal, CYPS CRHTT
  - MHSOP & AMH RPH Implications
- Now
  - Quality and Safety CYPS Inpatients
  - Trailblazers
  - Support to independent providers (PPL / ICLS / CRT)
  - Community and Urgent Care Services Review (RCRP)
  - Rehabilitation and Recovery

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**To continuously improve the quality and value of our work.**

● Previously

- Locality Report Out - to help share and spread
- PPCS Phase 2 Pilot Teams
- QIS with partners

● Now

- Coaching
- Leadership Programme
- QIS with Partners – LD Placement Breakdown
- New Models of Care – CYPS CRT / CED / Online Therapy & Supervision
- Case Management

making a

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

● Previously

- Ability to recruit consultant medical staff a serious concern (CYPS/AMH)
- Proportion of newly qualified and < 24 months post qualification nurses very high
- Embedding Roles of AC

● Now

- Ability to recruit consultant medical staff a serious concern (CYPS)
- Proportion of newly qualified and < 24 months post qualification nurses high in inpatient services
- Bank / Agency Use
- Staff wellbeing AMH Inpatients and CYPS Inpatient and Community
- Peer Support Workers

making a

difference

together

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

- Local
  - Crisis Care Concordat, Suicide Prevention Task Force
  - LA Health and Wellbeing Boards and Sub-groups
  - Durham Darlington and Teesside Mental Health and Learning Disability Partnership
- National
  - RRP Collaborative / BIHR
- International
  - Asklepios – Peer Support Workers / Transcultural Psychiatry / Use of Technology

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difference

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

- Financial Issues
  - Previously, LD Respite Services, Crisis Review, Enhanced Observations in MHSOP and DToC's, Enhanced Observations in CYPS Tier 4 (Acuity / Pathways)
  - Now, Clinical acuity and staffing pressures CYPs T4, MHSOP organic inpatients, OoL bed usage, AMH Rehab, agency use
- LMGB
  - Daily Lean Management
  - QuAGs continue to manage a broad range of issues
  - Increased Local Population knowledge

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FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	24 <sup>th</sup> September 2019
<b>TITLE:</b>	Board Action Log
<b>REPORT OF:</b>	Phil Bellas, Trust Secretary
<b>REPORT FOR:</b>	Information/Assurance

<b>This report supports the achievement of the following Strategic Goals:</b>	✓
<i>To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing</i>	✓
<i>To continuously improve the quality and value of our work</i>	✓
<i>To recruit, develop and retain a skilled, compassionate and motivated workforce</i>	✓
<i>To have effective partnerships with local, national and international organisations for the benefit of the communities we serve</i>	✓
<i>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.</i>	✓

**Executive Summary:**

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

**Recommendations:**

The Board is asked to receive and note this report.

## Board of Directors Action Log

### RAG Ratings:

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

	Minute No.	Action	Owner(s)	Timescale	Status
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	Sept-19	See agenda item 17
26/03/2019	19/65	A further report on waiting times to be presented to the Board	RH	Sep-19	See agenda item 11
26/03/2019	19/66	The response from the DWP to the letter highlighting concerns about the impact of benefit cuts on some vulnerable service users to be provided to Governors via the Governor Briefing	AK	-	Timing dependent on the receipt of the response from the DWP
26/03/2019	19/67	The issue of reporting two sets of data on the gender pay gap, due to the impact of salary sacrifice, to be raised at a national level	DL	Sep-19	Completed
30/04/2019	19/103	The shortage of SOADs and its impact on operational services to be included in the corporate risk register	RH	Sept-19	
21/05/2019	19/129	A Board Seminar discussion to be arranged on restrictive interventions	CM	To be included in the review to be undertaken in August 2019	Included in the list of potential Board Seminar topics under agenda item 19

	Minute No.	Action	Owner(s)	Timescale	Status
25/06/2019	19/164	Board Members to be provided with a refresh of the cases of readmissions within 30 days (KPI 14) broken down by diagnosis as provided previously to the Quality Assurance Committee	RH	Sep-19	See agenda item 15
25/06/2019	19/165	The opportunities for Board Members to engage with service users and carers to be mapped	CM	Oct-19	
18/07/2019	19/184	The provision of laptops to Trust doctors to be looked into	PM	-	Completed
18/07/2019	19/184	Arrangements to be made to enable the Board to hold in-depth discussions on lone working procedures	CM	-	Included in the list of potential Board Seminar topics under agenda item 19
18/07/2019	19/185	Discussions on AHPs and their future role in delivering care to be included in a future nurse staffing report or as part of an update on the Right Staffing Programme to a Board Seminar	EM	Jan-20 (six monthly Nurse Staffing Report)	
18/07/2019	19/187	To note endorsement of the 2018/19 WRES and WDES action plans	DL		To note
18/07/2019	19/189	To note approval to: - submit the community team self assessments and report to the Carers Trust - continue the Triangle of Care across services	EM		Approval

PUBLIC

BOARD OF DIRECTORS

<b>DATE:</b>	Tuesday 24 September 2019
<b>TITLE:</b>	Chief Executive's Report
<b>REPORT OF:</b>	Colin Martin, Chief Executive
<b>REPORT FOR:</b>	Information

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

**Executive Summary:**

A briefing to the Board of important topical issues that are of concern to the Chief Executive.

**Recommendations:**

To receive and note the contents of this report.

<b>MEETING OF:</b>	<b>Board of Directors</b>
<b>DATE:</b>	<b>Tuesday 24 September 2019</b>
<b>TITLE:</b>	<b>Chief Executive's Report</b>

## 1. West Lane Hospital

It has been a sad and sombre time for the Trust in the last few weeks. The deaths of Christie and Nadia at West Lane Hospital in Middlesbrough shocked everyone and I think I can safely say that there isn't a person in the organisation who isn't heartbroken for their families. It's always distressing when a patient dies, but especially so when it's someone so young.

The Care Quality Commission report made for tough reading and the follow up inspection, then announcement of the closure came very quickly after we'd received it. Since the 23<sup>rd</sup> August we've been working very closely with NHS England to find placements for patients or to complete treatment pathways for those who could be discharged. The last patient was planned to leave the hospital last week which was in line with our expectations of closing the hospital by the end of September.

We have been working through options to temporarily move staff affected by the closure into other Trust services as at this point it is difficult to predict when the service will reopen. NHS England have begun the process to commission an Independent Investigation which will involve all stakeholders including families and staff in the development of the Terms of Reference. The investigation team will be commissioned from the national independent investigations procurement framework to ensure full independence. One of the first actions will be an initial stakeholder meeting to ensure other statutory investigations are aligned and not compromised as a result of this investigation.

The Trust will establish a separate Programme team which will report regularly to the Board of Directors on all elements relevant to the position at West Lane Hospital.

## 2. Learning lessons to improve our people practices

All NHS trusts and NHS Foundation Trusts' Chairs and Chief Executives received a letter from Baroness Dido Harding, the Chair of NHS Improvement in May 2019. The letter described the outcomes of a recently completed piece of work undertaken in response to a very tragic event at a London NHS Trust in 2016.

In late 2015 Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically in February 2016, just prior to his Appeal Hearing, Amin took his own life. An independent investigation was subsequently undertaken which identified that in addition to serious procedural errors throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. The Trust accepted the investigation findings and recommendations.



NHS Improvement subsequently established a task and finish Advisory Group to consider to what extent the failings identified in Amin's case were either unique to the Trust or more widespread across the NHS, and what learning could be applied.

Analysis highlighted several key themes in both Amin's case and a number of other historical NHS cases. These themes included the poor framing of concerns and allegations, inconsistency in the fair and effective application of local policies and procedures, lack of adherence to best practice guidance, variation in the quality of investigations, shortcomings in the management of conflicts of interest, insufficient consideration and support of the health and wellbeing of individuals and an over reliance on the application of formal procedures, rather than consideration of alternative responses to concerns. A number of the comments received by NHS Improvement as part of the NHS People Plan engagement process also echoed these themes.

National guidance relating to the management and oversight of local investigation and disciplinary procedures has been prepared based upon the work of the Advisory Group. Chairmen, Chief Executives, HR teams and Boards are asked to review the guidance, to compare it to local policy and practice and where necessary to make local adjustments in line with best practice. In summary the guidance includes the following:

**Adhering to best practice** – the development and application of local investigation and disciplinary procedures should be informed by the provisions of current best practice e.g. the ACAS Code of Practice on disciplinary and grievance procedures. All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure and any actual or perceived conflicts of interest addressed;

**Applying a rigorous decision-making methodology** - consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, comprehensive and consistent decision making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps. Decisions about disciplinary sanctions should not be taken by one person alone;

**Ensuring people are fully trained and competent to carry out their role** – Case Managers, Case Investigators and Panel members should have received training in areas such as awareness of best practice, principles of natural justice and the application of race and cultural considerations within disciplinary proceedings;

**Assigning sufficient resources** - Case Managers, Case Investigators and any others with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of the disciplinary procedure;

**Decisions relating to the implementation of suspensions/exclusions** – any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where

immediate safety or security issues prevail, suspension exclusion should be a measure of last resort that is proportionate, time-bound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction;

**Safeguarding people's health and wellbeing** – concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support. Communication should be timely, comprehensive, unambiguous, sensitive and compassionate. Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm this should be treated as a 'never event' and therefore subject to an immediate independent investigation and report to the Board;

**Board-level oversight** - mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded and regularly and openly reported at Board level eg the number of procedures, reasons for these procedures, adherence to process, justification for any suspensions/exclusions, outcomes, impact on patient care and employees and lessons learnt;

The intention is to provide a detailed report to the Resources Committee, at its next meeting in November, about how local policy and practice compares to the national guidance described in this summary and what our next steps ought to be. A recent review of local policy and practice compared to the national guidance, undertaken by members of the TEWV operational HR team, concluded that local policy and practice is consistent with much of the national guidance. The review identified the potential need for the development of a formal decision making framework, more panel member training, the provision of more support for people between the post–investigation and Hearing stage and board-level oversight as being issues that require further consideration.

### 3. Freedom to Speak Up Guidance for Boards

In July the National Freedom to Speak Up Guardian's Office and NHS Improvement published guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts.

The guide sets out the expectations of the National Freedom to Speak Up Guardian's Office details individual responsibilities and includes supplementary resources. The aim of the guide is to support Boards to create a culture that is consistent with the Interim People Plan vision whereby staff can deliver the best care possible and that that they have a voice, control and influence. Directors completed the Freedom to Speak Up self-review tool that was published by The National Freedom to Speak Up Guardian's Office and NHS Improvement along with guidance last year. Receipt of the latest guidance provides an opportunity for the Board to consider the following:

- To clarify the responsibilities of the Freedom to Speak Up Executive and Non-Executive leads;
- To consider suggestions of how to assess the Trust Freedom to Speak Up Guardian's capability and capacity;
- To review how effectively the Trust is communicating about Freedom to Speak Up issues;
- To review progress made with implementation of planned actions that were identified as part of the self-review exercise last year;
- To consider the sources of tri-angulated information that can be gathered and reported about speaking up issues to identify patterns, trends and areas of concern;
- To consider how the Board is assured and updated about Freedom to Speak Up issues;
- To review the kind of information that is being reported to the Board by the Freedom to Speak Up Guardian;
- To review how the Trust's Whistleblowing policy is audited and the frequency of the audit.

The intention is to dedicate time at a forthcoming Board Seminar to consider in detail the latest guidance and to complete a further self-review to help identify what the current position is and the improvements needed. The latest guidance can be accessed via the link below.

[https://improvement.nhs.uk/documents/2468/FTSU\\_guidance.pdf](https://improvement.nhs.uk/documents/2468/FTSU_guidance.pdf)

#### **4. Triangle of Care**

This month, with the help of carers, the Trust has been awarded its second star in the National Triangle of Care Membership Scheme for demonstrating its ongoing commitment to the involvement of carers and families in the care and treatment of people with mental ill-health.

The Triangle of Care membership scheme managed by the Carers Trust, recognises long-term commitment from mental health providers who are working towards becoming more carer inclusive.

The Trust had already received its first Triangle of Care star for implementing the Triangle of Care principles and standards in its inpatient units and the second star is in recognition of its work towards embedding the standards within its crisis and community services. This has included audits and staff training involving carers to raise awareness of carers' experiences and discuss carer support.

#### **5. Roseberry Park Hospital Remedial Work – Update**

Following an extensive tendering process Interserve Construction Limited has been appointed as the preferred contractor to undertake the remedial work required at Roseberry Park Hospital, Middlesbrough. They commenced on site on 13 September 2019 on Blocks 5 and 10 and on 27 September work will start on

building a decant block to allow us to move patients from their current wards and those in temporary off-site wards to allow them to be refurbished.

The first phase of the rectification process will complete in May/June 2020 for Blocks 5 and 10 with Block 16 finishing in September/October 2020.

## 6. Mental Health Services in North East Prisons

The Trust, in partnership with Spectrum CiC and Humankind were successful in the tender for the provision of healthcare services to the 7 North East Prisons. The Trust will continue to deliver mental health services together with NTW NHS FT and Rethink Mental.

## 7. NHS Oversight Framework

On 23<sup>rd</sup> August 2019 NHS England and NHS Improvement (NHSE/I) published the NHS Oversight Framework 2019/20 which replaces the NHSI's Single Oversight Framework (SOF) for providers and the Clinical Commissioning Group (CCG) [Improvement and Assessment Framework \(IAF\)](#).

The key change to the approach is that there is now an increased focus on working with and through system leaders, wherever possible, with a greater emphasis on system performance and autonomy.

ICs and emerging ICs will be increasingly involved in the oversight process and in supporting organisations in their system. Regional teams will use data from the metrics as well as local information and insight to identify where commissioners and providers may need support, involving system leads in this process.

For providers, the approach being taken is similar to the SOF:

- The Framework continues to focus on the existing 5 themes of: quality of care (safe, effective, caring, responsive); finance and use of resources; operational performance; strategic change; and leadership and improvement capability (well-led).
- Regional teams will continue to monitor performance, wherever possible using nationally collected returns or evaluated datasets.
- Providers continue to be expected to notify the regional teams of any significant actual or potential changes in performance or any risks, outside of the routine monitoring, where these are material to their ability to provide safe and sustainable services.
- The segmentation of providers and levels of support offered are unchanged.

A greater emphasis is placed on leadership and staff engagement. The Organisational Health section within the SOF has been renamed to “Leadership & Workforce” and introduces metrics, in addition to those on sickness and staff turnover currently collected, in relation to:

- Staff experiencing harassment, bullying and abuse
- Staff agreeing that their team has a set of shared objectives and that their team often meets to discuss the those objectives

- Staff believing the Trust provides equal opportunities for career progression or promotion
- Staff experiencing discrimination
- The BME leadership ambition (WRES) re executive appointments (Trusts in the lowest third across the sector will be a concern)

From 2020/21, the metrics will include headline measures described in the NHS Long Term Plan Implementation Framework.

Copies of the NHS Oversight Framework and a briefing produced by NHS Providers have been unloaded into a reading room on the Diligent system for information.

## **8. Good news – Royal College of Psychiatrist Shortlisting**

It was great to learn that the following members of staff/teams have been shortlisted for the following categories:

### **Psychiatric Team of the Year: Working-age adults**

Adult Mental Health Acute Care Services at Roseberry Park

### **Psychiatric Team of the Year: Older-age adults**

Stockton Community Mental Health Team

### **Psychiatric Team of the Year: Intellectual Disability**

Adult Learning Disability North Tees Community Team

### **Psychiatric Team of the Year: Quality Improvement**

Dual Diagnosis

### **Carer Contributor of the Year**

Ros Savege

### **Service User/Patient Contributor of the Year**

John Venable

### **Psychiatric Educator of the Year**

Dr Jim Boylan

Colin Martin

**Chief Executive**

## FOR GENERAL RELEASE

## BOARD OF DIRECTORS

<b>DATE:</b>	Thursday 24 September 2019	
<b>TITLE:</b>	Assurance report of the Quality Assurance Committee	
<b>REPORT OF:</b>	Dr Hugh Griffiths, Chairman, Quality Assurance Committee	
<b>REPORT FOR:</b>	Assurance	
<b>This report supports the achievement of the following Strategic Goals:</b>		
<i>To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing</i>		✓
<i>To continuously improve the quality and value of our work</i>		✓
<i>To recruit, develop and retain a skilled, compassionate and motivated workforce</i>		
<i>To have effective partnerships with local, national and international organisations for the benefit of the communities we serve</i>		
<i>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.</i>		✓
<b>Executive Summary:</b>		
<p>The purpose of this report is to update the Board of Directors on any current areas of concern in relation to quality and to provide assurance on the systems and processes in place.  <u>Assurance statement pertaining to the QuAC formal meeting held on 05 September 2019</u></p> <p>The Quality Assurance Committee has consistently reviewed all relevant Trust quality related processes, in line with the Committee's Terms of Reference.  Key matters considered by the Committee were:</p> <ul style="list-style-type: none"> <li>• The top concerns for North Yorkshire Services</li> <li>• Compliance with CQC</li> <li>• Patient Safety and Patient Experience</li> <li>• Infection, Prevention and Control</li> <li>• Safeguarding &amp; Public Protection</li> <li>• Clinical Audit &amp; Effectiveness</li> <li>• Triangle of Care Stage 2 Submission</li> <li>• Community Mental Health Survey 2019</li> <li>• Quality Account Q1 and report from Quality Account Stakeholder Workshop with proposed priorities</li> </ul>		
<b>Recommendations:</b>		
<p>That the Board of Directors:</p> <ul style="list-style-type: none"> <li>• Receive and note the report of the Quality Assurance Committee from its meeting held on 05 September 2019.</li> <li>• Note the confirmed minutes of the formal meeting held on 04 July 2019 (Annex 1)</li> </ul>		

<b>MEETING OF:</b>	<b>Board of Directors</b>
<b>DATE:</b>	<b>Thursday 24 September 2019</b>
<b>TITLE:</b>	<b>Assurance report of the Quality Assurance Committee</b>

## 1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of any concerns and exceptions, together with levels of assurance in meeting the CQC fundamental high quality questions.

## 2. BACKGROUND INFORMATION AND CONTEXT

This report makes reference to the regular assurance and exception reports from the working groups of the Quality Assurance Committee, the localities and compliance with the Care Quality Commission regulatory standards.

## 3. KEY ISSUES

### 4 ARE OUR SERVICES WELL LED? *How do we gain assurance from each locality that they have effective systems and processes in place to ensure standards of care, compliance with relevant standards, quality, risk and assurance arrangements?*

#### 4.1 North Yorkshire Locality

The Committee discussed the North Yorkshire LMGB report covering the period 2019.

The key concerns highlighted were:

- Waiting times, impacting on services across NY and York, with most significant in the memory assessment service, secondary waits in IAPT and for autism services.
- This is linked to issues such as the capacity in nursing and medical posts across community and inpatient teams where vacancies, maternity leave, sickness, referrals rates and caseloads is impacting on productivity.
- Service changes with the final agreement to close the rehab and recovery inpatient unit, the planned merger of the two organic wards and the engagement plan for Harrogate in partnership with the CCG.

The Committee paid particular attention to seeking assurance at ward level and focused on discussion around those wards and teams that require support, they may be teams at risk or who are isolated. In addition the Committee requested that the locality update the risk register, which was currently being worked through following the recent merger to amalgamate all risks.

#### 4.2 Compliance with CQC Requirements

The Committee received the monthly update on compliance with CQC registration requirements.

The Board is to note:

- The report outlined the concerns found at West Lane Hospital and the details of the enforcement action placing conditions on the Trust's registration.

- The Quality Assurance Committee held an extraordinary meeting on 29 August 2019 to discuss the issues at West Lane Hospital in detail where all Non-Executive Directors were invited to attend.
- Assurance was given to the Committee that all inpatient services will be visited to check for any issues that need to be rectified including some of those identified at West Lane Hospital.
- There will be a CQC inspection of core services commencing on 23 September 2019 for two weeks. The Well-Led inspection will take place on the 5<sup>th</sup> and 6<sup>th</sup> of November 2019.

5 ARE OUR SERVICES SAFE? *Are lessons learned and improvements made when things go wrong?*

### 5.1 Patient Safety Group

The Committee received the assurance report of the Patient Safety Group.

The key matters for Board members to note are:

- Two items have been discussed from Director Panels involving CAMHS and EIP services not adhering to agreed standard operating processes when delivering care. There were failings around communication and transition between the crisis team and EIP. Assurance was given that all those involved in these processes have been sent communication to reinforce processes.
- The Patient Safety Group has developed a risk register on any patient safety issues considered to be a risk to the organisation where assurance isn't strong or clear. This will be known as the "issues log".
- From the data quality report the Group have discussed concerns around the number of level 3 self-harm incidents. Elm Ward was currently the biggest outlier in terms of self-harm and it was agreed that some work will be undertaken to look at teams on both Elm Ward and Maple, and at any support that might be needed in terms of cultural and leadership issues.
- Teesside are outliers in relation to restraint which is not reducing however includes the Tier 4 CAMHS data which explains the majority of the incidents for the locality.
- A draft strategy on sexual safety was tabled for discussion. It was agreed that some further work was required and that it would be brought back to QuAC at the October meeting.

### 5.3 Infection, Prevention and Control

The Committee received an assurance report on Quarter 1 for Infection, Prevention and Control.

There are no exceptions to note apart from fails by Elm and Esk wards around validation audits. There are 20 actions due to be completed for Elm Ward and three for Esk and assurance was given that the IPC Committee will be monitoring progress.

### 5.4 Safeguarding and Public Protection

The Committee received an exception report for safeguarding.

The Board is to note:

- The serious adult review has been agreed by Durham Safeguarding Adult Board, expected to start in 2020.
- Both of the recent deaths of young people on West Lane site are subject to a rapid response meeting, part of the Child Death Overview process.



- One of the deaths has been referred by Middlesbrough LSCB to the independent chair for a serious case review as the individual was a Looked After Child, detained under the Mental Health Act.
- Concerns have been raised by Darlington Local Authority and the CQC regarding an adult acute patient at West Park Hospital. Safeguarding was in place for this person however some wider concerns about response to safeguarding are being explored by doing 'dip-sampling' of safeguarding concerns not escalated to local authority to look for any themes.

6 *ARE OUR SERVICES RESPONSIVE? Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care*

### 6.1 Patient Experience

The Board is to note:

- The Patient Experience Report has been through a period of redevelopment and is now being presented to the QuaC on a quarterly basis and contains SPC charts with narrative and analysis of the information. This was welcomed by the Committee as a significant improvement in terms of understanding the information and being better informed.
- The 2018 Community Mental Health Survey results and action plan were detailed, however it was noted that the 2019 results were now available and the Committee asked that the 2019 report be considered in a timelier manner.
- Members requested how feeling safe needs to include "sexual safety" and the Patient Experience Group were tasked with thinking about how this can be captured and reported in future.
- Non-Executives sought assurance on patient advocacy and it was confirmed that patient groups are very active and engaged.

7 *ARE OUR SERVICES EFFECTIVE? – Outcomes for people who use services are consistently better than expected when compared with other similar services*

### 7.1 Clinical Audit & Effectiveness

- The Committee received a progress report on the Clinical Audit Programme which at the end of Q1 15.58% complete (12 out of 77 audits complete) and by the end of August 26.25% complete.
- The re-audit of blanket restrictions, subject to approval of the policy around this will be undertaken in December 2019 and reported to a future QuAC meeting.

### 7.2 Triangle of Care Stage 2 Submission

The Committee received a report detailing the update on the aims and objectives of the Triangle of Care (ToC)

The Board is to note that:

- ToC involves Trust staff working with carers and carers organisations to complete and submit self-assessment tools based on six national key standards.
- Following further assessments the Trust has achieved stage 2 of the Triangle of Care (and the 2 star kite mark).

### 7.3 Quality Account Q1 and Quality Account Stakeholder Workshop

The Committee received a progress report for Q 1 on the Quality Account and a report looking at the priorities for 2020/21.

The key issues for the Board to be aware of are:

- Progress on Q1 has been good with 53/56 (95%) either completed or on track for planned completion.
- Three out of nine of the quality metrics (33%) are reporting green. There are six out of nine metrics reporting as red (66%) however three of the four patient reported figures (feeling safe on the ward, overall experience excellent or good and respect from staff) is improving.
- Of the red metrics the most concerning was the number of physical interventions and restraint which was double the target rate and steadily going up. The Committee would continue to receive action plans and regular reports on this through the Positive and Safe report.
- The priorities recommended by the Committee for discussion at the Business Planning Workshop on 1<sup>st</sup> and 2<sup>nd</sup> October were:
  1. To reduce the number of preventable deaths;
  2. Feeling safe on the wards;
  3. Improving the CYP to AMH transition;
  4. Introducing personalised care planning (dialog system).

#### **7.4 Community Mental Health Survey 2019**

The Committee received the results on the Community MH Survey for 2019.

The key points for the Board to note are:

- The report is embargoed for internal use only until the CQC publishes the Trust results in November 2019.
- The overall results show a positive picture with all scores either in the top 20% or intermediate 60% ranges, with no scores in the lower 20% range. The results are comparable with 52 other MH Trusts.
- A further report will be written with an action plan for the Board later in the year.

### **8 IMPLICATIONS**

#### **9 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.

### **10 CONCLUSIONS**

The Quality Assurance Committee considered the corporate assurance and performance reports during the meeting.

### **11 RECOMMENDATIONS**

That the Board of Directors is asked to:

- (i) *Note the issues raised at the Quality Assurance Committee meeting on 05 September 2019.*
- (ii) *Note the confirmed formal minutes of the meeting held on 04 July 2019.*

Dr Hugh Griffiths  
Chairman of Quality Assurance Committee  
**24 September 2019**

## Item 1

### **NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 04 JULY 2019, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM**

#### **Present:**

Ms Miriam Harte, Chairman of the Trust  
Dr Hugh Griffiths, Chairman of the Committee  
Mr Colin Martin, Chief Executive  
Mrs Shirley Richardson, Non-Executive Director  
Dr Ahmad Khouja, Medical Director  
Mrs Jennifer Illingworth, Director of Quality Governance  
Mr Richard Simpson, Non-Executive Director  
Mrs Ruth Hill, Chief Operating Officer

#### **In attendance:**

Ms Donna Oliver, Deputy Trust Secretary (Corporate)  
Dr Julia Sutton-McGough, Non-Executive Director, Pennine Care NHS FT  
Mrs Gill Bailey, Assistant Trust Secretary, Pennine Care NHS FT  
Mr Levi Buckley, Director of Operations, Durham & Darlington (for minute 19/94)  
Mr John Savage, Head of Nursing, Durham & Darlington  
Dr S Babu, Consultant Psychiatrist, Forensic Services  
Mrs Rachael Weddle, Head of Nursing, Forensic Services (for minute 19/95)  
Mrs Linda Parsons, Associate Director Operational Services, Estates & Facilities (for minute 19/101)  
Mrs Emma Haimes, Head of Data Quality & Patient Experience, Nursing and Governance  
Mrs Ann Marshall, Deputy Director of Nursing  
Mr Stephen Davison, Lead Nurse, Positive & Safe (for minute 19/100)  
Mr Alan Williams, Public Governor Redcar & Cleveland

#### **19/91 APOLOGIES FOR ABSENCE**

Apologies for absence were received from, Mrs Elizabeth Moody, Director of Nursing & Governance Mrs Karen Agar, Associate Director of Nursing, Mrs L Taylor, Director of Operations, Forensic Services and Mrs Sharon Pickering, Director of Planning, Performance & Communications.

#### **19/92 MINUTES OF THE PREVIOUS MEETING**

The minutes of the meeting held on 06 June 2019 were accepted as a true recording of the discussion and signed by the Chairman.

#### **19/93 ACTION LOG**

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

18/170 Report on automated defibrillators was deferred to the July 2019 QuAC meeting. It was noted that some costing work was underway and this would be deferred to the September QuAC meeting.

19/40	D&D LMGB report: increasing referrals into IAPT and the rates that they convert from IAPT to secondary care, which referrals have come from IAPT and how many are taken on for treatment. Mr Buckley agreed to circulate this information following the meeting.	<b>Completed</b>
19/57a	Forensic Services: review membership and link of all IP units.	<b>Completed</b>
19/57c	Forensic LMGB report: look in more detail at the scorecard, 54% response for staff treated with dignity and respect. This matter was covered under agenda item number 3.	<b>Completed</b>
19/61	Positive and Safe draft annual report: break down of data around restrictive interventions with a view to using run charts. This matter was covered under agenda item number 6.	<b>Completed</b>
19/62	Issues for Datix to improve patient safety report to be discussed at EMT to think about balance of priorities. The matter had been discussed at EMT and the priority for the Trust at the moment was CITO.	<b>Completed</b>
19/64	Further assurance required around the high number of PALS themed as other. This item was deferred to the September QuAC meeting.	
19/79	Infection, Prevention and Control Annual Report: how many returns were there on the environmental audit. An email with this information had been circulated to QuAC members on 24 June 2019.	<b>Completed</b>

**19/94 DURHAM AND DARLINGTON SERVICES LMGB REPORT**

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

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

- (i) Pressures in Inpatient and community services, Adult Mental Health. There were high referrals in to the service as well as those that were waiting, with 59 cases in Easington unallocated due to staff vacancies and high caseload numbers. Solutions being considered were Mind the Gap arrangements and increasing non-medical Prescribers.
- (ii) Medical Recruitment – some improvements had been seen recently with the appointment of a Consultant and there were plans to try to recruit from India in January 2020. Committee members were cautioned that it was expected to take at least a year before recruitment issues would stabilise.
- (iii) Breaching the KPI for second appointment within nine weeks in Children and Young People’s services, however it was pleasing to note that the four week target was still being met. A deep dive was underway to identify what could be done to meet the demands. Psycho-education groups for low/moderate anxiety and low mood had helped to create some capacity and reduce the nine week waits.
- (iv) Pressure in the Learning Disability Inpatient Services.  
There were complexities around a patient from York where it would be detrimental to their wellbeing if they were to be moved, however this individual continued to damage the physical environment on

the ward and had a negative impact on the ability to flexibly manage the six beds across Bek and Ramsey.

In addition to the report assurance levels were noted around the following:

- (i) Exceptions were found around the checks on resuscitation bags in Cedar, Maple, Elm and Bek Ramsey Wards. Assurance was provided to the Committee that additional monitoring had been put in place. It was noted that some of these missing checks had been due to the presence of agency staff on the ward.
- (ii) There has been a single incident of using mechanical restraint in PICU Cedar ward in April 2019.

Following discussion members of the Committee expressed their concern around the potential for staff to move to the Trust as working employees from Whorlton Hall. It was noted that this has been picked up by HR to ensure that the process would be managed and recruiting staff would be aware if this was the case.

### **19/95 FORENSIC SERVICES LMGB REPORT**

The Committee received and noted the Forensic Services LMGB Report.

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

- (1) Service restructure.  
The LMGB had monitored reporting arrangements and escalation processes since the service restructure to ensure governance and assurance processes were embedded. To ensure an effective information flow between the Inpatient settings the Service Manager from Oakwood and Talbot locked rehabilitation wards would now attend the Secure Inpatient Service QuAG.
- (2) Resuscitation equipment.  
During the two month reporting period there had been an issue with missing signatures/checks and an issue with the use of the approved form. These were addressed immediately and action taken through supervision or informal counselling as appropriate. Further assurance was provided that the audit tool had been revised to reflect the Trust policy and this had now been adopted Trust wide.
- (3) Restrictive practice and interventions. Assurance was provided that there was an ongoing focus on any restrictive practices within the inpatient units and how they could be reduced, with challenge around the rationale. Consideration was now being given to how service users could be involved in the decision making and the Equality and Diversity lead would help to explore questioning from a human rights perspective.  
There had been 11 uses of soft restraint devices and 12 uses of tear proof clothing during the two month period.

Following discussion members expressed their concerns over the staff absence rates on several wards, which was over 20%, due to a range of issues including physical illness which then impacted on the remaining staff and then led to stress related sickness. The wards worst affected were LD and it was noted that the transforming care agenda, leading to staff that had been moved three or four times had made the problem worse and affected morale.

It was noted that there was an exceptionally high shortage of staff currently with 62 WTE at the moment and included in this were 35 expectant mums and/or on maternity leave on 16 wards.

### **19/96 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS**

The Committee received and noted an update report on Compliance with CQC Registration Requirements.

The following key matters were highlighted from the report:

- (i) There had been an unannounced visit to Children and Young People's Services to Baysdale Unit at Roseberry Park, Holly Unit at West Lane and Westwood, Newberry and Evergreen Centre at West Lane Hospital.
- (ii) The visit to West Lane had been a responsive inspection due to concerns raised to the CQC. A draft inspection report would be shared with the Trust with the opportunity for comments on factual accuracy.
- (iii) The CQC had issued a notice of decision against the Trust due to concerns identified in the inspection under Section 31 of the Health and Social Care Act: this related to issues with staffing, observations and medicines management relating to West Lane wards only. The unit had been suspended from taking any new admissions.

Following discussion members agreed that there should be an Extraordinary meeting of the Quality Assurance Committee held in August 2019 to give due consideration to the details around this inspection.

**Action: Ms D Oliver**

- (iv) The CQC had sent a Provider Information Request (PIR) to be completed by 16 July 2019, to inform the Trust of the start of a full well-led inspection within the next six months.
- (v) There were 11 outstanding actions from the 2018 well-led inspection, which were being followed up, mainly relating to evidence not yet sent to the Compliance Team.

#### **19/97 CLAIMS REPORT**

The Committee received a report setting out a summary of claims that had been managed by the organisation over the last three financial years and the cost implications.

Assurance was provided to the Committee that there were robust claims management and investigation processes together with awareness being raised with the services. This would ensure that early decisions could be made on claims to keep costs to a minimum and protect the reputation of the organisation.

#### **19/98 PATIENT SAFETY GROUP REPORT**

The Committee received and noted the Patient Safety Group Report.

The key matters highlighted from the report were:

- (i) Clarification was provided that the numbers of expected deaths by severity in 2018/19 (1,217) included deaths in the community and those patients that died from physical health/natural causes.
- (ii) A focus was being given to learning from root causes and/or contributory findings from the serious incident reviews and the locality with the highest proportion (61%) for York and Selby, however there had been some reduction from the previous year. The percentage of reports requiring a formal action plan within NY, Teesside and Durham and Darlington had all reduced.

Following discussion members requested further details around tier 4 incidents in CAMHS and this would be included for discussion at the Extraordinary Quality Assurance Committee meeting to be held in August 2019.

**Action: Mrs J Illingworth**

#### **19/99 PATIENT SAFETY ANNUAL REPORT**

The Committee received and noted the Patient Safety Annual Report.

## 19/100 POSITIVE AND SAFE REPORT

The Committee received and noted the Positive and Safe update report.

The key matters highlighted from the report were:

- (i) The report included two dashboards - a weekly snapshot, which provided information around a number of key indicators relating to the use of restrictive practices together with a monthly view using the same key indicators, over the period May 2017 to April 2018.
- (ii) The weekly dashboard was being used each week in clinical huddles to inform operational practice.  
Members of the Committee requested that the LMGB reports from localities include the dashboards in their reports in future to QuAC from September 2019 with a narrative around any trends or spikes.

**Action: Locality Directors**

- (iii) By speciality the only concerning trend related to NY and York LD services in relation to the number of physical interventions and self-harm. All other localities show a downward trend or are within normal variation.
- (iv) Risks relating to the use of physical intervention and management of challenging service users will be managed through operational services and work within the Positive and Safe team.
- (v) Assurance can be provided that the data demonstrates a downward trend in the use of tear proof clothing.

## 19/101 HEALTH, SAFETY, SECURITY AND FIRE REPORT

The Committee received and noted the six monthly update report on Health, Safety, Security and Fire.

The key issues highlighted from the report were:

- (i) There had been no risks reported during the six month period around health, safety, security and fire matters.
- (ii) A slightly higher number of incidents had been reported to the police (68 in 2018/19, compared to 62 in 2017/18).  
On this matter it was noted that any outcome following these being pursued by the Police was reliant on the injured persons to give feedback on any actions taken against the perpetrator by the Police or court.
- (iii) There had been significant improvement in the incidents of smoking inside and out of premises with a reduction from 338 in 2017/18 to 180 this year.

The Committee were assured that governance processes were robust around all matters.

## 19/102 SAFEGUARDING AND PUBLIC PROTECTION EXCEPTION REPORT,

The Committee received an exception report for Safeguarding and Public protection,

The following was highlighted from the report:

- (i) The Durham Safeguarding Adult Board would undertake a serious adult review regarding Whorlton Hall.
- (ii) A further meeting would take place in July 2019 following the safeguarding enquiries at Acomb Garth. The first two meeting dates had been changed by York Local Authority.

- (iii) There would be a review held by the local authority in Durham, under the Child Death Review Process of the young person who went from Newberry ward to James Cook Hospital and sadly died.

Assurance was provided in the report that both the safeguarding adult and children teams continue to deliver a comprehensive safeguarding service within the Trust and are compliant with legislation.

**19/103 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)**

There were no matters of exception raised.

**19/104 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD**

There were no other issues that required escalation.

**19/105 ISSUES DISCUSSED THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS**

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

**19/106 COMMITTEE EVALUATION**

Members expressed no concerns around the meeting, agenda and reports.

**19/107 ANY OTHER BUSINESS**

There was no other business to discuss.

**19/108 DATE AND TIME OF NEXT MEETING:**

The next meeting of the Quality Assurance Committee will be held on Thursday 05 September 2019, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.35pm

.....  
**Dr Hugh Griffiths**  
**Chairman**  
**05 September 2019**



ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	24 <sup>th</sup> September 2019
<b>TITLE:</b>	To consider the “Hard Truths” monthly Nurse Staffing Exception Report
<b>REPORT OF:</b>	Elizabeth Moody, Director of Nursing and Governance
<b>REPORT FOR:</b>	Assurance/Information

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

**Executive Summary:**

This report is an exception report for the Trust Board, regarding the monthly staffing of in-patient wards across the Trust.

**Assurance Statement:**

The Trust is meeting its requirements for safe staffing within the current legislative framework as set out in section 2.

**Recommendations:**

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

<b>MEETING OF:</b>	<b>Board of Directors</b>
<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>To consider the “Hard Truths” monthly Nurse Staffing Exception Report</b>

## **1. INTRODUCTION & PURPOSE:**

- 1.1 This report is to provide a monthly written exception report to the Trust Board to highlight any issues of note or concern.
- 1.2 This is in addition to the report required by the Board on a six monthly basis. This report refers to August 2019 data.

## **2. BACKGROUND INFORMATION AND CONTEXT:**

- 2.1 The monthly reporting of daily staffing levels is a requirement of NHSE and the National Quality Board in order to appraise the Trust Board and the public of staffing levels within inpatient wards.
- 2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013 and subsequent update of the NQB guidance in 2016) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. ([Nurse staffing - Tees Esk and Wear Valleys NHS Foundation Trust](#)).

## **3. EXCEPTIONS**

- 3.1 Staffing related to inpatient units have been coordinated during June, through the participation of inpatient services in daily huddles to review and understand staffing levels across sites and specialties. This has allowed for the staffing resource to be used in the most effective way to ensure high quality, patient centred care continues to be delivered safely across all inpatient units.
- 3.2 Themes remain consistent with previous issues that the Board have been appraised of with planned staffing not always met due to sickness, vacancies and high levels of patient acuity.
- 3.3 Where green fill rates were not achieved, patient safety on in-patient wards was maintained by nurses working additional unplanned hours, staff cross covering across wards, temporary staffing, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. Specific exceptions where safety concerns have arisen have been reported through Datix and escalated through operational management to action.

#### **4. IMPLICATIONS:**

##### **4.1 Compliance with the CQC Fundamental Standards:**

There are a number of areas that have had high levels of clinical activity necessitating increased observation and engagement levels with patients in addition to sickness and vacancies. This has resulted in difficulties in some wards meeting their planned staffing levels particularly with regard to registered nursing staff fill rates on days. In some ward areas this has resulted in high levels of agency and bank HCA's. This issue has been highlighted as a concern by the CQC in our recent inspection report and poses a risk to compliance under the safe domain.

##### **4.2 Financial/Value for Money:**

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

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

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

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

##### **4.4 Equality and Diversity:**

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

##### **4.5 Other implications:**

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

#### **5. RISKS:**

##### **5.1 Safe staffing and the risks regarding the Trusts ability to meet planned staffing levels on a daily basis have been escalated to the Trust Risk Register. Risks**

are managed and mitigated through operational services and the work being undertaken as highlighted within the Right Staffing work streams.

**6. CONCLUSIONS:**

- 6.1 The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments and continues to develop the data collation and analysis to monitor the impact of nurse staffing on patient safety, clinical effectiveness and experience.
- 6.2 The report sets out the work that continues in localities and through the Right Staffing programme to address shortfalls where planned establishments are not being met and to address capacity and capability in line with severity scores.

**7. RECOMMENDATIONS:**

- 7.1 That the Board of Directors notes the exception report and the issues raised within the attached Safe Staffing Report for further investigation and development.

**Emma Haimes**  
**Head of Quality Data and Patient Experience**  
**September 2019**

## Appendix 1

### Safe Staffing Report – August 2019:



Safe Staffing  
September Report us

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

Six workstreams exist to provide a framework to support the implementation of the Right Staffing Programme - based on the [NQB Guidance](#)



## Safe Staffing Fill Rates August 2019:

- The number of rosters equated to 65 inpatient wards in August.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 28 in August 2019, an increase of 4 when compared to July 2019.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - Bek/Ramsey (LD) – 54.6% RN on Days – Low fill rate is due to sickness. All shifts have had at least 1 qualified nurse on duty.
  - Harrier/Hawk (FLD) – 56.7% RN on Days and 89.5% HCA on Days – the low fill rate is due to long term sickness, maternity leave and restricted duties.
  - Acomb Garth (MHSOP) – 60% RN on Nights and RN on Days – the low fill rates were in relation to vacancies that the ward were carrying prior to merger of the unit with Meadowfields.
- There were 62 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues.
- The top 3 inpatient areas where a high staffing fill rate has been reported are:
  - Westerdale South (MHSOP) – 353.4% HCA on Nights and 166.7% HCA on Days - the increase

was necessary to support on average 3/4 enhanced observations during the month. The zonal observation pilot has been recruited to and will commence in October 2019 resulting in a significant reduction in temporary staffing

- The Evergreen Centre (CYPS) – 284.5% HCA on Nights, 199.5% HCA on Days and 125.6% RN on Nights – the increase was in relation to the acuity of the ward with continuous enhanced observations
- Elm Ward (Adults) – 253.7% HCA on Nights and 159.7% HCA on Days – the increase in staffing is due to high acuity and needs of patient group

## Bank Usage:

- The bank usage across the trust equated to 22.2% in August, which is an increase of 1% when compared to July.
- There was one ward (Eagle-Enhanced Care package, FLD) that had a bank usage rate of 69.4% of the actual hours worked in August and were the highest users of bank. The reasons given for requesting bank included enhanced observations (97 shifts) and vacancies (25 shifts).
- There were 19 wards that reported greater than 25% bank usage.

## Agency Usage:

- The agency usage across the trust equated to 7.5% in August, an increase of 0.2% when compared to July.
- Acomb Garth (MHSOP) reported the highest agency usage in August equating to 44% of the total hours worked. Enhanced Observations (865 shifts) and Vacancies (274 shifts) were cited as the highest reasons for using agency. The ward were using regular agency where possible. It is anticipated that the recent merger with Meadowfield will have a positive impact on temporary staffing use.
- Those wards reporting 4% or more agency usage in August equated to 24 wards.
- The Retinue report highlights the following information:
  - Fulfilment levels equated to 78%
  - August saw 400 shifts go unfilled; a reduction of 42 on July
  - Fulfilment for HCAs increased to 81% during August. 1178 HCA shifts were filled in August compared to 1230 in July
  - A total of 211 RMN shifts were filled in August with fulfilment increasing to 64% from 62%

Produced: 13<sup>th</sup> September 2019

The purpose of this document is to present to the Board by 'exception' the monthly safe staffing information as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to July 2019 data.

- Usage across Acomb Garth reduced significantly in August to only 41 requests from 174 in July. Westwood Centre was the ward with the highest usage with 185 requests; all of which were filled.
- Areas with lowest fulfilment – Ayckbourn Unit Danby Ward (29% - 14 shifts), Ayckbourn Unit Esk Ward (25% - 8 shifts), Birch Ward (45% - 39 shifts), Cedar Ward (33% - 6 shifts), Holly Unit (0% - 2 shifts), Kirkdale Ward (45% - 11 shifts), Maple Ward (35% - 26 shifts), Rowan Lea (39% - 95 shifts) and Willow Ward (44% - 9 shifts) - below 50%. All other wards were above 50% fulfilment.
- The total number of no shows reported for August decreased from 20 to 13. No shows as a percentage of shifts filled are 0.94%.
- HCA continues to attribute to 80% of overall spend
- All shifts booked during this period have been booked below cap with zero breaches recorded.

#### Missed Breaks:

- There were 1217 shifts in August where an unpaid break had not been taken. This is a substantial increase of 832 shifts when compared to July 2019.
- 1142 shifts where breaks were not taken were attributable to day shifts.
- 75 shifts where breaks were not taken were attributable to night shifts.
- A breakdown by locality is as follows:
  - Teesside = 472 shifts with no breaks (Bankfields Court, Unit 2, had the highest with 97 shifts)
  - Forensics = 375 shifts with no breaks (Northdale, had the highest with 68 shifts)
  - Durham & Darlington = 210 shifts with no breaks (Holly, had the highest with 40 shifts)
  - North Yorkshire & York = 160 shifts with no breaks (Cherry Tree, had the highest with 24 shifts)
- This information is being monitored daily as part of the operational services huddle process.

#### Incidents Raised Citing Staffing Levels:

- There were 36 incidents reported in August 2019 citing issues with staffing covering both inpatient and community services.
- Incidents detailed concerns related to staff well-being and patient care delivery mostly as a result of unplanned staffing pressures (e.g. sickness, patient acuity). When such issues arise, individual wards attempt to fill deficits with support from managers, cross-cover and duty nurse coordinators to maintain patient safety.
- Using a severity rating scale to identify potential outliers, the top 5 is as follows:
  - Westwood Centre – 11 points awarded

- Elm Ward – 10 points awarded
- Sandpiper – 9 points
- Bedale Ward – 9 points
- Evergreen Centre – 9 points
- Using the YTD score (August 18 to August 19) the following appear in the top 5:
  - Westwood Centre – 112 points awarded
  - Evergreen Centre – 100 points awarded
  - Elm Ward – 92 points awarded
  - Westerdale South – 92 points awarded
  - Newberry Centre – 88 points awarded

#### Care Hours per Patient Day:

- This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight.
- From 1<sup>st</sup> August 2019 there is an expectation to expand the current fill rate and CHPPD reporting to include all registered and non-registered nursing associates.
- Using standard deviation (August 18 to August 19) the following appear as positive outliers:
  - Harland – registered and unregistered nurses
  - Danby Ward – registered nurses
  - Jay Ward – registered nurses

#### Conclusion:

- The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments.

#### Key links to documents & guidelines:

[Monthly and Daily Staffing Report – August 2019](#)  
[NQB Guidance July 2016](#)

For more information on the content of this report please contact [elizabeth.moody1@nhs.net](mailto:elizabeth.moody1@nhs.net)

FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	Tuesday, 24 September 2019
<b>TITLE:</b>	To receive and note the Annual Report on Patient Safety
<b>REPORT OF:</b>	Elizabeth Moody, Director of Nursing and Governance
<b>REPORT FOR:</b>	Information / Assurance

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

**Executive Summary:**

The report highlights activity and learning in relation to Patient Safety for 2018/19.

The most common themes from the 144 Serious Incidents reviewed in the year were:

- Inadequate risk assessment
- Communication/Information Sharing
- Multi-agency working

The locality with the highest proportion of reports with root causes and/or contributory findings was York & Selby with 61% which is consistent with last year's findings although has reduced. The percentage of reports requiring a formal action plan within North Yorkshire, Teesside and Durham & Darlington has reduced.

Work continues to refine our mortality review processes, enhanced family engagement and the Trust will also be considering emerging themes from the latest National Confidential Inquiry report during 2019/20 to ensure we are providing the safest possible care based upon the best available evidence.

**Recommendations:**

The Board of Directors is asked to receive and note this report.

Jennifer Illingworth  
Director of Quality Governance  
September 2019



# Patient Safety Annual Report (2018/19)

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## Part 1 – Data

This report provides a look back over the 2018/19 financial year, with regard to incident reporting and associated Patient Safety activities. It includes details on all incident types reported, serious incidents and identifies themes that are emerging from the data.

All Serious Incidents (SI's) which occur are reported to the Executive Management Team (EMT) on a weekly basis to ensure any immediate patient safety issues requiring urgent action are addressed. EMT reviews a monthly performance report out in relation to Serious Incidents and also has a quarterly 'deep dive' in to patient safety issues which includes emerging themes. All other incidents are reported in line with the incident reporting policy and investigated by the operational services in which they occur.

There were a total of **27,090** incidents reported during the Financial Year 2018/19 of which **142** were categorised as Serious Incidents.

### 1. Incident Activity and Analysis

A total of **27,090** incidents were reported via the electronic incident management system (Datix). This is an increase of **1,515** incidents when compared to the previous financial year (2017/18) where there were **25,575** incidents reported. TEWV is recognised by the National Reporting and Learning System (NRLS) as a good reporter of incidents.

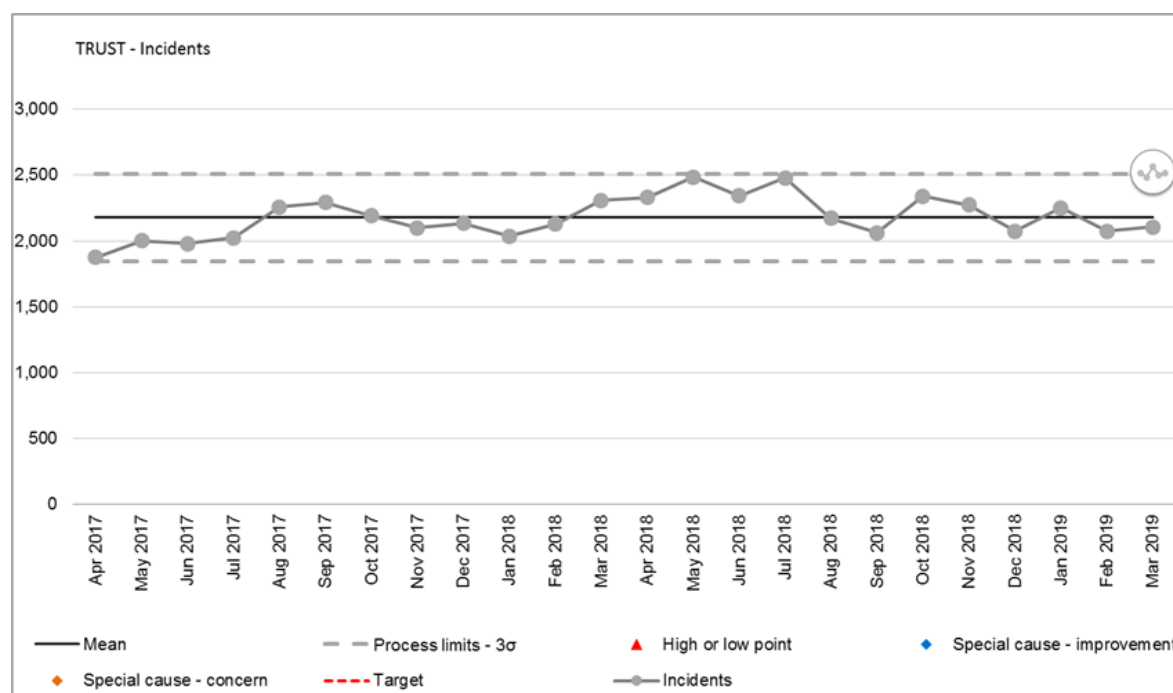
The following table indicates the numbers of incidents over the last 3 years showing a trend (where possible) on the previous financial year:

Financial Year	Total number of incidents	Trend on incidents (Previous Year)
2016/17	21,196	↗ 5,438
2017/18	25,575	↗ 4,379
2018/19	27,090	↗ 1,515

The table below shows the **27,090** incidents split into the number of Patient incidents and the number of serious incidents:

Financial Year	2016/17	2017/18	2018/19	Trend on Previous Year
Number of Incidents	21,196	25,575	27,090	↗ 828
Serious Incidents (As reported on STEIS)	102	130	142	↗ 12

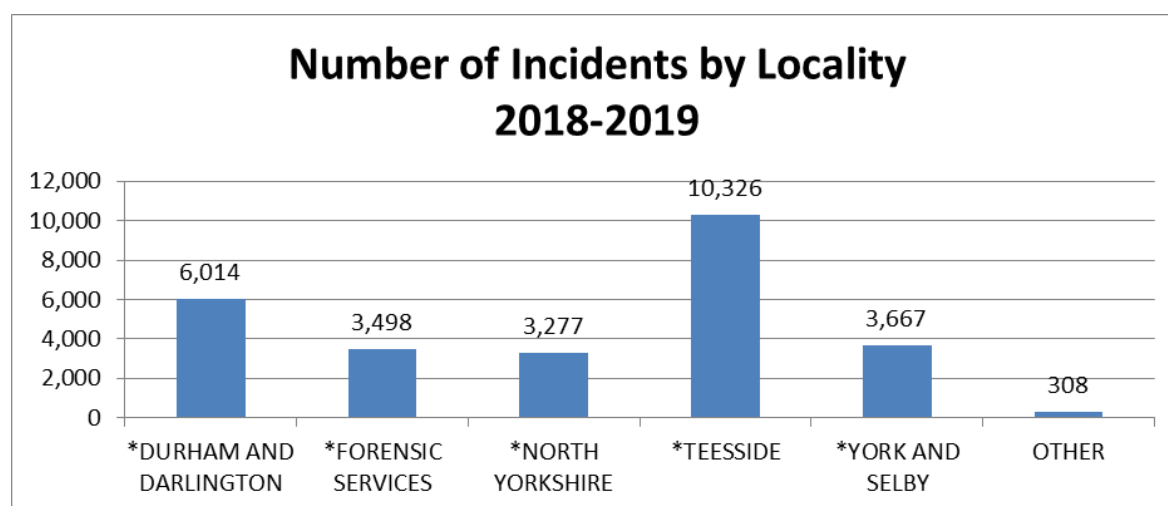
The SPC Chart (Trust) below shows the total number of Incidents reported for a rolling 24 months period:



The SPC Chart above shows that the process for incidents raised within the Trust is stable and in control (within normal variation) although May and July 2018 were close to the outer process limit.

**Appendix 1** of the report provides a locality specific SPC charts covering the same 24 month period. Rule breakages can be observed with regards to Durham and Darlington (between the period of February 2018 to August 2018); Tier 4 CAMHS (between the period of May 2018 to November 2018); and Forensic Services (between the period of June 2018 to December 2018).

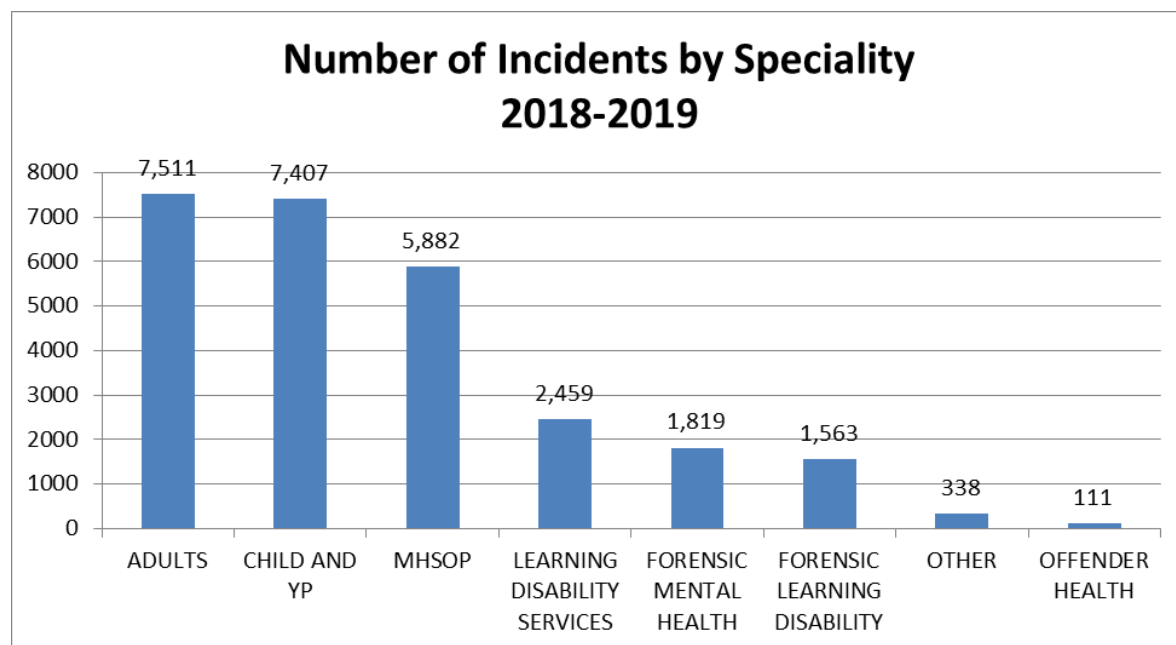
The Table below shows the total number of incidents reported by each locality:



NOTE: - \* Includes Management Teams

Teesside reported the highest number of patient incidents with **10,236** followed by Durham & Darlington with **6,014** incidents. Teesside locality has the most inpatient beds and the only Tier 4 CYPS beds which accounts for the increased numbers.

The table below shows the total number of incidents reported by speciality;



'Other' includes corporate teams.

Adult Mental Health Services reported the highest number of incidents during 2018/19 with a total of **7,511**. This was closely followed by Child and Young People who reported **7,407**. The numbers reported reflect predominantly (although not exclusively) in-patient services particularly for AMH and MHSOP. Of the **5,882** MHSOP Incidents **707** of these incidents related to Liaison & Diversion.

**Appendix 1** of the report provides an SPC chart by speciality. Rule breakages can be observed with regards to 7 sequential points that fell above the mean for the following:

- Children and Young People (May 2018 to November 2018)
- Mental Health Services for Older People (December 2017 to June 2018)
- Learning Disabilities (June 2018 to December 2018).

In addition Forensic Services and Offender Health highlighted 7 sequential points that had fallen below the mean (June 2018 to December 2018).

### Incidents per 1,000 OBD – Inpatient incidents only

The following section uses the incidents recorded against each locality with occupied bed days (OBD) to allow a like for like comparison against the other localities across the Trust.

Locality	13 Month Locality Rate	Adults	Child and YP	LD Services	MHSOP	Forensic LD	Forensic MH
Durham & Darlington	60.26	55.25	136.09	369.37	46.12	-	-
Forensic Services	45.13	-	-	-	-	67.83	35.48
North Yorkshire	58.66	45.58	-	-	75.15	-	-
Teesside	116.90	35.25	456.61	60.43	63.42	-	-
York and Selby	118.58	86.78	-	467.32	87.79	-	-
<b>Trust 13 Month Rates</b>	<b>76.12</b>	<b>49.05</b>	<b>430.79</b>	<b>156.74</b>	<b>66.51</b>	<b>67.83</b>	<b>35.48</b>

The above table highlights that CYPS and LD services report more incidents per occupied bed day than the Trust average of **76.12**.

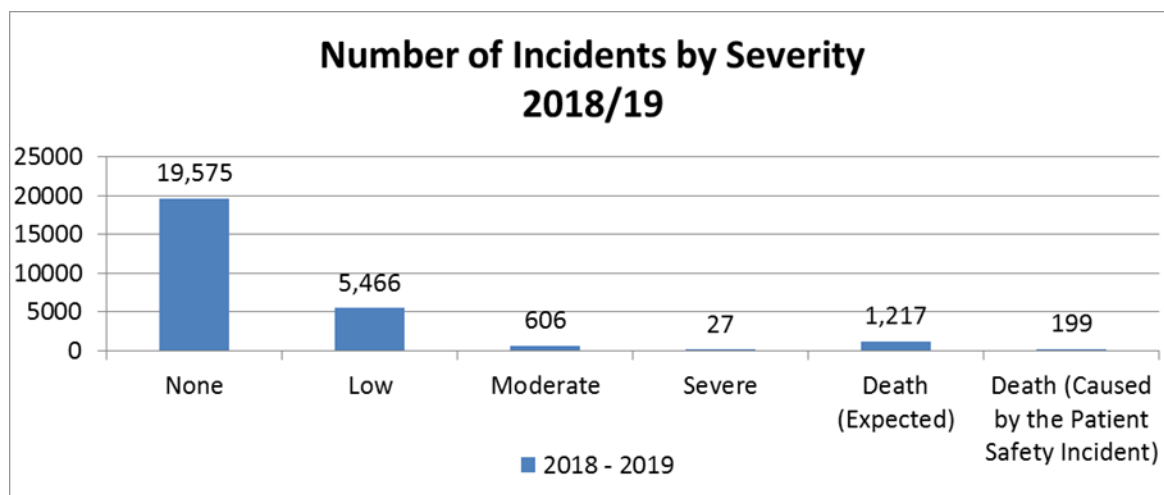
### Incidents per 1,000 caseload

The following section uses the incidents recorded against each locality compared to caseload to allow a like for like comparison against the other localities across the Trust.

Locality	13 Month Locality Rate	Adults	Child and YP	LD Services	MHSOP	Forensic LD	Forensic MH	Offender Health
Durham & Darlington	6.68	6.22	7.60	4.81	7.49	-	-	-
Forensic Services	31.71	-	-	-	-	32.12	-	32.49
North Yorkshire	11.66	6.73	34.64	10.91	9.01	-	-	-
Teesside	7.73	9.74	2.46	11.24	10.41	-	-	-
York and Selby	10.38	11.22	6.17	14.97	13.98	-	-	-
<b>Trust 13 Month Rates</b>	<b>8.28</b>	<b>7.78</b>	<b>7.66</b>	<b>7.60</b>	<b>9.21</b>	<b>32.12</b>	<b>0.00</b>	<b>32.49</b>

The table above highlights that overall the Forensics locality and MHSOP report more incidents per open caseload when compared to the Trust average of **8.28**

The chart below shows the total number of incidents reported by severity:



The vast majority of the incidents reported within the Trust have been defined as 'None' (no harm) **19,575** (72.26%). For the **1,443** incidents categorised as either 'severe' or 'death (caused by the Patient Safety incident)' **142** (9.84%) were defined as Serious Incidents.

The top 10 highest reported incident types within the trust were categorised as shown in the table below:

Top 10 Reported Categories	QTR1	QTR2	QTR3	QTR4	2018 - 2019
Behaviour	3,120	2,757	2,788	3,022	11,687
Behaviour (Including Violence and Aggression)	922	815	1,002	1,179	3,918
Nutrition Pharmacy Products	547	833	566	28	1,974
Patient Accidents/Falls	420	416	473	440	1,749
Administrative Processes (Excluding Documentation)	376	365	336	431	1,508
Unexpected Deaths or Severe Harm	360	340	344	381	1,425
Medication/Biologics/Fluids	392	379	291	276	1,338
Security of Organisation's Property, Data and Buildings	201	179	244	200	824
Exposure to Environmental Hazards	111	111	116	103	441
Diagnostic Processes/Procedures	132	91	69	72	364
	<b>6,581</b>	<b>6,286</b>	<b>6,229</b>	<b>6,132</b>	<b>25,228</b>

Behaviour incidents were the highest category with **11,687** incidents being reported. The second highest category was Behaviour (Including Violence & Aggression) equating to **3,918** incidents.

Incidents categorised as 'Behaviour' only relate to those in which a patient has been affected by the incident and include 'inappropriate/aggressive behaviour', 'missing patients', 'self-harming behaviour', 'patient refusal of diagnostic/therapeutic interventions', 'patient restraint processes', 'persons performing unauthorised acts' and 'use or possession of prohibited or stolen goods'.

The incidents categorised as 'Behaviour (including Violence and Aggression)' are those in which Staff/Contractors have been affected by the incident. There are 5 sub-categories that fall under this and examples include 'inappropriate/aggressive behaviour', 'persons performing unauthorised acts' and 'use or possession of prohibited or stolen goods'.

It is important that when looking at the incident process that we also consider the timeliness of reporting, reviewing and approval of incidents. This process is managed by the central approval team where greater emphasis can be given to this process.

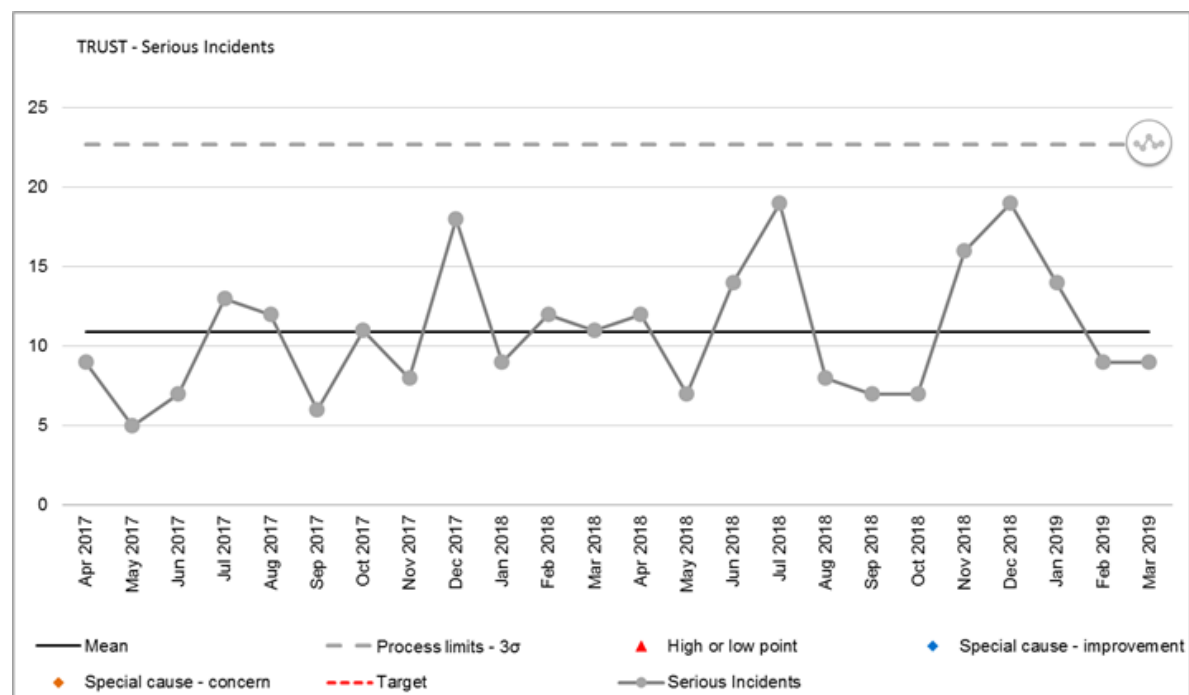
Within the reporting period from the incident occurring to it being reported is on average taking **2** days. In terms of when the incident has been reported to it being finally approved has taken on average **8** days. This is largely due to the year on year increase in the number of incidents being reported by staff which is a positive thing but may require additional resource to manage in a timelier manner.



## 2. Serious Incidents

There were a total of **142** serious incidents recorded across the Trust during 2018/19. This is an increase of **12** when compared to the same period during 2017/18 where there were **130** serious incidents recorded.

The SPC Chart (Trust) below shows the total number of Serious Incidents reported for a rolling 24 months period:

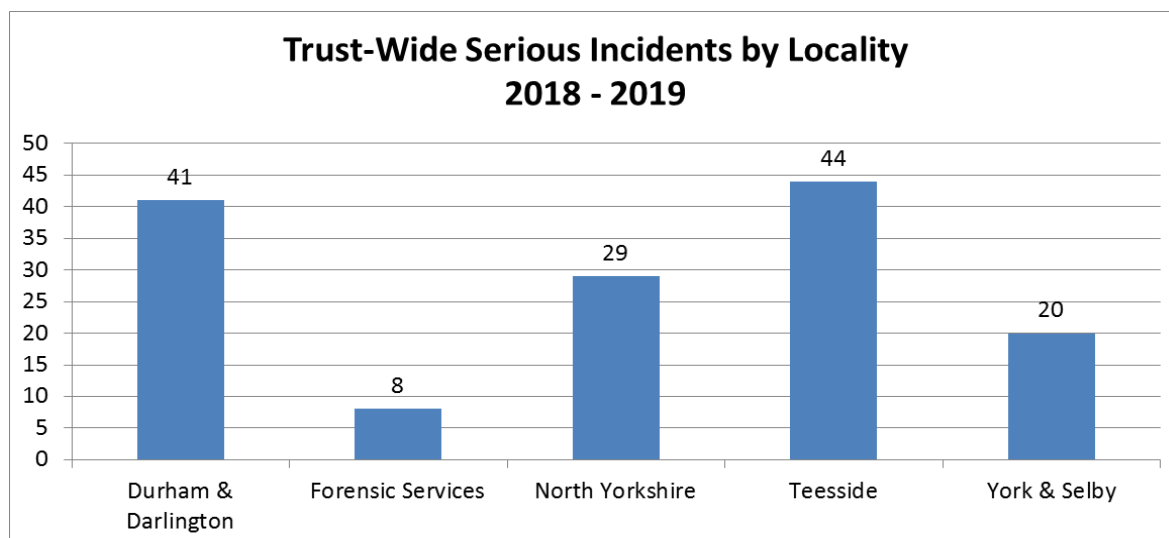


The SPC Chart above shows that the process for Serious Incidents raised within the Trust is stable and in control (within normal variation).

**Appendix 1** of the report provides Locality / Speciality specific SPC charts covering the same 24 month period.

- Durham and Darlington showed a high point in December 2018 of **11**.
- Forensic Services showed a Highpoint in October 2017 of **3**.
- Teesside showed a highpoint in March 2019 of **7**.

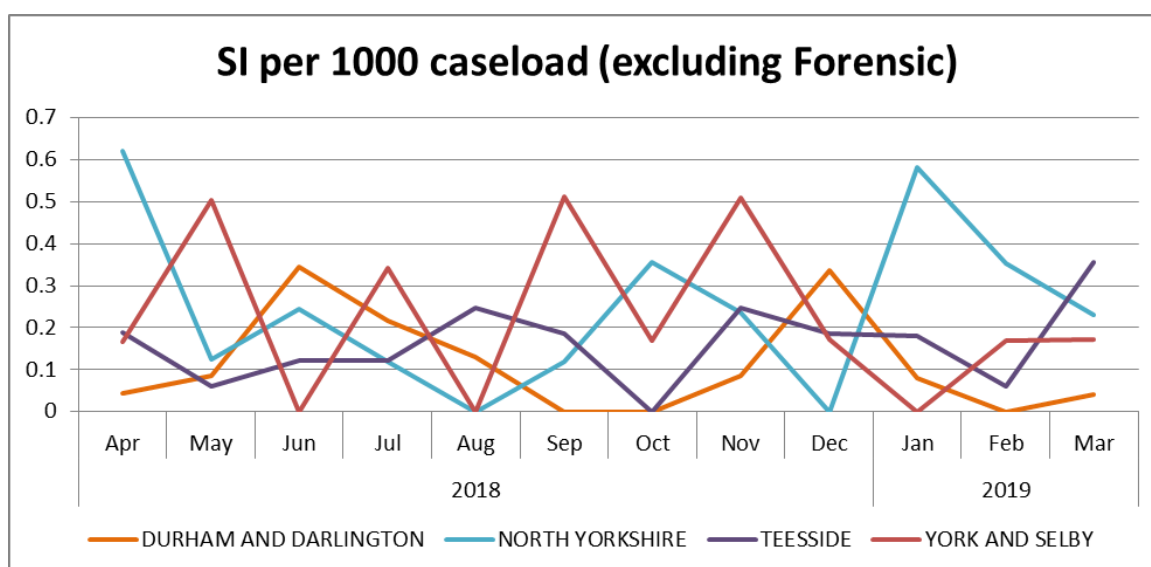
The breakdown of serious incidents by locality for 2018/19 is shown in the chart below as follows:



Of the **142** serious incidents reported for 2018/19 Adult Mental Health Services reported the most Serious Incidents with **93** (65.49%) being reported during the reporting period, MHSOP reported **34** (23.94%), CAMHS reported **6** (4.23%) SI's, Offender Health reported **7** (4.93%) with both Forensic Learning Disabilities and Learning Disabilities Service reporting **1** (0.70%) SI's in the reporting period.

Of the 34 MHSOP serious incidents **9** (26.47%) relate to Liaison and Diversion Teams across the Trust and the other **25** related to Older People's Services.

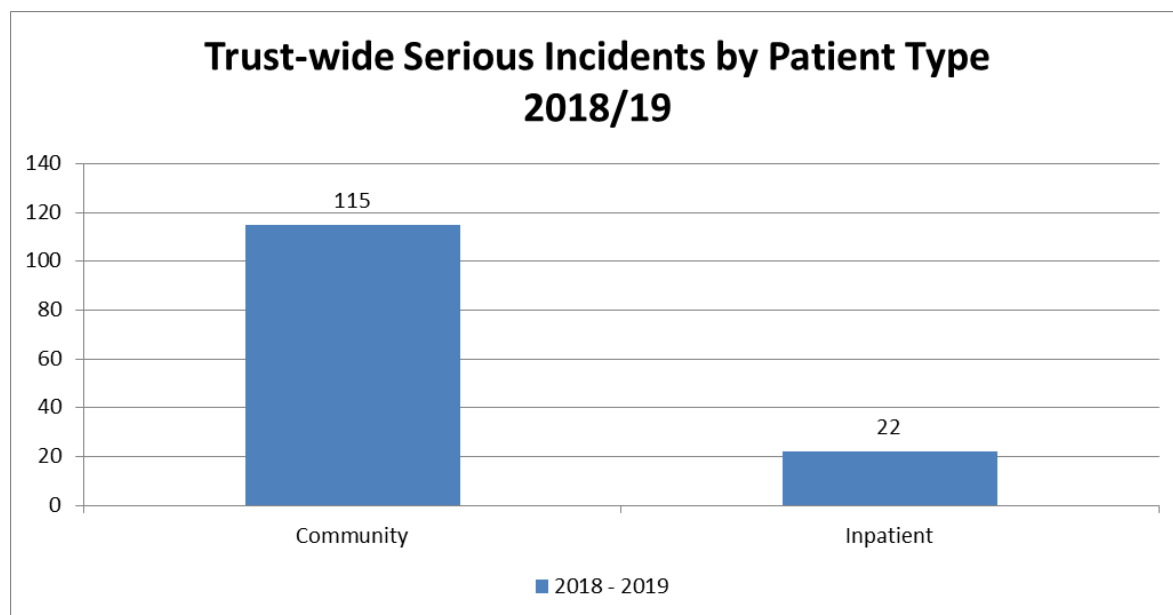
When the SI's are presented as a percentage of open caseload the locality position changes to make North Yorkshire the highest and Durham & Darlington the lowest (see chart below).



*(Forensics is excluded from this as the low numbers of patients in the service distorts the figures).*

**Appendix 1** of the report provides speciality specific SPC charts covering the same 24 month period. Child and Young Persons showed a high point in February 2019 of **2**, with Forensic LD / Offender Health showing a Highpoint in October 2017 of **2**.

The type of patient at the time of the serious incident is outlined as follows:



The majority of the serious incidents were from patients who were receiving treatment from our community teams **115** (80.99%) in total, this can be broken down further by speciality as follows:

- Adults being the highest reporting area with **84** Serious Incidents
- MHSOP **19**
- Offender Health **7**
- Child and YP **4**
- LD Services **1**

Those serious incidents occurring from patients who were receiving treatment from our inpatient services equated to **22** (15.49%) in total. This can be broken down further by speciality as follows:

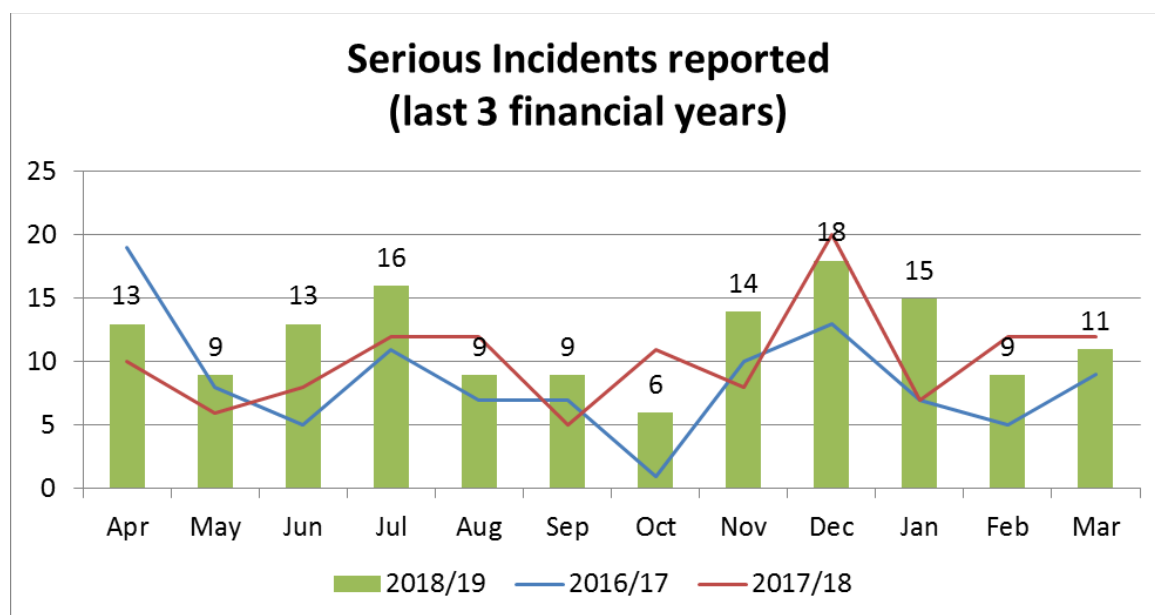
- MHSOP **14**
- Adults **5**
- Child and YP **2**
- Forensic LD **1**
- Other **5**

Of the **142** serious incidents reported during the reporting period, **2** occurred when the service user was on a period of planned leave.

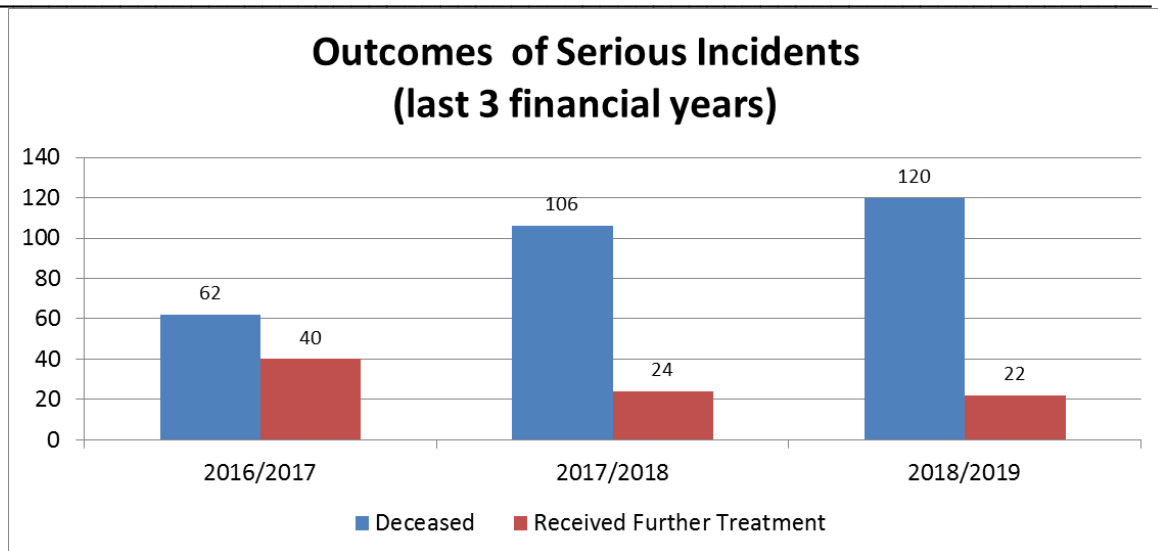
The ethnicity of those involved in a serious incident during the reporting period has been reviewed as follows:

Ethnicity	Total Number
Asian / Asian British / Pakistani	1
Black / Black British / Other	2
Mixed – Other	1
White – British	128
White – Other	2
Not stated	8
<b>Total</b>	<b>142</b>

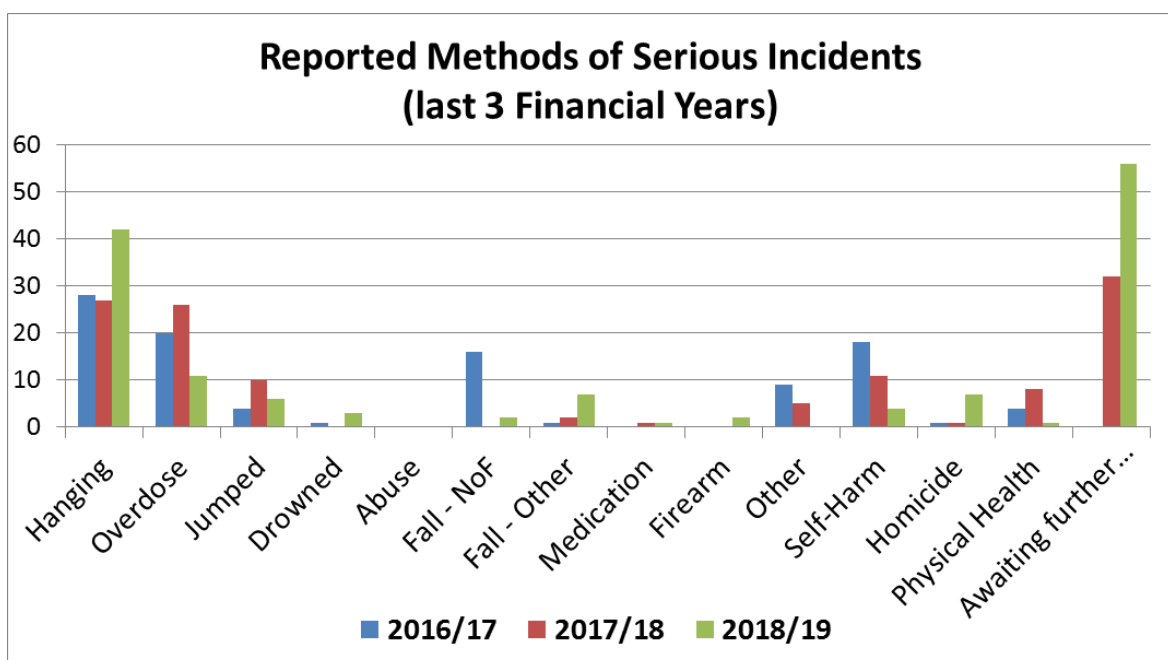
The following information has been collated from analysis of the serious incidents that have occurred during the last 3 financial years:



The chart above shows that there are 5 months whereby the numbers reported in 2018/19 has exceeded those from previous financial years with common trends in activity.

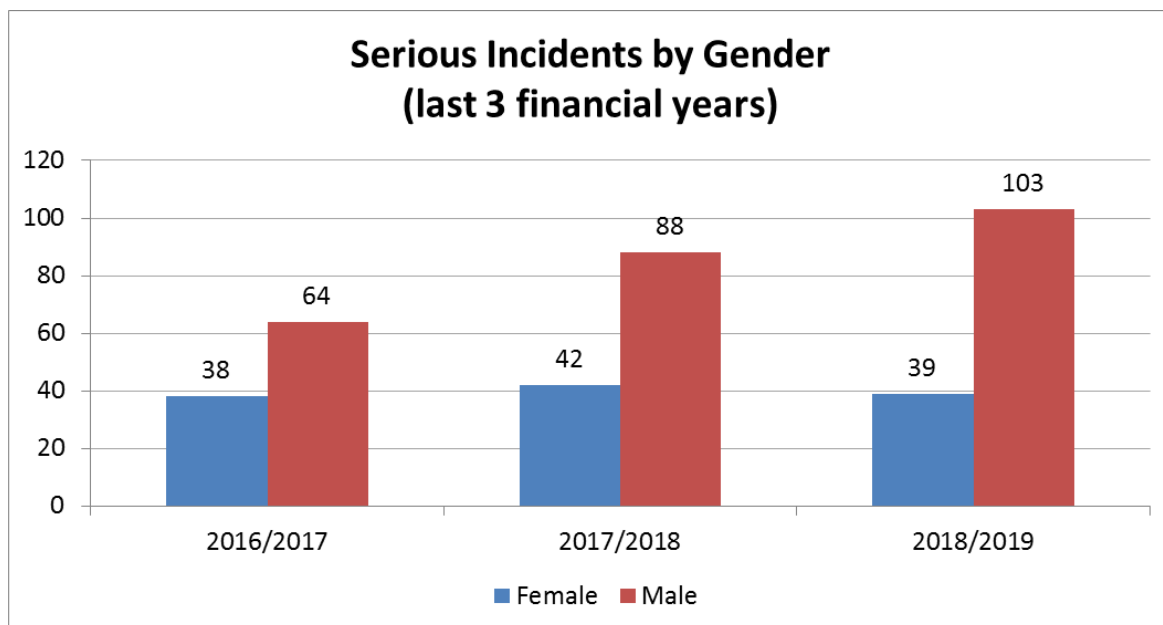


The chart above shows the categories of serious incidents which resulted in death versus those that did not during the past 3 financial years. This shows that the proportion of incidents which do not result in death (shown in red) has decreased during the reporting period. From the 142 serious incidents reported in 2018-19 the Trust is reporting a total of **22** (15.49%) incidents that did not result in death at the end of the financial year 2018/19. This compares to **24** (18.46%) incidents that did not result in death reported during 2017/18.

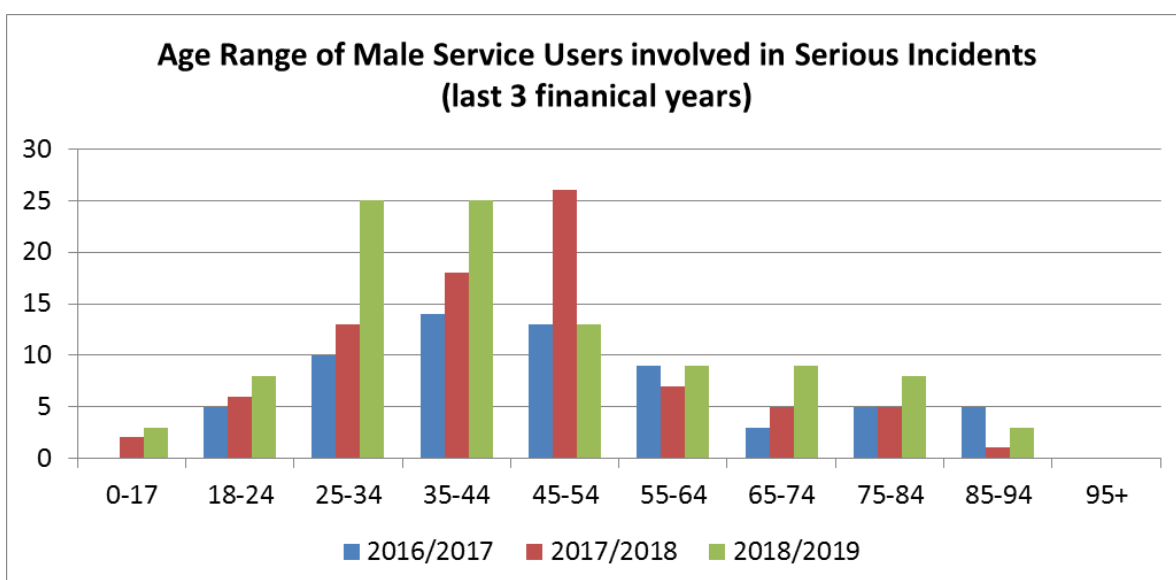


The Chart above shows the categories of serious incidents over the past 3 financial years. Hanging is consistently the most common method of suicide with **42** in 2018-19 closely followed by overdose with **11**. This mirrors the findings from the latest National Confidential Inquiry report. At the time of writing this report the

Trust await further information relating to the confirmed method/cause of death regarding **56** Serious Incidents.

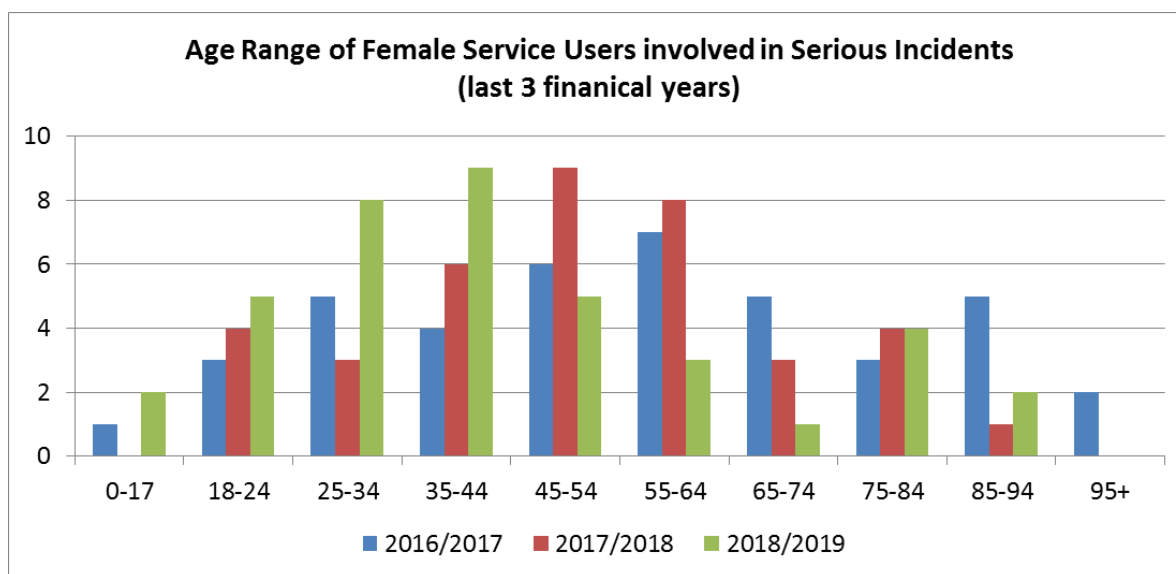


The chart above shows the split by gender for serious incidents reported. There was an increase of **15** serious incidents relating to males reported during the Financial Year 2018/19 compared to those reported in 2017/18. Of the **142** Serious Incidents reported in 2018/19 **93** resulted in Death (65.49%).



The chart above looks at the male age range. Within the Financial Year 2018/19 the most common age group for males were 25-34yrs and 35-44yrs both with **25**

SI's reported. These are followed by the 45-54yrs age group where **13** SI's have been reported during the same period. Of the 25 incidents in the 25-34yrs age range **13** resulted in Death. For the 35-44yrs age range **19** incidents resulted in death. The 2018 National Confidential Inquiry data shows the national trend for male age range to be 45-54yrs which suggests the Trust is currently following that pattern.



The chart above shows that during the reporting period 2018/19 there were **9** SI's reported against the age group 35-44yrs of which all **9** resulted in deaths, and there were **8** reported against 25-34yrs of which **3** resulted in death.

### 3. Patient Safety Alerts

Patient safety alerts are issued via the Central Alerting System (CAS), a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care.

During the reporting Financial Year 2018/19 the trust has received **81** alerts which is a decrease of **23** when compared to the same period 2017/18 where there were **104** alerts. Action was not required for the majority (79%) of these alerts and where action was required it was carried out accordingly. Details of the alerts received which required Trust action during the reporting period can be found at **Appendix 2**.

### 4. Patient Safety Team KPI's

The introduction of the upgraded Datix system in October 2015 has enabled robust systems to record key patient safety activity. In turn this has been translated into specific measurable indicators whereby the performance of the

patient safety team can be monitored. From October 2015, 4 key metrics have been reported monthly to the Patient Safety Group and are listed below:

- Percentage of SI's that are reported on STEIS within 2 working days -
- Percentage of initial reports received within 3 working days (72 hours) for all SI's to be reported onto STEIS
- Percentage of action plans forwarded to CCG's within 60 days (unless extension agreed)

**Appendix 3** provides a monthly breakdown of the Trust's compliance against the KPI's listed above during financial year 2018/19.



## Part 2 – Learning

### 5. Learning from Incidents

This section of the report summarises the themes from the 144 Serious Incidents (SI's) that were completed and signed off by the TEWV Directors panels during 2018/19. The numbers, therefore, will not correlate with those *reported* during the same time period as the reports from the beginning of the financial year will have been incidents that occurred in the previous year and those reported at the end of the year would not yet have been completed.

The findings discussed within this report relate to contributory and root cause findings only. **Appendix 4** provides a trust wide overview of the incidental findings or learning points (smaller issues picked up during the course of the investigation which had no bearing on the incident occurring) from 2018/19.

Locality	Total no of SI reports completed in 2018/19	Total no of SI reports with actions*	No of separate contributory findings	No of separate root causes
Teesside	41	6 (15%)	9	4
Durham & Darlington	46	13 (28%)	24	4
York & Selby	23	14 (61%)	25	4
N Yorks	34	8 (24%)	17	-
Total	144	41 (28%)	75	12

\*these actions are those classed as contributory or root cause only

The above table shows the total number of SI's completed during 2018/19 for each locality and of these, the number that required action plans. Proportionately York & Selby have a significantly higher percentage of reports resulting in actions followed by Durham & Darlington, North Yorkshire and Teesside; this is consistent with last year's findings.

#### Duty of Candour

The formal statutory requirement of the Duty of Candour was applied in 41 of the 144 serious incident cases (28%) which were signed off by Directors Panel during 2018/19.

#### Themes

The themes from all of the action points have been gathered and are summarised in the following table.

Root Cause or Contributory Findings	Tees	D&D	Y&S	North Yorks	Combined Total
Inadequate risk assessment, formulation, intervention planning, management	7	17	15	10	49
Failure to follow procedure/policy/pathway	1	-	1	2	4
Communication/information sharing issues	1	4	2	1	8
Physical health deterioration/recognition of symptoms	2	-	-	-	2
Family Involvement	-	1	1	-	2
Access to services/referral	1	-	2	-	3
Poor record keeping	-	1	-	-	1
Medicines Management	-	-	-	-	-
Delay in accessing treatment	-	-	-	-	-
Staffing issues	-	-	3	1	4
Training	-	-	2	1	3
Multi-agency working	-	2	1	2	5
Post incident response/management	-	1	-	-	1
Insufficient/incomplete discharge process	1	2	2	-	5
<b>Total per locality</b>	<b>13</b>	<b>28</b>	<b>29</b>	<b>17</b>	<b>87</b>

The most common finding overall from all Serious Incidents in the period relates to the risk assessment, formulation and intervention planning which remains consistent with last year's findings.

The second highest category relates to communication and information sharing issues, however, the number of findings relating to this category have slightly reduced in comparison to the previous year. The second highest category in 2017/18 was failure to follow policy/procedure/pathway with 19 incidences being identified; this year's data shows that this has significantly reduced to only 4 incidences being identified.

### **For actions relating to risk assessment, formulation and intervention planning (and family involvement)**

Harm Minimisation is mandatory training for all clinical staff of all specialities. The face to face training is continuing, supported by one hour safety summary training with dates available into 2020. The training incorporates the principles of trauma

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informed care, recovery and force reduction. It emphasises the importance of shared decision making and family involvement during the risk assessment process as well as with formulations and intervention planning. The Harm Minimisation Lead has also agreed to deliver bespoke training for any teams that require it.

A recent audit of the Safety Summary on PARIS has been carried out by the Clinical Audit Team in conjunction with the Harm Minimisation Lead. The aim was to assess compliance with completion of the tool and to establish the level of service user/carer involvement in the process. Early indications are that although service user and carer involvement is not always evidenced in the safety summary, clinical records indicate that there has been involvement. This issue together with the quality of information contained in the Safety Summary will be addressed in the action plan.

Any findings from serious incident investigations relating to risk assessment/use of safety summaries are fed back to the harm minimisation lead on a monthly basis to enable these to be disseminated to clinicians trust wide during the face to face training sessions. Similarly, findings from serious incident investigations relating to risks in the context of safeguarding are considered for incorporation to mandatory training; the most recent example being the importance of multi-agency working when dealing with potentially dangerous patients.

In April 2019 a 3 day event was held by the Trust's Medical Director which considered the theoretical framework for a 'Single Plan' which included a review of the risk assessment tool (safety summary). The Trust's aim is to create an 'individualised' formulation which is produced with the service user/carer and provides a detailed understanding of potential factors that contribute towards harms and are recovery focussed. It is envisaged that developments around the Electronic Care Record system (CITO) and the use of DIALOGUE will also make a difference to the assessment of risks, formulation and intervention planning.

Work undertaken in relation to the triangle of care Trust-wide has facilitated greater involvement of families in risk assessments, formulation and intervention planning. Where patients specifically state they do not want families present at these events, a proforma has been devised for relatives to complete to enable their views to be incorporated into discussions. National accreditation was achieved by in-patient services in 2018, and community services hope to be accredited in 2019. External audits are also planned twice a year.

Staff are being encouraged to provide a link to the Zero Suicide Alliance's free suicide awareness training to families where considered appropriate.

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### **For actions relating to failure to follow policy**

For any instances whereby an individual staff member has been found to be not following policy, targeted supervision and training will be implemented as part of the action plan. In teams where particular issues have arisen with regards to policy non-compliance a series of spot checks will be undertaken for a number of months to ensure the issue has been resolved. These will be undertaken by a variety of staff such as Heads of Nursing, Modern Matrons or the Clinical Audit Team. Occasionally it is found that a policy needs to be amended or strengthened following an incident and in such cases this would be quickly cascaded through the SBARD process and then followed up by locality management to ensure all staff members are aware.

During 2018/19 the main policies which were not always adhered to were:

- Did Not Attend policy (DNA)
- Clinical Record Keeping policy
- Clinical Supervision policy
- Engagement & Observation policy

The DNA policy has recently been reviewed and a revised copy drafted; it is now renamed the Did Not Attend/Was Not Brought Policy. As well as Trust wide consultation, members of the Trust's Patient Safety Group have been requested to review the policy; it will then be forwarded to EMT for ratification.

One of the themes identified in the 2016/17 report was inadequate leave planning. A key piece of work was undertaken across the Trust to remind clinical staff of their responsibilities in relation to this – it included immediate SBARD, training for all registered nurses and a policy refresh. As leave did not appear on the list of themes identified for 2017/18 it appeared that shared learning from these incidents had been successful. Mental Health Act visits have recently raised issues around Section 17 leave; a member of the compliance team together with a member of the Patient Safety Team have been tasked to identify what these issues are and to identify actions required.

### **For actions relating to communication/information sharing**

This can be a multi-faceted issue as our services interact with many external agencies and providers notwithstanding the fact that we also have communication issues between internal teams. Some of the issues that have arisen in this area are:

- Lack of multi-agency working when dealing with potentially dangerous individuals

- Omitting to obtain contact details for relevant others involved in a patient's care
- Incorrect GP details recorded/not updated on initial contact therefore key information not shared with relevant agencies
- Pertinent patient information being held on other organisations systems that staff do not have access to or cannot access quickly if a person is in crisis
- All appropriate staff are not always present at discharge meetings which means they do not have access to all required information
- GP's not being updated in a timely manner when we have changed a person's medication (and vice versa)
- Safeguarding information not being shared with the Trust Safeguarding Lead and/or directly with the Local Authority Safeguarding Team
- No evidence of the consideration of the involvement of other agencies in a person's care/life such as drug & alcohol services, probation services, local authority

When a communication issue is so significant that it is classed as a contributory finding or root cause to a serious incident then it will form part of the formal action plan and be addressed accordingly with all involved parties.

### **Shared learning**

It is expected that each team involved in a Serious Incident Review will share the learning points in team meetings and/or supervision and this will also be discussed in the locality management meetings. For any urgent issues that need to be shared across the organisation rapidly the SBARD process is adopted. Patient Safety bulletins are also circulated with key lessons learned for staff (see section below).

### **Further work on themes and dissemination of learning**

A learning event will take place in July 2019. A scoping session to prepare for this event is to be held on 01/07/2019 with a full day event to follow soon after. Attendees will include the patient safety team, complaints, safeguarding and workforce; a coaching approach will be utilised. The aim of this event is to better understand how learning takes place across the Trust and how we use lessons learnt to change practice and then embed the learning.

### **Patient Safety Bulletins and SBARD's**

Due to the vast geographical nature of the Trust there is a requirement to use various methods of communication to share learning when incidents happen and try to prevent them from re-occurring. Two of the ways we do this are to issue Patient Safety bulletins and SBARD alert notices – during 2018/19 the following topics were covered in this way:

The importance of incident reporting	Triangle of care
Family & carer involvement	Access to medical records
Minimum standards for record keeping	Engagement and Observation procedure
Pressure ulcer risk assessment	Use of historic information in risk

	assessment process.
Transfers of care	Coroners warning regarding Clozapine prescribing

Many of the above areas are also the subject of clinical audits which allows us to monitor the effectiveness of sharing information in this way.

## **6. Mortality Reviews & Learning from Deaths**

In September 2017 the Trust Board ratified the ‘Learning from Deaths’ policy which sets out the Trust’s intentions towards mortality reviews, learning from deaths and family engagement.

Representatives from the Trust attend the regional Mortality Alliance Group which is working towards achieving consistency in reporting deaths in the Northern region as well as sharing learning via thematic reviews.

The Trust’s Patient Safety Group currently reviews all expected deaths of service users on CPA (other than those that result in an SI); a member of the Patient Safety Team will then carry out a structured judgement review where requested. The findings are taken back to the Patient Safety Group for discussion and agreement of any learning to be shared (including good practice).

During 2018/19 there was a total of 204 mortality reviews undertaken compared to 108 in 2017/18.

The criteria used for selecting which expected deaths are reviewed is currently being reviewed to ensure that the opportunities for learning are maximised. It is also envisaged that by October 2019, clinical areas will start to undertake structured Judgement reviews to enhance learning and to facilitate more involvement with family members. These changes will be incorporated into the ‘Learning from Deaths’ policy which is due for review in October 2019.

The most notable learning point from the reviews so far is that of good practice/care and this has been fed back to the teams involved. Emerging areas for improvement would appear to be similar to those from some of the incidental findings from our serious incident investigations (communication to/from GP, family involvement, early warning score monitoring and multi-agency working).

## **8. Recent developments**

The first annual conference for families bereaved by suicide went ahead in March 2019. The conference was well attended by both families and clinicians. An

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information booklet for families bereaved by suicide received its final consultation during this event and is currently being piloted for 6 months prior to further review. One of the actions from the conference has been to appoint a family liaison officer to improve the support provided to families bereaved by suicide.

Following a Kaizen event, the serious incident investigation process has been streamlined. A new process, which has been piloted in North Yorkshire, facilitates improved involvement/communication between the PST and clinical services during the investigation process. The new process will be rolled out across the remainder of the Trust over the next 12 months.

## **8. Conclusion**

The report highlights activity and learning in relation to Patient Safety for 2018/19. There were 142 Serious Incidents reported in total which is an increase of 12 on the previous year.

The most common themes from the 144 Serious Incidents reviewed in the year were:

- Inadequate risk assessment
- Communication/Information Sharing
- Multi-agency working

The locality with the highest proportion of reports with root causes and/or contributory findings was York & Selby with 61% which is consistent with last year's findings although has reduced. The percentage of reports requiring a formal action plan within North Yorkshire, Teesside and Durham & Darlington has reduced.

Work continues to refine our mortality review processes, enhanced family engagement and the Trust will also be considering emerging themes from the latest National Confidential Inquiry report during 2018/19 to ensure we are providing the safest possible care based upon the best available evidence.

**Jennifer Illingworth**  
**Director of Quality Governance**  
**June 2019**

**Appendix 1:**

***SPC Charts by Directorate / Locality***



Appendix 4 - SPC Charts - Directorate 2018



Appendix 4 - SPC Charts - Locality 2018

**Appendix 2:**

***Patient Safety Alerts 2018/19***



Appendix 2 - Patient Safety Alerts - 2018-19

**Appendix 3:**

**Patient Safety Team KPIs**

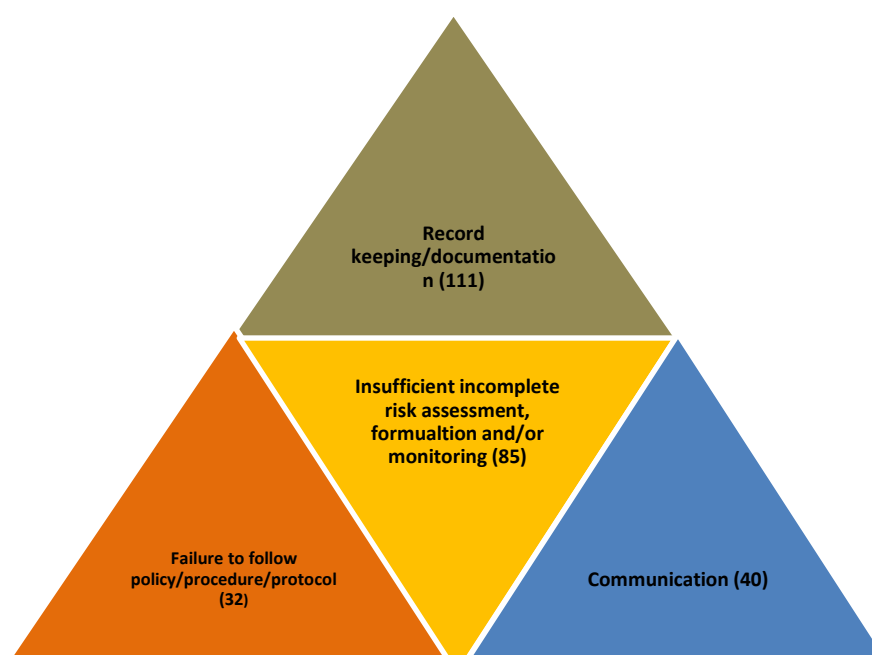
Metric	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018-19 YTD
		%	%	%	%	%	%	%	%	%	%	%	%	%
All serious incidents to be reported on STEIS within 2 working days of a serious incident being identified, in line with NHSE SI Framework.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
All initial reports received within 72 hours (3 working days) of all SIS reported onto STEIS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
A detailed and comprehensive action plan is required within 60 days of reporting on STEIS	100%	67%	83%	79%	88%	75%	75%	90%	86%	100%	100%	90%	75%	84%
Number of unexpected deaths classed as a SI per 1,000 cases Trust	Numerator	10	7	13	12	8	9	4	11	15	10	8	11	118
	Denominator	53761	54215	54623	54411	54183	54677	55233	55340	55416	55944	56551	56993	661347
	Rate	0.19	0.13	0.24	0.22	0.15	0.16	0.07	0.20	0.27	0.18	0.14	0.19	0.18



**Incidental Findings Overview 2018/19**

**Trust wide summary of Incidental Findings**

Between April 2018 and March 2019 there were **144** Serious Incident reports completed, approved by Directors panel and submitted to Commissioners which included incidental findings. There were a total of **383** incidental findings from the 144 reports which fall into the following 4 main categories:



Incidental findings are minor issues which are picked up as part of the investigation process that need to be learnt from however did not directly contribute to the incident occurring.

These findings are shared in each locality with key messages via the LMGB meeting. The idea is that they are discussed and then cascaded to Ward/Team Manager level so the information can be shared across all services via team meeting discussions. This is a simple way of sharing learning across the organisation.



**ITEM NO. 11**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Analysis of Waiting Times</b>
<b>REPORT OF:</b>	<b>Ruth Hill Chief Operating Officer/ Sharon Pickering Director of Planning, Performance and Communications</b>
<b>REPORT FOR:</b>	<b>Information and discussion</b>

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

<b>Executive Summary:</b>
<p>The purpose of this report is to provide the Board with a further update analysis of the Trust wide position on the Waiting Times indicators.</p> <p>The report highlights the position for each locality and each specialty within that locality against the 4 week access and 6 week treatment KPIs. It provides some information in terms of factors impacting on performance in addition to actions that have been taken since the previous Board report and are planned in order to improve performance.</p> <p>The report identifies a number of issues for the organisation around waiting times. There are locality differences in terms of performance and there is ongoing work to ensure that we are working towards meeting these targets. There continue to be challenges in meeting the targets which are often linked to staffing pressures and referral increases. In some areas there has been further investment in services which should impact on the position which will be monitored closely to assess the impact on waiting times.</p>

**Recommendations:**

The Board is asked to:

- Discuss and comment on the report.
- Identify any further actions it would like to be addressed
- Consider if it requires any further information.

<b>MEETING OF:</b>	<b>Board of Directors</b>
<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Analysis of Waiting Times</b>

**1. INTRODUCTION & PURPOSE:**

1.1 The purpose of this report is to present to Board a further update and analysis of the Trust wide position on the Waiting Times indicators.

**2. BACKGROUND INFORMATION AND CONTEXT:**

2.1 The Board received a report outlining the waiting times analysis in March 2019. It was agreed that a further update would be presented to the Board in six months' time to consider the ongoing issues around waiting times and reassess actions which had been undertaken during this period.

2.2 The two indicators in question are:

- %age of people seen within 4 weeks following an external referral (Note that in line with other NHS Mental Health Waiting Time targets DNA no longer 'stop the clock' for this indicator). Referred to as '4 week wait' in the rest of this report.
- %age of people starting treatment is considered to have started when a treatment intervention code is added to PARIS for the first time). Referred to as 'Wait for treatment' in the rest of this report.

2.3 In preparing this report the figures for each locality by speciality have been produced and analysed. Localities have provided narrative in terms of the issues they are facing and what work they have done and have planned in order to try to ensure performance is improved wherever possible. The data set covers the period up until June 2019.

**3. KEY ISSUES:**

**3.1 Trust Wide Position**

The performance at Trust level for the two indicators is given in **Appendix 1**. For the 4 week wait target from April 2016 the decline in performance noted at Jan 2019 has not continued but there has been fluctuating performance up until June 2019. In terms of the wait for treatment indicator there has

been a steady improvement in performance with a seasonal dip in January 2019. It can be seen from Appendix 1 that the number of unique referrals received in the Trust has increased steadily over the three years. Clearly this will have an impact on the ability to respond to those referrals in 4 weeks and to start treatment within 6 weeks.

- 3.1.1 On drilling down into the locality position for both indicators **Appendix 2** shows that the locality of North Yorkshire and York continue to be challenged in meeting the targets. It should be noted that following the merger of the localities there is now a single report. Durham and Darlington continues to have variable performance in meeting both waiting times targets albeit there are positive signs around improvement for the six week target. Teesside continue to achieve the 4 week target and have improved performance against the wait to treatment target, however, CYP pressures are emerging and will need to be monitored for this impact on waiting times.
- 3.1.2 A number of factors were identified in each locality around the reasons for the performance position and the March Board paper outlined some of the actions that was being undertaken to address this position. The localities have provided a further update on the actions undertaken and progress to date. It is of note that there continues to be challenges around staffing which has impacted on some services, however, some areas have identified additional investment plans which will be monitored closely to assess the impact on waiting times.
- 3.1.3 As part of the review it has been noted that there have been a number of capacity and demand assessments undertaken in localities and specialties. It has been agreed that there will be a standard Trustwide approach to this analysis to enable consistency and read across different areas. Stockton CAMHS services are testing this model and approach.

## **3.2 Locality Positions**

### **3.2.1 North Yorkshire & York**

North Yorkshire & York is the locality that has the greatest challenge in achieving the two waiting times targets. For the four week wait the areas of particular concern are AMH, MHSOP and CAMHS services. All three specialties have been under target in Q1 2019/2020.

The CAMHS headlines are:

- 4 week waiting time stands at 86% for June.
- The wait to treatment indicator is below target since Feb 2019 (44% at June 2019).
- Increasing numbers of unique referrals.

The service has identified a number of influencing factors around its performance including:

- The changing experience and expertise of its workforce within the Single

Point of Access which has led to changes in time taken to undertake assessments and different thresholds for face to face assessments.

- Recruitment to vacancies is being undertaken – full recruitment is anticipated by October 2019.
- Discussions with commissioners around further improvements around the service model are being undertaken.

For AMH the performance issues are:

- AMH 4 week wait has been consistently under target ranging from 69% to 80% over the last 12 months.
- The number of unique referrals for AMH showed a declining trend from April 2016 however, there have been increases in numbers of unique referrals in Q1 2019/2020.
- AMH has seen steady improvement in Q1 against the wait for treatment indicator and achieved the target in June 2019 from a previously static position over the previous 3 years.
- There has been further work to address EIP waiting times which was reported in the last Board report and the staffing position has stabilised.

Within AMH the changes to North Yorkshire County Council (NYCC) social care pathway has led to reduced assessment capacity from January 2019. This had a particular impact on the Harrogate area, and less so the York area which was previously not linked to this NYCC collaboration. The service is working to adapt to this change and is also supporting a programme of recruitment in Harrogate specifically, that will improve capacity and access to the service in Q3 and Q4 2019/2020.

There has been considerable long term sickness in certain teams and some staff turnover (Whitby / Ryedale integrated team in particular). This is being monitored closely. The plans for Harrogate Transformation will help address some of the waiting time issues as staff are refocused to community programmes, however, the impact of some of these changes may not be noted until Q1 2020/21.

MHSOP has also been consistently under target ranging from to 72% at its lowest to 83% at its highest performing month during 2018/2019 for 4 week waits and between 44% to 51% for 6 week treatment. This is in the context of increasing numbers of unique referrals to the service.

There are specific challenges in memory services in particular, which are related to addressing dementia diagnosis rates. There have been new developments through:

- Additional investment for York memory services to support dementia diagnosis rates.
- A Dementia Coordinator has been jointly appointed with GP practices in South Ryedale until April 2020.
- Further recruitment is under way to secure an Advanced Nurse Practitioner in the York area and there is ongoing workforce redesign to increase nurse skills and support the medic capacity in the teams.

- Revising pathways to ensure that there is a consistent approach to managing referrals and discharges of non complex dementia cases back to GPs with a particular focus on Scarborough and Ryedale. Addressing these discrepancies and capacity issues will be areas of work through Q3 and Q4 in 2019/2020 and are expected to bring improvements.
- There are some ongoing issues in Harrogate memory service which is being considered as part of the transformation process focusing on early intervention and prevention with GP practices into 2020/2021. There also issues with CT scans which remains an ongoing challenge.

Learning Disability services have achieved target in June 2019 at 93% from its previous widest range of 72% to 87% over the last 12 months. Whilst the four week wait metric is seeing an improvement, it takes only one or two people to cause a breach in the LD targets because of the very low numbers within the service. The service has performed well against the six week treatment metric and has achieved amber or green levels of performance consistently from June 2018.

### 3.2.2 Durham and Darlington

There are some variable performance issues which are described below.

For AMH services:

- The 4 week wait has deteriorated to 50% in June.
- The 6 week wait has remained between 53 – 59% in the last 3 months.
- Referral rates continue to increase.

The service continues to proactively work to maximize capacity in services, this includes:

- The new locality manager has made proactive visits to every community team to understand their pressures and reinforce the commitment to review caseloads.
- Consideration of the way the Community Teams operate and a move away from a functional split. This will ensure the caseload is more evenly spread. This will be reviewed via the LMGB to agree an overall approach and ensure benefits realization during Q3.
- Workforce redesign to mitigate medical vacancies including recruiting to a Nurse Consultant post and developing the Approved Clinician role and the use Non Medical Prescribers (NMPs) to help triage and provide medication advice to patients/ GPs - rather than a patient waiting to see a medic.
- Recent investment from the CCG will be used to employ 8 x Band 4 Assistant Psychologists plus a Psychologist who will develop groups – such as psychoeducation – from the point of access. This should reduce the number of referrals to secondary mental health services and increase our offer for evidence based group interventions, which will also support recovery.
- A RPIW is planned on 21<sup>st</sup> October to explore options for Access in order to increase capacity. Scoping for this event includes



implementation of a single point of access and reviewing the administrative time it takes to complete an assessment. Reducing the administrative burden will release clinical capacity and therefore increase the number of access appointments the service can offer.

- The CMHTs are currently over recruiting to 2 x Band 5 posts in each community team. These posts are on preceptorship and will have limited experience so their caseloads will be carefully managed. Therefore it will take time to see the positive impact.

The MHSOP service is meeting 4 week wait target, and is demonstrating an improving trajectory for 6 week waits (56% at June 2019). There is a slight increase in unique referrals.

- The services is continuing to use daily lean management processes which enable Team Managers to horizon scan, as well as identify current issues.
- As in other localities the service is undertaking workforce redesign which includes the development of ANP role as point of assessment, employment of peripatetic associate nurse consultant (and the service is looking to appoint a further band 6 nurse to work peripatetically), early recruitment and promotion of retire and return.
- Current team pressures are noted at Darlington and Sedgefield, given vacancies and high levels of sickness, respectively. Strategies already implemented include over recruited to nursing posts at Darlington, being mindful of retirements pending. Peripatetic post now working into Sedgefield team, ward staff secondment agreed to support Community work.
- Waiting times for Persistent Physical Symptoms (PPS) (This was previously known as Medically Unexplained Symptoms - MUPS) are below target. This is in relation to historical issues around the commissioning of the service. However, the CCG have agreed additional funding which will offer an opportunity to extend the team and develop a new model – expect to see impact from Q4 2019/20.
- In terms of 6-week external waiters there has been a focus on ensuring that staff are recording specific activities e.g. for scan requests. There is continued redesign work which includes the discharge back to GPs patients within memory service function who do not need secondary Mental Health Services. This will realign resources to support managing caseloads more effectively.

As in other localities the C&YPS service has known pressures, however the locality performance is good:

- The service is consistently meeting the 4 week target.
- The 6 week position has improved since January and now is at over 70%.
- The number of referrals are increasing (with known seasonality impacting on rates between months).

The service has benefited from the allocation of interim staffing (whilst some of the ASD work has been in development) and the wider development of

group work which is thought to have helped address the 6 week position. There will be close monitoring of the position during Q3 and there will be ongoing review of the SPA in Q3.

Team Managers continue to implement Daily Lean Management (DLM) approaches to ensure that there is close oversight of the capacity and demand issues.

ASD waiters are below target for Durham but continue to breach for Darlington – this relates to capacity for Speech and Language therapies which is out with our control and Commissioners are aware.

For ALD 4 week performance can be variable but the 6 week treatment is consistently met.

Most referrals come through Social Care Direct - which has its own waiting list process that TEWV team managers engage with. Waiters are managed through DLM processes. The 4 week wait performance can be impacted on by small number of patients who may require assessment by a particular specialist e.g. sensory assessments where there are a limited number of staff trained to do them. An increase in autism diagnoses has also resulted in more waiters. However, the service has funded two additional Occupational Therapists to attend sensory training in October 2019.

We continue to work with Durham County Council to review team interfaces with Social Care Direct to ensure referrals are triaged effectively. This includes a recently completed a review of LD services.

### 3.2.3 Teesside

Overall performance in terms of the 4 week wait is strong with the exception being in Children's Services. In terms of the wait for treatment indicator MHSOP have seen an improving picture since Quarter 2 of 2017/18. Children's services have also shown an improvement since this quarter but have not yet consistently achieved the 60% target. All services (with the exception of LD) have seen an increase in the number of unique patient referred, with AMH and CYP services seeing the greatest increase.

Within CYPS services the 4 week wait has deteriorated since April 2019 (to 84% in June), and the 6 week treatment position has also reduced from April (47% in June). However referrals have increased. There are particular referral pressures within the Stockton team which is putting pressure on the capacity within the team. The service is currently trialing a new triage system and a Kaizen event has been held in terms of the new PWP role. The service is also undertaking a detailed demand and capacity analysis within Stockton initially to get a better understanding of the gap. This will then be fed into discussions with the CCG and local authority. Finally the service is using some non-recurrent waiting list money received for Hartlepool to pilot a digital offer which is expected to reduce demand on the services (based on

evidence from its use in other parts of the country).

#### **4. IMPLICATIONS:**

##### **4.1 Compliance with the CQC Fundamental Standards:**

There are no direct implications from this report on the compliance with the CQC Fundamental Standards, however it should be noted that waiting times are a piece of information that the CQC use in their assessment of services

##### **4.2 Financial/Value for Money:**

There are no direct financial implications of this report.

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

There are no legal implications as a result of this report. Currently there are no constitutional targets that apply to all Mental Health and Learning Disability Services. There are however some specific waiting time targets for example for EIP and Children's Eating Disorder Services. These are monitored and reported monthly by the Trust and its commissioners.

##### **4.4 Equality and Diversity:**

There are no direct equality and diversity issues associated with this report. The analysis is not refined enough to show whether there is significant differences in the time people with protected characteristics wait for access to services and for treatment to commence. Further exploration is going to take place on whether it is possible to get an analysis of waiting times by protected characteristic, initially focusing on ethnicity.

##### **4.5 Other implications:**

#### **5. RISKS:**

5.1 It is a risk that long waiting times for assessment and / or treatment will have a detrimental impact on patients and impact on the quality of care they receive.

5.2 There are reputational issues for the organisation where there are significant waits in parts of the patient pathway.

#### **6. CONCLUSIONS:**

6.1 The report identifies a number of issues for the organisation around waiting times.

6.2 The report identifies a number of issues for the organisation around waiting times. There are locality differences in terms of performance and there is ongoing work to ensure that we are working towards meeting these targets. There continue to be challenges in meeting the targets which are often linked to staffing pressures and referral increases. In some areas there has been further investment in

services which should impact on the position which will be monitored closely to assess the impact on waiting times.

## **7. RECOMMENDATIONS:**

The Board is asked to:

- Discuss and comment on the report.
- Identify any further actions it would like to be addressed
- Consider if it requires any further information.

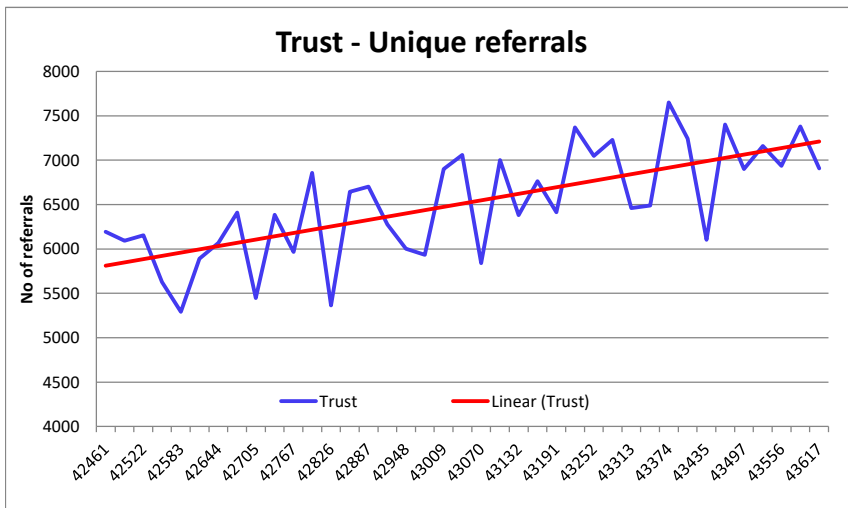
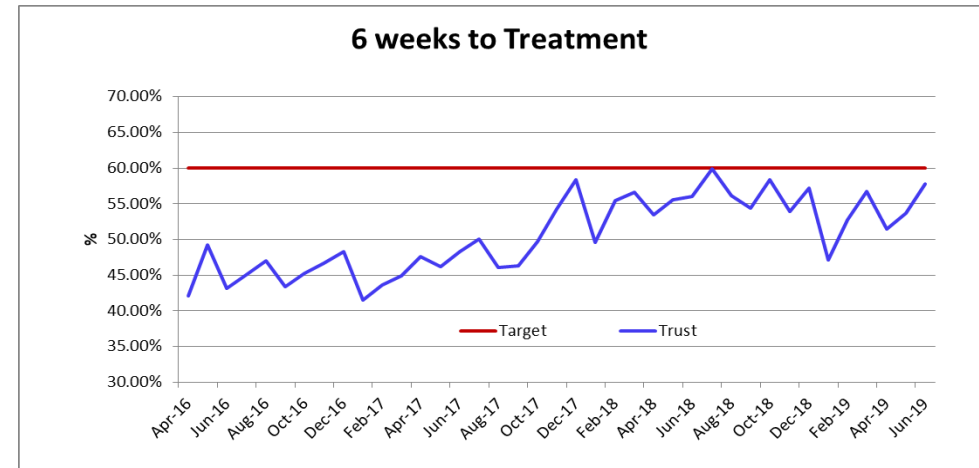
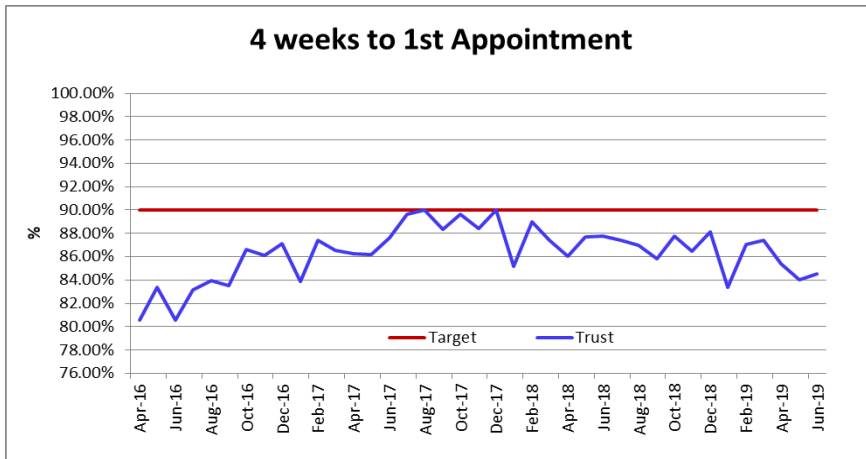
**Ruth Hill Chief Operating Officer/ Sharon Pickering Director of Planning, Performance and Communications**

**Background Papers:**

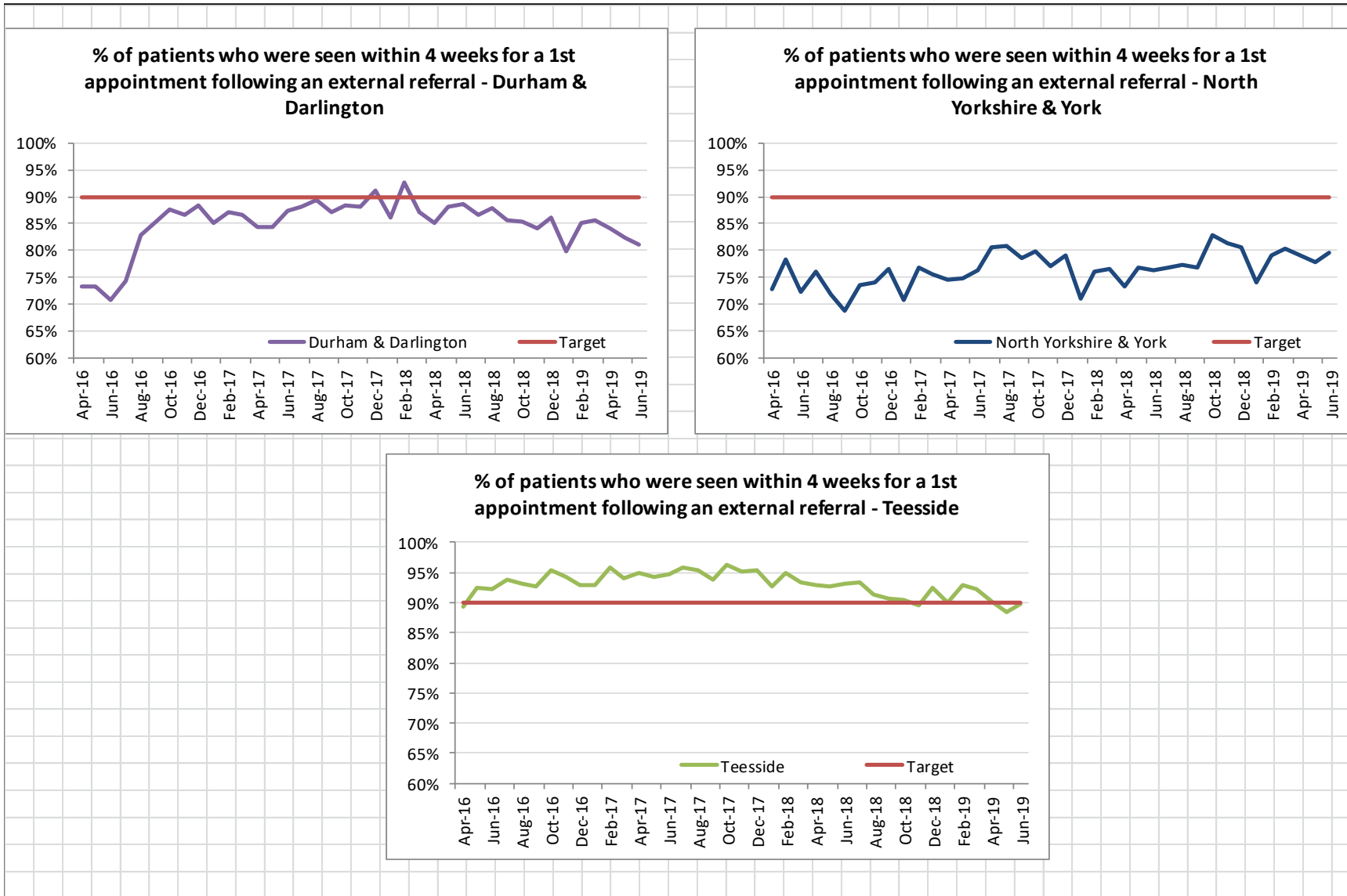
**Waiting Time Reports - Appendices 1 and 2**

**Waiting Time Reports - Detailed individual locality level reports**

Waiting Times Trust Wide Performance

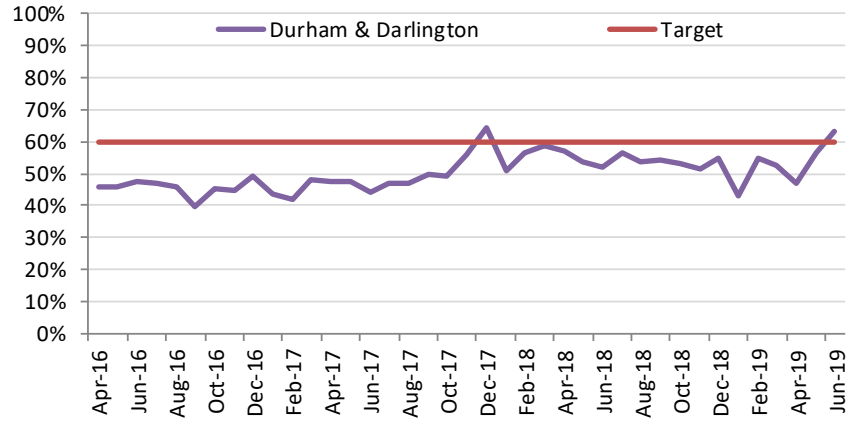


Waiting Times - Locality Performance 4 Weeks

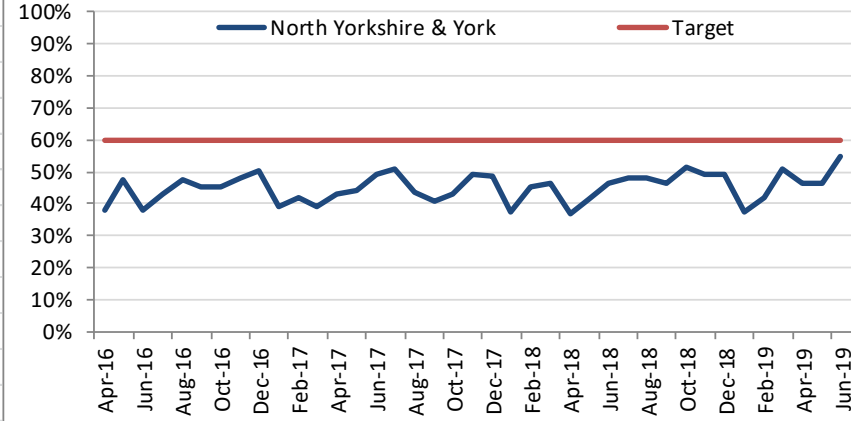


Waiting Times - Locality Performance 6 Weeks

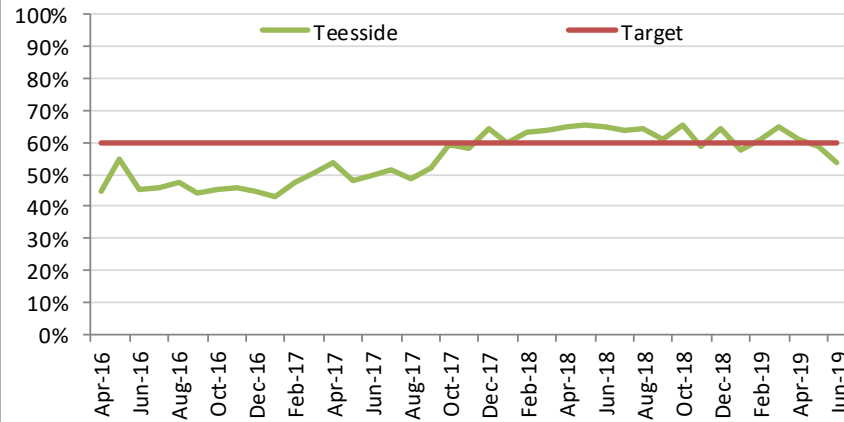
Percentage of patients starting treatment within 6 weeks of an external referral - Durham & Darlington



Percentage of patients starting treatment within 6 weeks of an external referral - North Yorkshire



Percentage of patients starting treatment within 6 weeks of an external referral - Teesside



FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	18 July 2019
<b>TITLE:</b>	Annual report on progress on actions arising from Directors' Visits during the period June 2018 to May 2019
<b>REPORT OF:</b>	Ruth Hill
<b>REPORT FOR:</b>	Information

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

**Executive Summary:**

Since 2005 the Board of Directors has undertaken a regular programme of Structured Board visits. These visits provide an opportunity for members of the Board to be visible, meet staff, learn about services and offer the opportunity for teams to highlight areas of good practice and to feedback on areas that require improvement.

Those participating in the visit are required to submit a short report on a proforma, which is stored on a log on the EMT shared drive. This report is the Annual Report on those actions.

**Recommendations:**

Board of Directors is asked to receive the Directors' Visits annual review of actions.



<b>MEETING OF:</b>	<b>Board of Directors</b>
<b>DATE:</b>	<b>18 July 2019</b>
<b>TITLE:</b>	<b>Annual report on progress on actions arising from Directors' visits during the period June 2018 to May 2019</b>

**1. INTRODUCTION & PURPOSE:**

- 1.1 Since 2005 the Board of Directors has undertaken a regular programme of Structured Board visits. These visits provide an opportunity for members of the Board to be visible, meet staff, learn about services and offer the opportunity for teams to highlight areas of good practice and to feedback on areas that require improvement.
- 1.2 Over time the visit format has been modified to encompass key lines of enquiry to include a focus on fundamental standards and engaging with the wider clinical team.
- 1.3 Those participating in the visit are required to submit a short report on a proforma, which is stored on a log on the EMT shared drive. This report is the Annual Report on those actions.

**2. BACKGROUND INFORMATION, CONTEXT AND KEY ISSUES:**

- 2.1 At the Board of Directors meeting in May 2013 it was recognised that as this programme of visits had been under way for some considerable period of time it would be worth producing an annual review of actions to provide commentary on the actions undertaken in response to these reports and to provide assurance that these matters were being dealt with accordingly. In addition, there has been a revised focus to ensure that there is an opportunity for greater engagement with the visiting team staff and alignment with fundamental standards.
- 2.2 During the past year the visits log, with reports embedded, has been submitted to the Executive Management Team (EMT) on a monthly basis for scrutiny and monitoring. This provides assurance that actions are being followed up.
- 2.3 The attached log of Directors' visits from June 2018 to May 2019 shows the majority of the actions as green, having been completed. Further details on all the visits can be seen on the visit reports in a reading room on Diligence.
- 2.4 Further to the review of the 60+ reports that have resulted from the last 12 months' visits, recurring issues and trends are very similar to issues raised previously, but specifically:
  - Effective leadership in supporting teams to deliver care with the right support.

- Issues relating to Estates and Facilities, minor actions to pick up relating to, eg, unwanted furniture or small works (not always requested formerly or outstanding, but identified during the visit).
- Issues with IT kit and navigation of PARIS effectively.
- The importance of staffing, team resilience, recruitment and retention and skill mix and the potential impact on care when there were various staffing challenges identified.

### **3. IMPLICATIONS:**

#### **3.1 Compliance with the CQC Fundamental Standards:**

Addressed in individual actions.

#### **3.2 Financial/Value for Money:**

Addressed in individual actions.

#### **3.3 Legal and Constitutional (including the NHS Constitution):**

Addressed in individual actions.

#### **3.4 Equality and Diversity:**

Addressed in individual actions.

#### **3.5 Other implications:**

Addressed in individual actions.

### **4. RECOMMENDATION:**

Board of Directors is asked to receive the Directors' Visits annual review of actions.

**Ruth Hill**  
**Chief Operating Officer**

**LOG OF MONTHLY DIRECTORS' VISITS JUNE 2018 – DECEMBER 2018**

	2.00 pm – 5.00 pm Monday 11/06/18 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 9/07/18	2.00 pm – 5.00 pm Monday 13/08/18 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 10/09/18	2.00 pm – 5.00 pm Monday 08/10/18 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 12/11/18	2.00 pm -5.00 pm Monday 10/12/18 <b>(Governors included)</b>
<b>Team 1</b> Jennifer, Dominic, David Levy and Hugh Griffiths	<b>Patient Safety Team</b> Lanchester Road Hospital	<b>Talking Changes</b> North Durham St Aidan's House	<b>Hambleton MHSOP CMHT</b> Gibraltar House Northallerton	<b>Clover/Ivy/Rudland</b> Roseberry Park Hospital	<b>Durham Affective</b> North End House Durham	<b>Bransdale Ward</b> Roseberry Park Hospital	<b>York CLDT</b> Systems House York
Visit Reports	<b>Visit Cancelled</b>		<b>Visit Cancelled</b>		<b>Visit Cancelled</b>		
Action Updates							
<b>Team 2</b> Adele, Ahmad, David Brown, Lisa and Paul Murphy	<b>Information – Supporting Users</b> Flatts Lane Centre, Normanby	<b>Northallerton IAPT</b> Gibraltar House Northallerton	<b>Sedgefield Durham Dales MHSOP CMHT</b> Auckland Park Hospital Bishop Auckland	<b>Kestrel/Kite/Blakey</b> Roseberry Park Hospital	<b>SW CMHT</b> Acomb Gables York	<b>Maple Ward</b> West Park Hospital	<b>SWR LD Community</b> Eastfield Clinic Scarborough
Visit Reports							<b>Visit rearranged to 21st January 2019</b>
Action Updates							
<b>Team 3</b> Patrick McGahon, Sarah, Brent and Marcus Hawthorn	<b>Information Governance</b> Lanchester Road Hospital	<b>Harrogate IAPT</b> Windsor House Harrogate	<b>Derwentside MHSOP CMHT</b> Derwent Clinic Consett	<b>Linnet/Whinstone (Forensic LD Ridgeway)</b> Roseberry Park Hospital	<b>Redcar &amp; Cleveland Appleton</b> Foxrush House Redcar	<b>Overdale Ward</b> Roseberry Park Hospital	<b>H&amp;R LD Community</b> Gibraltar House Northallerton
Visit Reports	<b>Visit rearranged to 4<sup>th</sup> October 2018</b>		<b>Visit rearranged to 29<sup>th</sup> October 2018</b>				
Action Updates							
<b>Team 4</b> Tim, Sharon, Levi and Richard Simpson	<b>Patient Liaison Service (PALS)</b> Flatts Lane Centre	<b>Whitby IAPT</b> Whitby Hospital Whitby	<b>Redcar &amp; Cleveland MHSOP CMHT</b> Reed Marsh House Redcar	<b>Mandarin Ward</b> Roseberry Park Hospital	<b>Easington Psychosis</b> Merrick House Easington	<b>Danby Ward/Ayckbourn Unit</b> Scarborough	<b>South Long Term &amp; Review Integrated Team</b> Council Offices Spennymoor
Visit Reports				<b>Visit rearranged to 21st January 2019</b>			
Action Updates							

	2.00 pm – 5.00 pm Monday 11/06/18 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 9/07/18	2.00 pm – 5.00 pm Monday 13/08/18 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 10/09/18	2.00 pm – 5.00 pm Monday 08/10/18 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 12/11/18	2.00 pm -5.00 pm Monday 10/12/18 <b>(Governors included)</b>
<b>Team 5</b> Elizabeth, Ruth Hill, Paul Foxton/ Rob Cowell and David Jennings	<b>Workforce Development</b> Flatts Lane Centre	<b>York IAPT</b> Huntington House York	<b>Hartlepool MHSOP CMHT</b> Sovereign House Hartlepool	<b>Brambling/Leystone</b> Roseberry Park Hospital	<b>CMHT Scarborough</b> Ellis Centre Scarborough	<b>Minster Ward</b> Peppermill Court York	<b>East Long Term Integrated Team</b> Spectrum 8 Seaham
Visit Reports							
Action Updates							
<b>Team 6</b> Patrick Scott, Phil and Shirley Anne Richardson	<b>Capital Development Team</b> Flatts Lane Centre	<b>Talking Changes</b> South Durham Rowan Building Darlington	<b>NE MHSOP CMHT</b> Huntington House York	<b>Lark/Northdale Centre</b> Roseberry Park Hospital	<b>CMHT Ripon</b> Windsor House Harrogate	<b>Farnham Ward</b> Lanchester Road Hospital	<b>Adult LD Community</b> Flatts Lane Middlesbrough
Visit Reports							
Action Updates							

**LOG OF MONTHLY DIRECTORS' VISITS JANUARY 2019 – MAY 2019**

	2.00 pm – 5.00 pm Monday 14/01/2019	2.00 pm – 5.00 pm Monday 11/02/19 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 11/03/19	2.00 pm – 5.00 pm Monday 8/04/19 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 13/05/19
<b>Team 1</b> Patrick McGahon Levi Buckley & Hugh Griffiths	<b>MHSOP - Oak Ward</b> West Park Hospital	<b>Redcar CAMHS</b> The Ridings, 13 Milbank Terrace	<b>AMH - Tunstall Ward</b> Lanchester Road Hospital	<b>Pharmacy Team</b> The Retreat York	<b>Hotel Services Team</b> Lanchester Road Hospital
Visit Reports		Visit rearranged to 22 <sup>nd</sup> July 2019			
Action Updates					
<b>Team 2</b> Ruth H, Jennifer, Rob Cowell, Paul Foxtan & Paul Murphy	<b>MHSOP – Acomb Garth</b> York	<b>CAMHS Team</b> Northallerton	<b>AMH – Cedar Ward</b> Briary Wing Harrogate General Hospital	<b>Pharmacy Team</b> Roseberry Park Hospital	<b>Hotel and Estates Team</b> West Lane Hospital
Visit Reports		Visit rearranged to 17 <sup>th</sup> June 2019			
Action Updates					
<b>Team 3</b> Elizabeth, Dominic Marcus Hawthorn	<b>MHSOP – Westerdale South</b> Sandwell Park Hartlepool	<b>North Durham CAMHS</b> North End Durham	<b>AMH – Stockdale Ward</b> Roseberry Park Hospital	<b>Pharmacy Team</b> Lanchester Road Hospital, Middlesbrough	<b>Estates &amp; Grounds &amp; Gardens Team</b> Lanchester Road Hospital
Visit Reports		<b>Report awaited</b>			
Action Updates					
<b>Team 4</b> Ahmad, Phil & Richard Simpson	<b>MHSOP - Rowan Lea</b> Cross Lane Hospital Scarborough	<b>Hartlepool CAMHS</b> Dover House	<b>AMH – Bilsdale Ward</b> Roseberry Park Hospital	<b>North of Tees CRHT</b> Parkside	<b>Estates and Hotel Services</b> Auckland Park Hospital Bishop Auckland
Visit Reports					
Action Updates					

	2.00 pm – 5.00 pm Monday 14/01/2019	2.00 pm – 5.00 pm Monday 11/02/19 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 11/03/19	2.00 pm – 5.00 pm Monday 8/04/19 <b>(Governors included)</b>	2.00 pm – 5.00 pm Monday 13/05/19
<b>Team 5</b> Sharon, Lisa & David Jennings	<b>MHSOP – Meadowfields</b> York	<b>Stockton CAMHS</b> Viscount House Falcon Court Stockton	<b>AMH - Elm Ward</b> West Park Hospital	<b>South of Tees CRHT</b> Block 7 Roseberry Park Hospital	<b>Estates and Hotel Services</b> Roseberry Park Hospital
Visit Reports					
Action Updates					
<b>Team 6</b> David L, Sarah, <del>David B</del> , Tim, Naomi & Shirley Anne Richardson	<b>MHSOP - Springwood</b> Malton Hospital	<b>South Durham CAMHS</b> Acley Centre Newton Aycliffe	<b>AMH – Ebor Ward</b> Peppermill Court York	<b>Pharmacy Team</b> West Park Hospital	<b>Estates and Hotel Services</b> Cross Lane Hospital Scarborough
Visit Reports					
Action Updates					

FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	Tuesday 24 September 2019
<b>TITLE:</b>	Report of the Mental Health Legislation Committee
<b>REPORT OF:</b>	Richard Simpson, Non-Executive Director
<b>REPORT FOR:</b>	Assurance/Information

<b>This report supports the achievement of the following Strategic Goals:</b>	✓
<i>To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing</i>	✓
<i>To continuously improve the quality and value of our work</i>	✓
<i>To recruit, develop and retain a skilled, compassionate and motivated workforce</i>	
<i>To have effective partnerships with local, national and international organisations for the benefit of the communities we serve</i>	
<i>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.</i>	✓

**Executive Summary:**

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 1, 2019/20.

**Key areas for consideration:**

- Reports on Discharges from Detention, use of Section 136, Section 132
- **Human Rights, Equality and Diversity Information**
- Seclusion Report
- Report on MCA and DoLS
- CQC Quarterly Update
- Liberty Protection Safeguards Update
- Case study

**Recommendations:**

The Board of Directors is asked to:

Receive and note the assurance report, following the MHLC meeting held on 24 July 2019 and to note the approved minutes of the MHLC meeting held on 24 April 2019. (Annex 1)

<b>MEETING OF:</b>	<b>Board of Directors</b>
<b>DATE:</b>	<b>Tuesday 24 September 2019</b>
<b>TITLE:</b>	<b>Report of the Mental Health Legislation Committee</b>

### 1. INTRODUCTION & PURPOSE:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for Quarter 1, 2019-20; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 24 July 2019.

### 2. BACKGROUND INFORMATION AND CONTEXT:

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

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

### 3. KEY ISSUES:

The confirmed minutes of the Mental Health Legislation Committee held on 24 April 2019 are attached as Annex 1.

The MHLC also met on 24 July 2019. The key issues considered at this meeting were as follows:

## COMPLIANCE WITH MHA PROCESSES

### 3.1 Discharges from Detention

The Committee considered the Discharges report.

The key points for the Board to note are:

- In Quarter 1 there were 116 Hospital Managers' review meetings with no patients discharged. Whilst it was unusual to see over Q1 that no patients were discharged compared to the last quarter, it is not uncommon over the last few years for this to happen on occasion. Assurance can be provided to the Board that there are no concerns.
- There were 135 First-tier Tribunals in Q1, which resulted in 13 patients being discharged. There are no concerns.

### 3.2 Section 136

The Committee considered data and trends around S136.

- There were 165 uses of S136 across the Trust, compared to 174 in the previous quarter.
- There were 11 episodes that lasted 12 hours or more.
- For those that were sectioned for longer than 12 hours details were provided in the report with the rationale, including assessment delay due to the unavailability of an AMHP and an aggressive and hostile individual that had to be taken into custody for a time due to risk before being returned to Roseberry Park Hospital for assessment.



- There were nine individuals aged between 14 and 17 held under section 136 in the Q1.
- The overall use of S136 across the Trust showed TEWV place of safety (PoS) being used as the optimum choice with police stations not being used across the whole Trust area in the last quarter.
- The report demonstrated that the Trust has good working relationships with the Police and the notable improvements on the reduced amount of time that individuals spend under 12 hours in a place of safety.

### 3.3 Section 132

The Committee discussed the Section 132 report – Information to detained patients.

The key matters for the Board to note are:

- In Q1 the escalation process was used 13 times, including twice to the MHL Team Manager with all 132b forms were eventually received.
- Assurance can be provided to the Board that the number of times escalation is required is negligible compared to the number of sections applied, however it could also mean that not all instances have been captured due to the newness of reporting this information.
- It is anticipated that with the introduction of CITO there will be further developments and improvements on this matter as currently this report only provides assurance of patients being given their rights on admission.

## COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS

### 3.5 Human Rights, Equality and Diversity Information

The Board is to note that following some work by the Equality and Diversity and Mental Health Legislation team the reporting of information around the number of detentions under the Mental Health Act by gender and ethnicity will be considered by the MHL Committee in order to try and monitor equalities to understand how people with protected characteristics are affected by the Mental Health Act.

### 3.6 Seclusion

The Committee discussed the seclusion report.

The Board is to note:

- In Q1 there were 99 episodes of seclusion, (81 in previous quarter). Of the 99 episodes 75 were over 12 hours, of which 64 were over 24 hours.
- The longest completed seclusion for those in excess of 24 hours was 328 hours (13.6 days), which compared well with 739 (30.8 days) hours in Q4.
- There were 23 patients that had multiple seclusion episodes, of these two patients had five episodes in the quarter.
- The Committee had agreed at its meeting held on 24 April 2019 (minute 19/34 refers) that a piece of work would be undertaken by the MHL team which would entail clinically auditing every completed seclusion for a period of at least 2 weeks to determine whether the requirements of the policy had been adhered to. This was following concerns with regard to whether the requirements of the Code of Practice and Trust Policy were being adhered to on every occasion that seclusion occurred.

- A sample of ten individuals was audited and the longest period for seclusion had been 12 days. Some further work would be done around looking in greater detail at the medical reviews for seclusion.

## **EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS**

### **4.0 Mental Capacity Act and DoLS**

The Committee discussed the quarterly update report on MCA and DoLS.

The key points to note are:

- E learning training for the MC Act for clinical staff shows compliance at 96%.
- There were currently 44 active cases under DoLS, all within respite settings and 9 new applications were made and authorised in Q1.

The Board can be assured that the Trust is compliant with the DoLS legislation.

## **KEY GOVERNANCE INFORMATION**

### **4.1 CQC Report**

The key issues for the Board to note are:

- The Trust has conditions of registration imposed following the unannounced inspection to the children and young people's inpatient services. The Trust has been working with the CQC to manage the situation and immediate steps and actions were taken to ensure the safety and quality of care at West Lane improved.
- There were five CQC Mental Health Act inspections in Q1 and the top themes raised were restrictive practices, care plans and MHA leave. Actions continue to try and reduce these common recurring issues.
- There was a thematic review by the CQC to MHSOP core services (excluding liaison) following different concerns such as safeguarding issues, complaints and serious incidents and this combined with an unimproved rating of 'requires improvement' in the latest inspection led to them requesting assurance. A report was submitted to the CQC on 14 June 2019.

### **4.2 Liberty Protection Safeguards**

- Following the Mental Capacity (Amendment) Act gaining Royal Assent in May 2019, the Liberty Protection Safeguards (LPS) will replace the Deprivation of Liberty Safeguards (DoLS), earliest implementation date 1st October 2020.

The key point to note is that when DoLS are replaced by the Liberty Protection Safeguards the Trust will not be reliant on Local Authority supervisory bodies to authorise deprivations of liberty within TEWV settings and the Trust will become a Responsible Body and authorise deprivations of liberty itself. The implications for the Trust would become clearer with the publication of the revised MCA Code of Practice and Regulations.

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

A case study of a patient requiring seclusion was received which was welcomed by members as the information humanises the data and statistics which are presented in meetings.

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

There are no concerns to raise that might impact on the Trust's strategic or key risks.

### 6.0 IMPLICATIONS:

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

CQC MHA visit reports do not indicate any significant issues with regard to compliance with the Fundamental Standards in terms of the MHA and MCA however themes from MHA inspections continue to reoccur and it is important that actions and progress against these are closely monitored.

#### 6.2 Financial/Value for Money:

There are no implications.

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

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

#### 6.4 Equality and Diversity:

There are no implications.

### 7. CONCLUSIONS:

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

### 9. RECOMMENDATIONS:

The Board of Directors is asked to:

- (i) *Receive and note this report including the confirmed minutes of the meeting of the MHL Committee held on 24 April 2019.*

**Mrs Elizabeth Moody**  
**Director of Nursing & Governance**  
24 September 2019

#### **Background Papers:**

Annex 1 – Confirmed minutes of the 24 April 2019 MHL Committee Meeting

## Annex 1

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### MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 24 APRIL 2019 IN SEMINAR ROOM 4, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM.

#### Present:

Mr R Simpson, Non-Executive Director, Chairman of the Committee  
Mr P Murphy, Non-Executive Director  
Mr C Allison, Public Governor, Durham  
Mrs E Moody, Director of Nursing & Governance  
Mrs R Hill, Chief Operating Officer  
Mrs S Richardson, Non-Executive  
Dr A Khouja, Medical Director

#### In Attendance:

Mrs J Illingworth, Director of Quality Governance  
Ms D Oliver, Deputy Trust Secretary, (Corporate)  
Miss M Wilkinson, Head of Mental Health Legislation  
Mrs J Ramsey, Mental Health Team Manager  
Mrs J Harrison, Expert by Experience Representative  
Mrs R Down, MHL Advisor  
Dr Thakkar, Deputy Medical Director, Forensics  
Mr A Williams, Public Governor, Redcar & Cleveland  
Mrs H Griffiths, Public Governor, Harrogate & Wetherby  
Mrs J Kirkbride, Public Governor, Darlington

**Apologies:** There were no apologies for absence.

#### 19/16 MINUTES OF LAST MEETING

**Agreed** – That the minutes of the last meeting held on 24 April 2019 be approved as a correct record and signed by the Chairman.

#### 19/17 ACTION LOG

The Committee noted the actions and following updates:

- 17/33 Benchmarking – talk to NTW about seclusions.  
Mrs Hill agreed to raise this through the Chief Operating Network. The PIR information for NTW would also be considered and an update would be brought to the January 2019 meeting.  
This matter remained outstanding; however NTW had agreed to share their data and an update would be brought to the July 2019 meeting.
- 18/20 Separate out CQC feedback report and frame sections around high quality questions. **Completed**
- 18/42 Conversation to take place about SOADs

It was noted that this was a national and regional problem. A conversation had taken place with NTW, Leeds and York about how we could encourage more people to take up the role of SOAD, including those who had retired.

- 18/42a Section 62 information to be reported to MHLC in October 2018 and then annually. Miss Wilkinson sought clarification on the content of the report and undertook to bring it next time.  
This report was deferred to the July 2019 meeting.
- 18/54 MCA/DoLS report: Issue of long waiting list for DoLS at Middlesbrough County Council, with some clients waiting more than two years.  
A meeting had taken place with the DOLs lead for Middlesbrough Council and some of the issues had been worked through with marked improvements since that time. Members requested that this was left on the action log to check on progress at the July 2019 meeting.
- 18/56 Talk to Equality and Diversity lead regarding the potential for volunteers from the South Asian community in Teesside to carry out the Hospital Managers role.  
A meeting with the Asian community on the 4 April 2019 had led to 15 people expressing an interest in becoming volunteers for the Hospital Managers role and this would be pursued.
- Completed**
- 19/06 Section 132 Report to be shared with OMT, Quality Compliance Group and Modern Matrons.  
It was noted that this report had been to Modern Matrons and would go to the Compliance Group and OMT at the end of May 2019.  
It would be raised again at the MHLC July 2019 meeting for completion.

## **HOW DOES THE TRUST DEMONSTRATE COMPLIANCE WITH MHA PROCESSES?**

### **19/18 DISCHARGES REPORT**

The Committee considered and noted the MHA Discharges Report.

The following was highlighted from the report:

- In Quarter 4 there were 106 Hospital Managers' review meetings with three patients discharged.  
The patient detained under section 3 had been discharged from detention with agreement of the clinical team and remained as an informal patient at the time of writing the report to MHLC; one individual was discharged against the agreement of the RC or care coordinator but remained under community care and the third patient detained under section 37 was discharged without the agreement of the RC and named nurse but with the agreement of the care coordinator and they were not readmitted.
- There were 123 First-tier Tribunals in Q4, which resulted in 5 patients being discharged.
- Assurance was provided to the Committee around the processes for discharge from detentions.
- Over the last three months the First Tier tribunal had disagreed with clinicians that some patients needed to remain subject to the Mental Health Act. The Mental Health Legislation department monitored all of the discharges; however it was inevitable that professionals would disagree over certain issues despite the comprehensive written and oral reports.

- Members were provided with further assurance (appendix 1) to the report, with a detailed narrative around a patient discharged from CTO.

## **19/19 SECTION 136 REPORT**

The Committee received and noted the Section 136 report.

The following was highlighted from the report:

- There had been 174 uses of S136 across the Trust, compared to 193 in the previous quarter.
- There had been 16 episodes that lasted 12 hours or more.
- For those that had been sectioned for longer than 12 hours assurance was provided in the report with the background details and the rationale behind this.
- There had been 10 individuals aged between 14 and 17 held under section 136 in the last quarter.
- The overall use of S136 across the Trust showed TEWV place of safety (PoS) being used as the optimum choice with police stations only being used once across the whole Trust area in the last quarter.

Following discussion it was noted that it was not uncommon for S136 suites to be out of order as there could be a lot of damage caused by individuals, particularly to the doors.

Dr Khouja advised members that operational services were doing a fantastic job making sure that individuals spent the least amount of time in a S136 suite and the figures, compared nationally were impressive for the Trust.

The Chairman of the Committee suggested thinking about the introduction of SPC charts to outline trends and tolerances as was being introduced in to other areas, such as the Quality Assurance Committee.

Assurance was provided to the Committee that despite the pressure on beds and acuity across the Trust there has been the appropriate use of S136, with no exceptions.

## **19/20 SECTION 132 REPORT**

The Committee received and noted the Section 132 report.

The key issues highlighted from the report were:

- The level of compliance around notifying patients of their rights following admission to hospital under the MH Act was good.
- In the last quarter the escalation process had been used nine times, none which had required escalation to the MH Legislation team and included wards - Bilsdale, Esk, Newberry, Overdale, Rowan and Tunstall.
- Three of the wards had been escalated to Modern Matrons.
- Compared to the number of sections applied, the number of times escalation had been used was low, however this process only captured the period following admission and S132 continued to feature on MHA inspection reports therefore additional processes had been implemented that would be monitored at ward level.
- Members were reassured that the numbers had slightly decreased and requested that repeat offenders be highlighted in future reports.

## **19/21 SECTION 18 AWOL SIX MONTHLY REPORT**

The Committee received and noted the Section 18 AWOL report.

The key matters highlighted from the report were:

- (1) In Q3 and Q4 there had been 170 AWOL episodes across the Trust and the background details to these were provided. There had been numerous people who were AWOL on repeat occasions.
- (2) Members considered whether it would be helpful to record the reasons why individuals abscond and it was recognised anecdotally that there were a variety of reasons, including to have alcohol and drugs or to go home and most individuals returned of their own accord.

Following discussion members were assured that the Trust could demonstrate that it captured information regarding AWOL and that the notifications were sent to the CQC as required by the Regulations. All patients who were AWOL were returned using section 18, or their whereabouts/circumstances were known.

### **19/22 MENTAL HEALTH ACT INSPECTION FEEDBACK Q4 2018/19**

The Committee received and noted for the first time a report on MHA Inspection Feedback for Quarter 4.

The following key points were highlighted:

- (1) The report detailed the CQC activity for the period January to March 2019, there had been 10 MHA inspections compared to 8 in the previous quarter.
- (2) A review of the key themes picked up from the inspections showed frequent issues with care plans (20 times), issues with leave (20 times) and issues with patients' rights (13 times).
- (3) Localities had been asked for a response to the matters picked up in the inspections and EMT had discussed additional actions to be taken.
- (4) Members recognised that this was an ongoing problem for the Trust and noted the frustration of not being able to rectify, what sometimes felt like basic processes.

Following discussion members sought further assurance for this report next time with demonstration of compliance with colour coding against the Code of Practice.

**Action: Mrs J Illingworth**

### **19/33 ASSOCIATE HOSPITAL MANAGERS REPORT**

The Committee received and noted the Associate Hospital Managers Report:

The following key points were highlighted:

- There were currently 49 AHM's across the Trust and three NEDs involved in MHA reviews of detention.
- There had been a recent event to expand the diversity of AHM's through engagement with the South East Asian community and this had been very positive - it was anticipated that there would be an opportunity to include members of this group as AMH's in the future.
- The expenditure in 2018/19 was approximately £10,000 less than the previous year and this was due to better planning in using AHM's who lived closest to the hearing venue.

- All AHM's go through an appraisal and review undertaken by the Mental Health Legislation team.
- All AHM's had now been registered with the electronic Disclosure and Barring Service.
- Assurance is provided that the Trust has established a committed and skilled group who undertake the role of AHM.

## **HOW DOES THE TRUST DEMONSTRATE COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS?**

### **19/34 SECLUSION QUARTERLY REPORT**

The Committee received and noted the Seclusion report.

- In Q4 there had been 81 episodes of seclusion, (71 in previous quarter). Of the 81 episodes 66 had been over 12 hours, of which 52 had been over 24 hours.
- The longest completed seclusion for those in excess of 24 hours was 739 hours (30.8 days).
- There had been 15 patients that had multiple seclusion episodes, with one patient having five episodes in the Quarter.
- Following concerns with regard to whether the requirements of the Code of Practice and Trust Policy were adhered to on every occasion that seclusion occurs from week commencing 22 April, a piece of work would be undertaken by the MHL team which would entail clinically auditing every completed seclusion for a period of at least 2 weeks to determine whether the requirements of the policy had been adhered to.

Non-Executive Directors queried whether more information could be provided in future reports to give trends both quarterly and annually.

Mrs Ramsey undertook to look at providing this information for the July 2019 meeting.

**Action: Mrs J Ramsey**

### **19/35 SECTION 5 MHA 1983 (HOLDING POWERS) SIX MONTHLY REPORT**

The Committee received the Section 5 MHA report.

The key matters highlighted were:

- The report sets out to provide assurance that Section 5(4) and Section 5(2) 'holding powers' were being used appropriately and lawfully.
- There were 36 uses of Section 5(4) and 190 uses of Section 5(2) in Q3 and 4 with no exceptions.
- Assurance was provided to the Committee that the Trust could demonstrate that it captured information regarding the use of Section 5 holding powers and that any lapses or issues were investigated to ensure that there were no adverse effects.

## **HOW DOES THE TRUST DEMONSTRATE EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS?**

### **19/36 MENTAL CAPACITY ACT AND DOLS REPORT**



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

Arising from the report it was noted that:

- The results from a re-audit around compliance with the Mental Capacity Act in December/January 2019 highlighted that many of the Inpatient and Community Teams across all directorates audited, could not evidence the consideration of capacity by the completion of appropriate documentation. Specific work with operational teams, staff and the MCA Champions would focus on areas that required improvement. Additional work would be required in order to ensure preparation for the implementation of the Liberty Protection Safeguards in early 2020.
- DoLS activity for the period January to March 2019 revealed that there were 45 current active cases
- E Learning modules continued to provide training for staff, as well as face to face around the Mental Capacity Act and MH Act and compliance had reached 93%.
- A third cohort of Champions with 20 successful participants had taken place in March 2019.
- Assurance was provided that work continued collaboratively with clinical and governance teams to ensure compliance with the legislative requirements around MCA/DoLS.

The Committee was assured that the Trust was compliant with the Mental Health Act and DoLS legislation.

## **WHAT KEY GOVERNANCE INFORMATION DOES THE MHLC NEED TO BE AWARE OF/AGREE?**

### **19/37 CQC REPORT**

The Committee received and noted the CQC report.

The report provided updates around CQC engagement meetings, CQC Insight, Learning from Deaths and the CQC's annual report on the use of the Mental Health Act where it had been found that there have been some improvements in aspects of care in 2016-2018.

This report was currently being considered against the fundamental CQC questions to provide more tailored assurance going forward.

### **19/38 ANNUAL COMMITTEE PERFORMANCE RESULTS**

Committee members discussed the annual Committee performance results for 2018/19.

- (1) The Chairman noted that there had been considerable improvement in the performance of the Committee in the last year, with more focused reporting demonstrating a greater level of assurance.
- (2) Eleven out of twenty areas had improved with only six slightly worse than the year previous.
- (3) Going forward members looked forward to some improvement around induction for new members onto the Committee, however this would be linked to the induction and training needs of the Board of Directors as a whole.

**HOW IS THE COMMITTEE ASSURED THAT IT IS REFLECTING THE VIEWS AND LIVED EXPERIENCES OF SERVICE USERS?**

**19/39 CASE STUDY**

A case study of a patient requiring seclusion was received which was felt to be very useful in describing the personal circumstances and context in which this occurred and gave a good example of bringing the subject matter of the Committee 'to life'.

**19/40 TRUST'S STRATEGIC RISKS**

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

**19/41 ANY OTHER BUSINESS**

There was no other business to discuss.  
The meeting concluded at 4.05pm

Richard Simpson  
Chairman – Mental Health Legislation Committee  
24 July 2019

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PUBLIC

BOARD OF DIRECTORS

<b>DATE:</b>	Tuesday 24 September 2019
<b>TITLE:</b>	Approval of the Memorandum of Understanding for the North East and North Cumbria Integrated Care System
<b>REPORT OF:</b>	Colin Martin, Chief Executive
<b>REPORT FOR:</b>	Approval

<b>This report supports the achievement of the following Strategic Goals:</b>	✓
<i>To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing</i>	
<i>To continuously improve the quality and value of our work</i>	
<i>To recruit, develop and retain a skilled, compassionate and motivated workforce</i>	
<i>To have effective partnerships with local, national and international organisations for the benefit of the communities we serve</i>	✓
<i>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.</i>	

**Executive Summary:**

The purpose of this paper is to bring to the attention of the Board the latest draft version of the Memorandum of Understanding (MOU) for the North East and North Cumbria Integrated Care System.

The MOU has a number of key principles including the importance of strong clinical leadership, the continuing statutory responsibilities of constituent organisations and the role of Lay members and Non Executives in the ICS through the proposed Partnership Assembly.

The Trust is or will be represented in all elements of the ICS Governance infrastructure and it should be noted that Mental Health and Learning Disabilities have been identified as priorities for the ICS which is very positive.

**Recommendations:**

To consider and approve the latest draft version of the Memorandum of Understanding for the North East and North Cumbria Integrated Care System

# North East and North Cumbria Integrated Care System

## Memorandum of Understanding for NHS clinical commissioning groups and foundation trusts

### Introduction and Context

1. This Memorandum of Understanding (Memorandum) is an understanding between the North East and North Cumbria NHS organisations within our ICS. It sets out the details of our commitment to work together to realise our shared ambitions to improve the health of the 3.1 million people who live in our area, and to improve the quality of their health and care services.
2. In working together as a system we will place the people we serve, and the communities in which they live, at the centre of our decision-making, alongside a commitment to clinical leadership at every level of our ICS, and to an appropriate balance between primary, community and acute care.
3. Our ICS is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of ICP subsidiarity, to ensure that we have collective ownership of the delivery of our shared priorities.
4. Although this MOU has a focus on collaboration between NHS organisations, the next stage of our ICS development will be to engage with our partners, in local authorities and beyond, to develop shared priorities and the optimal governance arrangements to oversee their delivery.
5. The Memorandum is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum.

### A new approach to collaboration

6. Our approach to collaboration begins in each of our fourteen local authority areas which make up the North East and North Cumbria. These places are the primary units for partnerships between Local authorities, NHS commissioners and providers, independent sector providers and the wider public and voluntary sector, working together with the public and patients to agree how to improve health and wellbeing and improve the quality of local health and care services.
7. In seeking to work together we will recognize the operational and financial pressures of our Local Government and other partners, and work with them to optimise the use of our resources in the interests of the people we serve.
8. Place-based working, overseen by Health and Wellbeing Boards, is key to achieving the ambitious improvements in health outcomes that we all want to see. As an ICS we are clear that

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subsidiarity is vitally important and operated wherever appropriate. It is in our 'places' where the majority of services will continue to be commissioned, planned and delivered.

9. It is also intended to establish an ICS Partnership Assembly that will provide a strategic view on issues where working at scale makes sense and adds value, with inclusive representation from NHS organisations (both non-executive and executive) and partners from each of our ICPs (see below). The ICS Partnership Assembly will help to shape and endorse our strategic priorities - and make recommendations to statutory decision makers - so that local plans are complemented by a common vision and a shared plan for the North East and North Cumbria as a whole.

### Working at scale as an Integrated Care System

10. Although we recognise that local relationships and place-based activity takes precedent, we must also ensure strong connections through to the overall aims and objectives of the ICS. In addition, we must deliver the constitutional standards and deliver the best possible care for patients and the best possible experience for staff.
11. As one of the largest ICSs our operating model is different to other places, as we work across three broad levels of scale.
- **Neighbourhood and Place** – this is the main focus for partnership working between the NHS and local authorities in our cities, boroughs and counties, where primary care networks (serving populations of 30,000-50,000) operate within local authority/current CCG areas of between 150,000 to 500,000 people. Services commissioned and delivered at this level will be predominantly community based, with flexibility to adapt to local circumstances and need.
  - **Integrated care partnerships** – will cover populations of around one million (with the exception of North Cumbria, which has unique geographical and demographic features). These are partnerships of neighbouring NHS providers and commissioners, working with their local authorities and other partners, to deliver safe and sustainable predominantly hospital-based health and care services for the people in their area.
  - **Integrated care system** – covering a population of circa 3.1 million people, focussed on key strategic priorities for 'at scale' working allowing all NHS and partner organisations to:
    - Collectively prioritise based on a shared understanding of need and areas of underperformance
    - Act with 'one voice' to represent the North East and North Cumbria and therefore be in a better position to access resources that support our shared priorities.
    - Set stretching and consistent service standards – especially for vulnerable groups – and ambitious targets to improve patient and staff experience
    - Manage risks and pressures better together as a system
    - Share and spread best practice

- Reduce duplication and develop shared functions where appropriate

**Our principles, values and behaviours as a collective senior leadership community:**

12. To operate as an effective integrated health and care system we commit to working beyond organisational boundaries. We will build our collective capacity to better manage the health of our population, striving to keep our people healthier for longer and reducing avoidable demand for health and care services. We will:

- Act collectively, demonstrating what can be achieved with strong system leadership
- Speak with one voice, where appropriate, in relation to matters relating to national health and care policy
- Maintain an unrelenting collective focus with our partners on improving health outcomes, based on the principle of prioritising patient first, then system and organisation
- Recognise the continued strengths of each organisation and treat each other with respect, openness and trust, whilst also working as part of an ICS to identify shared priorities and where possible to collectively manage risk.
- Place innovation and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
- Maximise opportunities for system-wide efficiencies
- Consider opportunities to manage our resources within a shared financial framework.

**ICS Planning in Progress**

13. To tackle the challenges of continuous improvement, and to ensure the sustainability of our services, NHS and other Partners are already developing six priority workstreams:-

- I. **Population Health and Prevention** – making fast and tangible progress on improving population health through more effective screening and public awareness to better prevent, detect and manage the biggest causes of premature death in the North East and North Cumbria: cardiovascular disease, respiratory disease and cancer.
- II. **Optimising Health Services** – setting clinical standards and coordinating initiatives across the ICS to find sustainability solutions for those of our health services under the greatest pressure. This workstream will coordinate the work of our Clinical Networks, including the Cancer Alliance, Urgent Care Network and others, and manage the dependencies between the service improvement and reconfiguration proposals as they are developed by each ICP, and maintaining an oversight on quality across our patch.
- III. **Digital Care** – Use digital technology to drive change, ensure our systems are inter-operable, and improving how we use information technology to meet the needs of care providers, patients and the public, helping clinicians to share information and our patients to manage their healthcare.

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- IV. **Workforce Transformation** – building a future workforce for our ICS, with the right skills and flexible support arrangements to enable them to work across multiple settings whilst working collectively to ensure we can recruit and retain staff in priority areas.
  - V. **Mental Health** - improving outcomes for people who experience periods of poor mental health, particularly those with severe and enduring mental illness, and doing more to improve the emotional wellbeing and mental health of children and young people, and breaking down the barriers between physical and mental health services.
  - VI. **Learning Disabilities** – transforming care for people with learning disabilities and autism and improving the health and care services they receive so that more people can live in the community, with the right support, and close to home.

### Our governance

14. We will always respect the principle of subsidiarity, and the ongoing responsibilities and accountabilities of statutory CCGs and foundation trusts for services commissioned and delivered at ‘place’ level. The ICS cannot and will not replace or override the authority of ICS members’ boards, councils and governing bodies. Instead, the ICS’s governance has been designed to provide a strategic mechanism for collaborative action and common decision-making for issues which are best tackled on a wider scale.
15. The proposed governance model for the ICS has two main features;
  - The development of a strategy and shared priorities, through a Health Strategy Group and Partnership Assembly.
  - The execution of these priorities through an ICS Management Group and then the ICPs themselves.
16. NB the development of our governance arrangements is an iterative process, and will be kept regularly under review. Their chief purpose is to provide mechanisms to build consensus and ensure delivery of agreed priorities, but they do not over-ride the statutory authority of CCG governing bodies and trust boards.

### Development of our ICS strategy

17. **The ICS Health Strategy Group (HSG)** will be a quarterly meeting, with membership encompassing CEOs of each of our statutory NHS organisations, alongside clinical leaders and representation from our emerging primary care networks, the Association of Directors of Adults and Children’s Social Services, the Directors of Public Health Network, Public Health England, and the Academic Health Science Network.
18. In conjunction with the ICS Partnership Assembly (see below), and ensuring the principle of ICP subsidiarity, the role of the HSG will be to
  - Agree an overall ICS strategy based on an understanding of both shared challenges, and the objectives in the Long Term Plan – and the priority workstreams that will deliver these priorities.

- Develop a single leadership architecture, including system rules, behaviours and leadership development.
- Share information and showcasing effective practice from across the ICS

19. The development of an **ICS Partnership Assembly** is now in discussion with our partners, but will have a key role in shaping our shared priorities for collaboration across health and care, and the wider determinants of health – including, for example, inclusive economic development, the environment, and climate change– that can drive improvements in population health. This Assembly will have an independent chair and vice-chair, and its membership is likely to comprise nominated representatives from each ICP, which could include Health and Wellbeing Board chairs as well as lay members and non-executive directors from NHS organisations. How this body is constituted will be subject to further discussions with our partners over the coming months.

### Execution of priorities

20. The **ICS Management Group** will meet monthly, under the chairmanship of the ICS Executive Lead, with two CEO-level representatives from each of our ICPs (one NHS commissioner and one NHS provider), plus senior clinical leaders, representatives from tertiary acute and mental health providers, and NHS England/NHS Improvement.

21. The role of the Management Group will be to

- strengthen our system leadership capacity to tackle shared challenges
- oversee the delivery of the LTP and the ICS’s strategic priorities
- provide mutual support and accountability for the development of our ICPs
- manage performance challenges and ensure robust oversight of emerging service quality issues
- jointly develop plans as a system to bridge financial gaps, and agree systems for prioritising, distributing and holding each other to account for transformation funding.
- Assess the recommendations emerging from our ICS workstreams, referring them on to ICPs for implementation if the proposals are supported

22. The ICS Management Group will have a symbiotic relationship with the **governance arrangements of each ICP**. These arrangements are now under development in each of our ICPs, and will need to agree their own governance model, including the relationship between the ICP and their constituent statutory bodies, as well as the role of clinical leaders and non-executive and lay members.

23. The ICS Management Group will ensure mutual accountability by focusing on the delivery of strategic macro-level system work - with the ICPs taking forward a detailed work programme that fits the needs and requirement of their local populations.

24. It will be the responsibility of the ICP Leads to feedback from the Management Group and agree locally how ICS workstream recommendations are best ratified and implemented in their ICPs. ICP leads will also escalate any local challenges to the ICS



Management group for consideration of how best the wider system can provide support.

### **Mutual Financial Accountability**

25. The ICS has a key role in supporting organisations and ICPs to collectively drive financial sustainability and improve productivity. As an ICS, we have agreed a set of principles for working together which include adopting a transparent, open-book approach to financial planning, in year reporting and a collective approach to financial risk management.
26. NHS organisations within our ICS are committed to working in collaboration to drive a system response to the financial challenges we face and to take the necessary actions to achieve financial sustainability within the resources available. NHS organisations within our ICS have already committed to the delivery of the 19/20 ICS operational plan, which demonstrated full sign up to delivery of organisational control totals.
27. The ICS will also play a key role through relevant working groups, such as the ICS Finance Leadership Group and Strategic Capital Working Groups, to provide guiding oversight and advice on ICS capital investment priorities and productivity and efficiency opportunities where this is appropriate to do so. This will include oversight of system level efficiency programmes informed by the Rightcare, Model Hospital and GIRFT programmes.
28. Working within our ICS, each ICP is now developing comprehensive 5 year financial plans in support of the NHS Long Term Plan commitments to 2023/24. ICP plans, underpinned by common financial planning assumptions, but tailored to local priorities and circumstances will form the foundations upon which the overarching ICS system long term plan will be constructed.
29. Once plans are established, each ICP will need to engage in collective performance management through open and transparent discussions, peer challenge and support. Local financial governance and accountability arrangements will be established within each ICP and principles associated with management of risk have been agreed. ICPs will take appropriate supportive action should individual organisations within the community be unable to deliver on agreed plans.
30. In the event that the ICP collective is unable to support delivery of agreed ICP plans, the ICS will open discussions across the wider North East and North Cumbria NHS system to determine whether flexibility exists to offset deteriorating performance in one ICP against improving performance in another.

### **Conclusion**

31. Through this Memorandum the NHS organisations in the North East and North Cumbria ICS commit to
  - working together in partnership to realise our shared ambitions to improve the health of the 3.1 million people who live in our area
  - take a collaborative approach to improving population health, and to ensure the quality and sustainability of their health and care services.



Signed: Chief Executive

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Signed: Chair

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Date:

FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Board Dashboard as at 31<sup>st</sup> August 2019</b>
<b>REPORT OF:</b>	<b>Sharon Pickering, Director of Planning, Performance &amp; Communication</b>
<b>REPORT FOR:</b>	<b>Assurance</b>

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

**Executive Summary:**

As at the end of August 2019, 4 (24%) of the indicators reported are not achieving the expected levels and are red across two of the four domains (two in the Quality domain and two in the Workforce domain). This is the same position as at the end of July 2019. In addition there are 4 KPIs (24%) that whilst not achieving the target are within the 'amber' tolerance levels, with 9 achieving the target and being rated as green (52%) which is an improvement on 8 in July 2019. In terms of the Year to Date position 9 (52%) of the KPIs are rated as green with 3 rated as red.

In terms of the Single Oversight Framework (SOF) targets the Trust achieved all the monthly operational standards with the exception of IAPT- proportion of people completing treatment who move to recovery which was 46.37%. There was also variation in terms of delivery of the SOF targets at CCG level and further details are provided in the report.

In response to an earlier request from the Board Appendix D contains a report following a deep dive into the performance for KPI 14 %age of patients readmitted within 30 days. A summary of the key findings of the deep dive can be found in Section 2.1.

**Recommendations:**

It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

<b>MEETING OF:</b>	<b>Board of Directors</b>
<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Board Dashboard as at 31<sup>st</sup> August 2019</b>

**1. INTRODUCTION & PURPOSE:**

- 1.1 To present to the Board the Trust Dashboard as at 31<sup>st</sup> August 2019 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. Definitions of the KPIs within the dashboard are provided in Appendix B.

**2. KEY ISSUES:**

- 2.1 At a previous Board meeting the Board asked for further analysis to be undertaken on KPI 14: %age of patient re-admitted to Assessment and Treatment wards within 30 days. This further analysis, using data from April 2018 to August 2019, has been undertaken and is included in Appendix D. The conclusions drawn from the analysis are as follows:
- Variations in the monthly performance are due to common cause variation.
  - The most common diagnosis of those people readmitted within 30 days was psychosis, followed by personality disorder, and mood disorder/non-psychotic.
  - The 74 readmissions that took place between April 2019 and June 2019 were reviewed to see if on reflection any further input, at discharge or by the community team, could have prevented the readmission. The results of this were:
    - For 71% of the readmissions it was not felt that alternative action at discharge or in the community would have prevented the readmission.
    - Of the 29% where it was felt that an alternative action may have prevented the readmission, the main finding was that the crisis team and home treatment teams should have had greater involvement.

2.2 Performance Issues

The key issues in terms of the performance reported are as follows:

- As at the end of August 2019, 4 (24%) of the indicators reported are not achieving the expected levels and are red across two of the four domains (two in the Quality domain and two in the Workforce domain). This is the same position as at the end of July 2019. In addition there are 4 KPIs (24%) that whilst not achieving the target are within the ‘amber’ tolerance levels, with 9 achieving the target and being rated as green (52%) which is an improvement on 8 in July 2019.

Of the 8 indicators that are either red or amber none are showing an improving trend over the previous 3 months. Furthermore the vast majority

(13) of the indicators are showing a declining trend over the previous 3 months.

In terms of the Year to Date position 9 (52%) of the KPIs are rated as green with 3 rated as red. Clearly given the three month trend there is a risk that this position could worsen although for most of the indicators that are achieving target they are comfortably above target.

- In terms of the Single Oversight Framework (SOF) targets the Trust achieved all the monthly operational standards with the exception of IAPT- proportion of people completing treatment who move to recovery. There were also variation in terms of delivery of the SOF targets at CCG level and further detail is provided below:
  - IAPT/Talking Therapies – proportion of people completing treatment who moved to recovery – The standard was not achieved in August when 46.37% of people achieved recovery as measured by the outcome tools (compared to target of 50%). The target was only achieved in Hambleton Richmondshire and Whitby CCG (HRW). The Quarter 2 position to date is 49.15%. This was the subject of a discussion at the September Performance Improvement Group where it was recognised that the reasons differed across the localities. A number of actions were agreed to improve the positions.
  - CPA 7 day follow up – the standard was not achieved in 2 CCGs: HRW CCG and South Tees CCG. This indicator continues to be monitored on a weekly basis and there are no specific concerns.
  - Access to Early Intervention in Psychosis – Whilst the Trust significantly over performed in August we did not achieve the expected level of access in Harrogate and Rural District CCG (HaRD) and Scarborough and Ryedale CCG (S&R). In HaRD this is linked to when assessments are undertaken jointly with CAMHs and the two services are discussing how this can be improved. In S&R this links to staffing levels in the team, including sickness and annual leave. There are also issues with the availability of certain psychological treatments such as family therapy within the NY&Y services.
  - Inappropriate Out of Area Occupied Bed Days – the standard was not achieved in August for 3 CCGs (Darlington, North Durham and Hartlepool and Stockton). These all related to ‘Internal’ Out of Area admissions i.e. admissions within other areas of the Trust. There were no patients were admitted externally from the Trust due to pressure on beds.

### 3.2 Key Risks

- Waiting times for first appointment (KPI 1) – As a Trust we are not seeing people for their first appointment as promptly as we planned, with only 84% of people being seen within the 4 week internal standard. From a quality perspective this impacts on the ability to identify the level of risk

that may exist in a timely manner. Furthermore this continues to be one of the lowest levels of achievement in the past 3 years. There remain particular concerns in Durham and Darlington AMH services. Work is being undertaken by the new Head of Adult Mental Health Services in Durham and Darlington to identify how the position can be improved, which includes an improvement event in October, although capacity due to vacancies and sickness is also having an impact on delivery. North Yorkshire and York are also an area of concern. Vacancies and sickness are also a key factor contributing to this position and agency staff are being used to try to mitigate this. A detailed report on waiting times is included in the September Board agenda.

- Percentage of patients reporting their experience as excellent or good (KPI 4) – Feedback collected from our service users, via our patient experience surveys, continues to be less positive than we want it to be, with none of the four localities achieving the standard we have set ourselves. There has however been an improvement in Forensic services that has historically been a particular area of concern. This reflects some specific work that has been undertaken in July and August to improve completion rates in order to improve the understanding of what action can be taken to improve the experience of our service users.
- Percentage of Serious Incidents which are found to have a root or contributory cause (KPI 5) – There has been a further increase in the %age of serious Incidents which are found to a root or contributory cause. The cases completed during August have been reviewed by the Patient Safety Team and there are no obvious reasons at this stage for the increase in root cause or contributory findings. This will continue to be monitored and reported back to EMT at the Patient Safety Deep Dive in December 2019.
- Bed Occupancy (KPI 12) – Bed occupancy increased further in August and was greater than we planned for the third consecutive month at 93.32%. Work has been undertaken in terms of improving how we manage access to beds across the Trust and this is continuing as part of the Right Care Right Place Programme. It should be noted that despite the increase in bed occupancy we continue to accommodate more of these bed days in the ‘home area’ than we expected which is positive.
- Vacancy Rate (KPI 15) – The level of vacancies being actively recruited to continues to be higher than we planned, although there was some improvement in August. This position impacts on the quality of care we can deliver and the financial position of the Trust as we use other ways to cover the vacancies such as overtime and agency staff, which incur greater cost. The Right Staffing Programme has a work stream looking at recruitment and retention and has recently developed a dashboard which demonstrates by locality, the number of vacancies and progress being made in terms of the recruitment to those posts. Executive Management Team undertook a deep dive review into the vacancy recruitment process during August and discussed a vacancy census report on Inpatient vacancies. The Community Vacancy Census report has been produced and will be discussed by EMT in September.
- Sickness Absence Rate (KPI 19) – The Trust continues to have a greater amount of sickness than it would wish, which clearly impacts on service

users, the member of staff and also the other staff in the team. The position in August deteriorated further to the highest point in the year at 5.65% which is also higher than the same period in the past two years. Teesside report the highest figure at 7.02%. This is in the main due to the exceptional circumstances within this locality that are being addressed by the Trust. Appropriate action is being taken to support both staff and patients. The Sickness Absence Management Procedure is currently being reviewed and a revised procedure is due to be agreed by December 2019.

- Financial Targets (KPI 19, 20 and 21) – All three financial targets were achieved in August.

#### 2.4 Data Quality Assessment.

The Data Quality Assessment for the new dashboard indicators is attached in Appendix C. There have been no changes to that reported in July 2019.

### 3. **RECOMMENDATIONS:**

It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

**Sharon Pickering**  
**Director of Planning, Performance and Communications**

<b>Background Papers:</b>
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**Quality**







	August 2019				April 2019 To August 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	90.00%	84.01%			90.00%	84.20%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	61.80%			60.00%	56.92%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,169.00	1,302.00			2,169.00	1,302.00		2,169.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	94.00%	90.82%			94.00%	91.60%		94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	32.00%	66.67%			32.00%	35.09%		32.00%
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	60.00%	63.92%			60.00%	63.75%		60.00%
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	65.00%	73.12%			65.00%	69.70%		65.00%

**Activity**













	August 2019				April 2019 To August 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
8) Number of new unique patients referred		6,438.00				35,273.00		
9) The number of new unique patients referred with an assessment completed		3,873.00				20,714.00		
10) Number of new unique patients referred and taken on for treatment		1,616.00				7,861.00		
11) Number unique patients referred who received treatment and were discharged		2,825.00				12,442.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	90.00%	93.32%			90.00%	90.40%		90.00%












# Trust Dashboard Summary for TRUST

	August 2019				April 2019 To August 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	61.00	55.00			61.00	55.00		61.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.00%	23.30%			23.00%	25.74%		23.00%

## Workforce

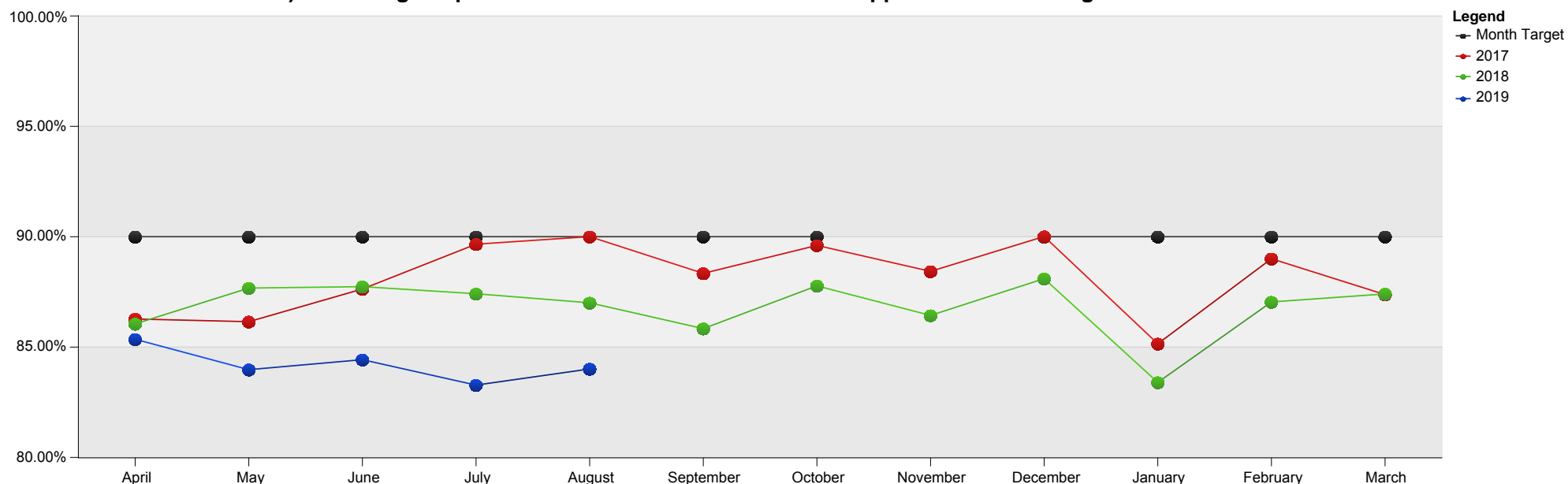
	August 2019				April 2019 To August 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Vacancy Rate (Healthcare Professionals only)	6.50%	12.33%			6.50%	9.73%		6.50%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	91.78%			95.00%	91.78%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	93.91%			92.00%	93.91%		92.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.65%			4.50%	5.09%		4.50%

## Money

	August 2019				April 2019 To August 2019			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-524,000.00	-730,839.00			-2,282,000.00	-2,490,510.00		-5,485,000.00
20) CRES delivery	824,916.00	978,602.00			4,124,580.00	4,893,009.67		9,898,992.00
21) Cash against plan	82,444,000.00	91,781,645.00			82,444,000.00	91,781,645.00		54,409,000.00

# Trust Dashboard Graphs for TRUST

## 1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral



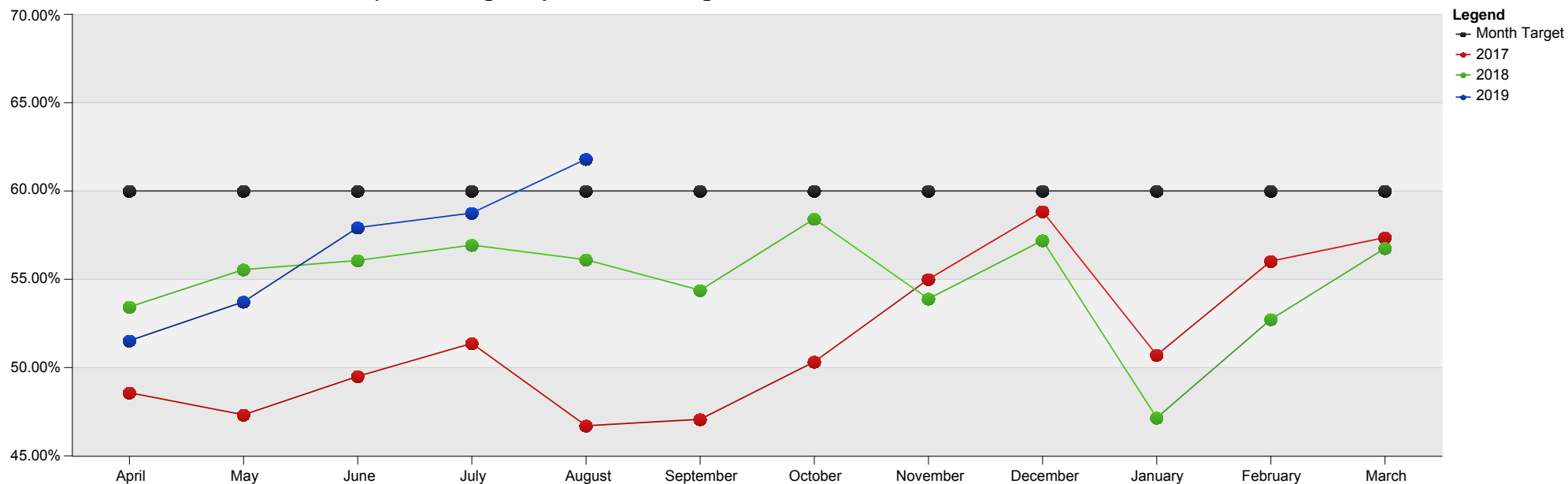
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	84.01%	84.20%	82.40%	82.73%	89.38%	89.47%	76.75%	77.27%	98.67%	98.68%		

### Narrative

The position for August 2019 is 84.01%, which is not meeting the standard of 90.00% and a marginal improvement to that reported in July 2019. This continues to be one of the lowest positions reported since 2017/18. Durham and Darlington and North Yorkshire and York localities are reporting the lowest positions at 82.40% and 76.75%. Key areas of concern are as below: • Durham and Darlington AMH at 57.05% (287 out of 503 patients). A new management structure is in place and a review of the service is underway. An RPIW is planned in October 2019 to review processes and increase productivity. Capacity continues to be impacted by vacancies, the recruitment process is ongoing and start dates have been agreed. Sickness and high referral levels are also impacting. • North Yorkshire and York AMH at 76.89% (456 of 593 patients). Performance continues to be impacted by high sickness levels and vacancies. Agency staff are being utilised as an interim measure until permanent staff are in post. • North Yorkshire and York CAMHS at 77.39% (202 of 261 patients). This is due to staffing issues relating to sickness and support being provided to other localities. Improvements are anticipated as staff return to work. • North Yorkshire and York MHSOP at 76.41% (528 of 691 patients). Issues in the memory service across all areas due to staffing vacancies which are currently out to advert.

# Trust Dashboard Graphs for TRUST

## 2) Percentage of patients starting treatment within 6 weeks of an external referral



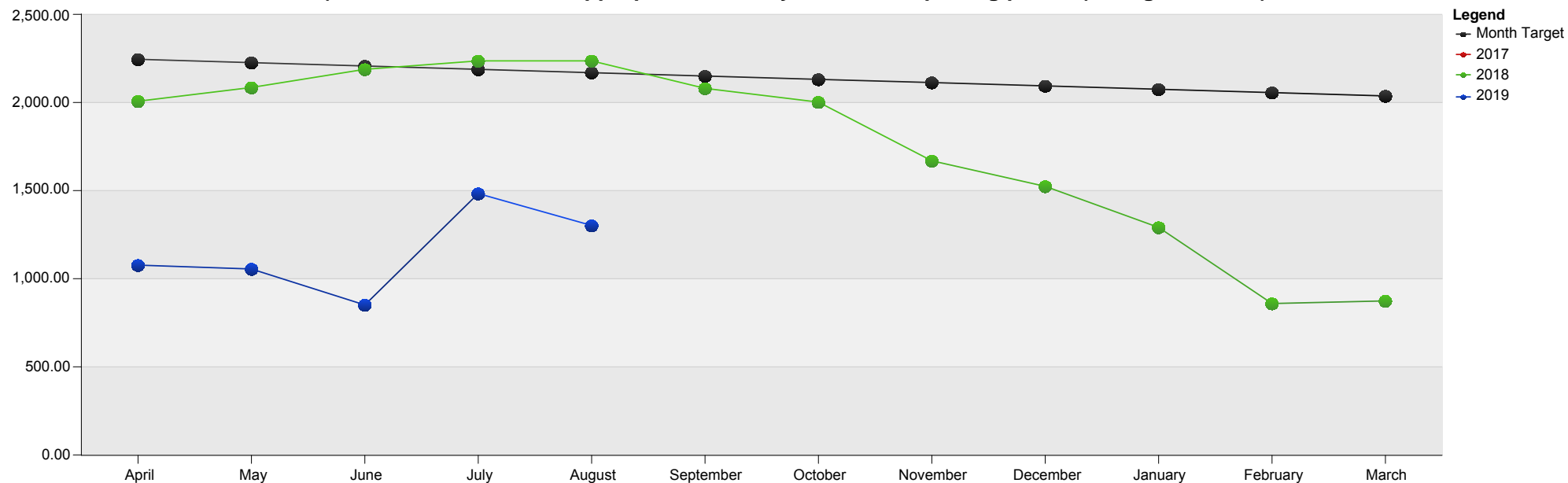
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients starting treatment within 6 weeks of an external referral	61.80%	56.92%	71.07%	60.57%	55.32%	56.50%	58.06%	53.11%	94.92%	92.86%		

**Narrative**

The position for August 2019 is 61.80% which is meeting the standard of 60.00% and an improvement on that reported in July 2019. Forensic services and Durham and Darlington are the only localities meeting target. Teesside continues to report the poorest performance. It has been agreed that this indicator will be the focus of discussion at Performance Improvement Group taking place in October.

# Trust Dashboard Graphs for TRUST

## 3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)



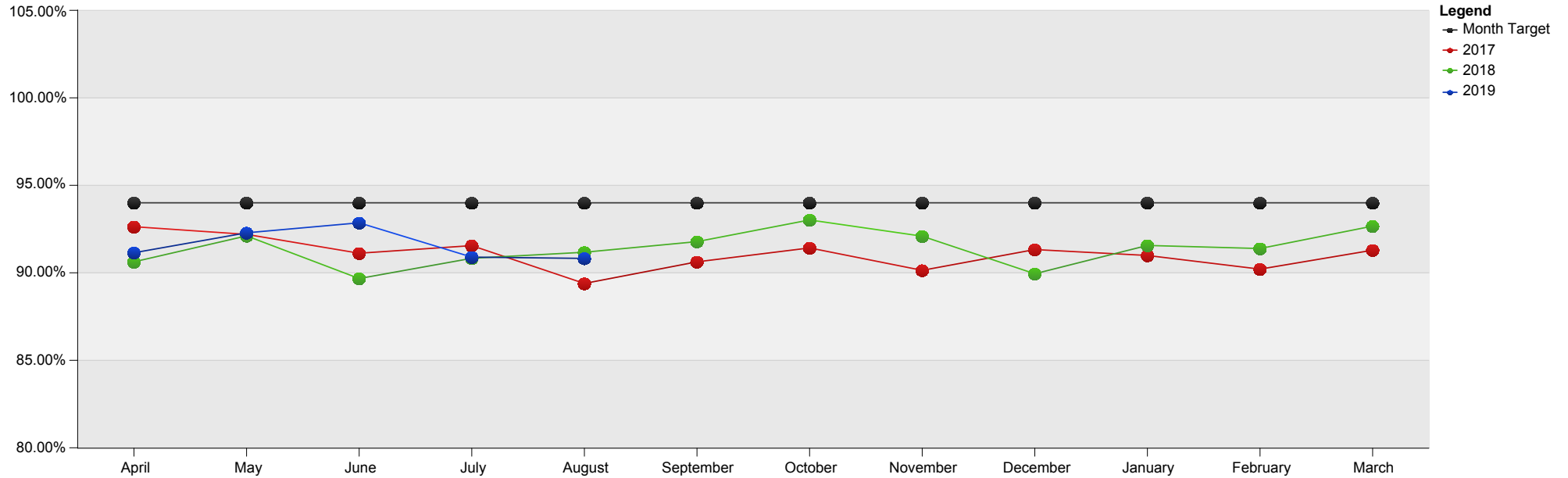
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	1,302.00	1,302.00	172.00	172.00	510.00	510.00	620.00	620.00				

**Narrative**

The Trust position for August 2019 is 1,302 which is a decrease on the 1,483 recorded in July 2019 and below the standard of 2,169. This is an improvement to the figure reported in August 2018. Durham and Darlington is the only locality not meeting the standard for this indicator. The key pressure is in older peoples services, bed pressures here are due to the admission of patients from localities elsewhere in the Trust. Specific work is being taken forward with regards to bed management as part of the Right Care Right Place Program.

# Trust Dashboard Graphs for TRUST

## 4) Percentage of patients surveyed reporting their overall experience as excellent or good



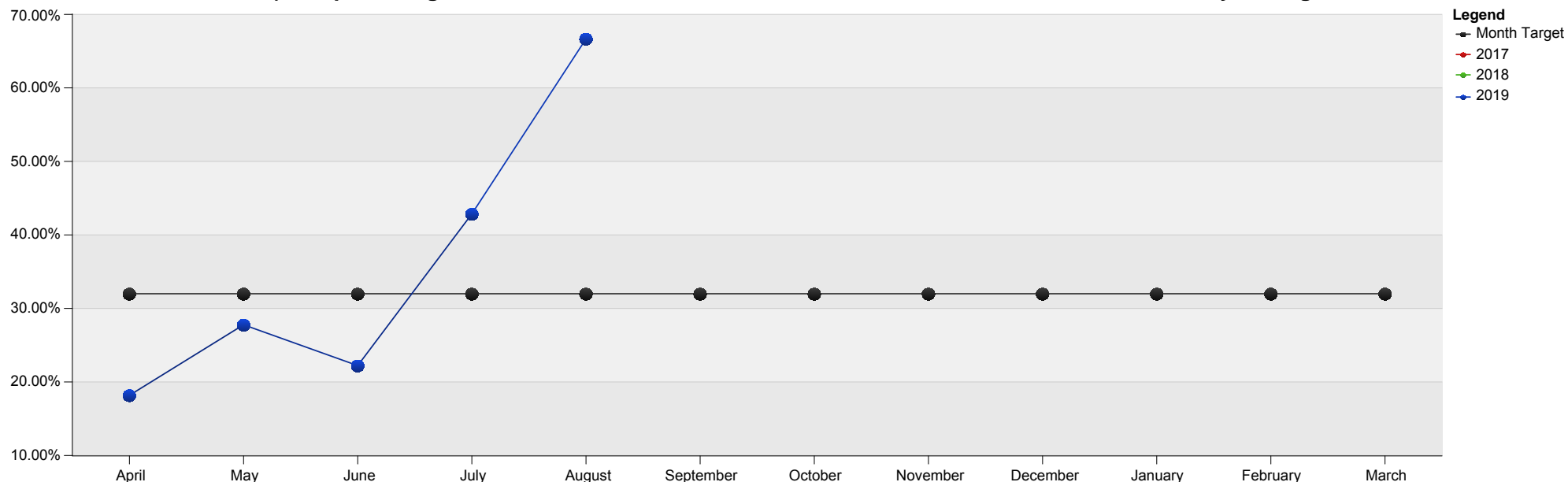
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	90.82%	91.60%	91.02%	91.89%	92.11%	91.58%	89.26%	92.25%	90.40%	88.45%		

**Narrative**

The Trust position for August 2019 is 90.82% which is not achieving the standard of 94.00% and similar to that reported in July 2019 and a slight deterioration to that reported in August 2018. No localities are meeting target for this indicator, however all localities are reporting above 90%, with the exception of North Yorkshire and York who report a position of 89.26%. A good improvement has been seen in Forensics where the challenging nature of the patient group is acknowledged. Work has been ongoing during July and August 2019 to improve completion rates of patient experience surveys. Focus was given to this area in the report out process to ensure visibility and monitoring of progress.

# Trust Dashboard Graphs for TRUST

5) The percentage of Serious Incidents which are found to have a root cause or contributory finding



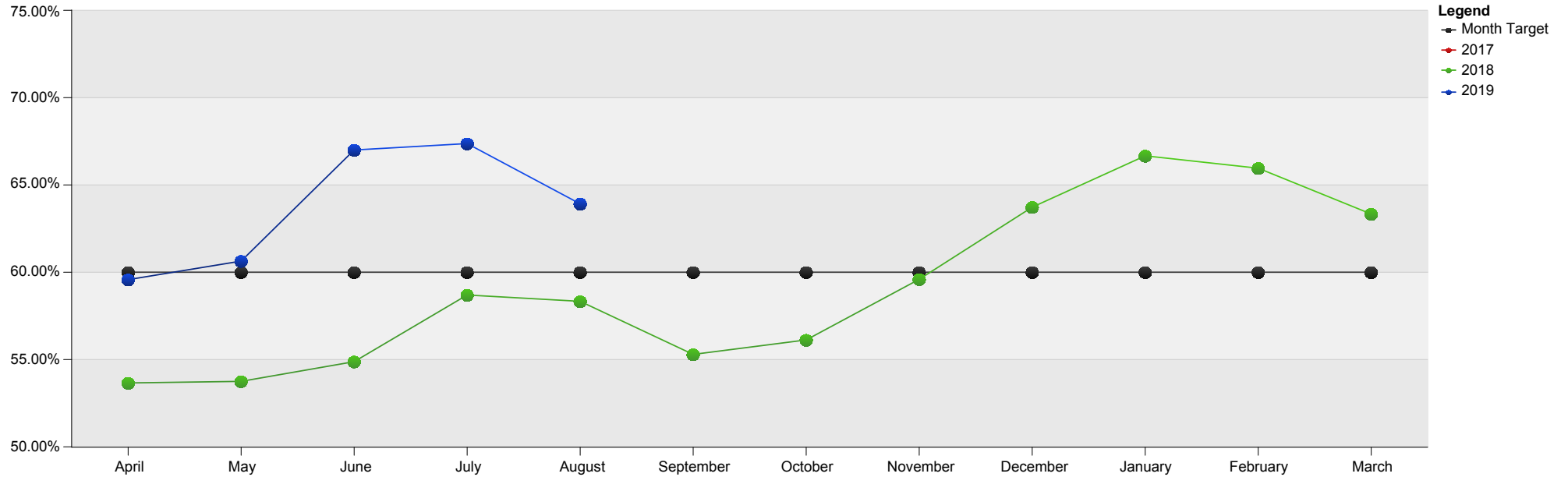
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	66.67%	35.09%	60.00%	53.33%	33.33%	10.53%	100.00%	43.48%				

**Narrative**

The Trust position for August 2019 is 66.67% which is not meeting the standard of 32%; and this is a deterioration compared to that reported in July 2019, and the second consecutive month where a deterioration has been seen. This relates to 8 serious incidents out of 12 which were found to have a root cause or contributory finding in August 2019. The 8 incidents occurred in the following localities: 4 x North Yorkshire and York 3 x Durham and Darlington 1 x Teesside. The cases completed during August have been reviewed by the Patient Safety Team and there are no obvious reasons at this stage for the increase in root cause or contributory findings. This will continue to be monitored and reported back to EMT at the Patient Safety Deep Dive in December 2019.

# Trust Dashboard Graphs for TRUST

6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind



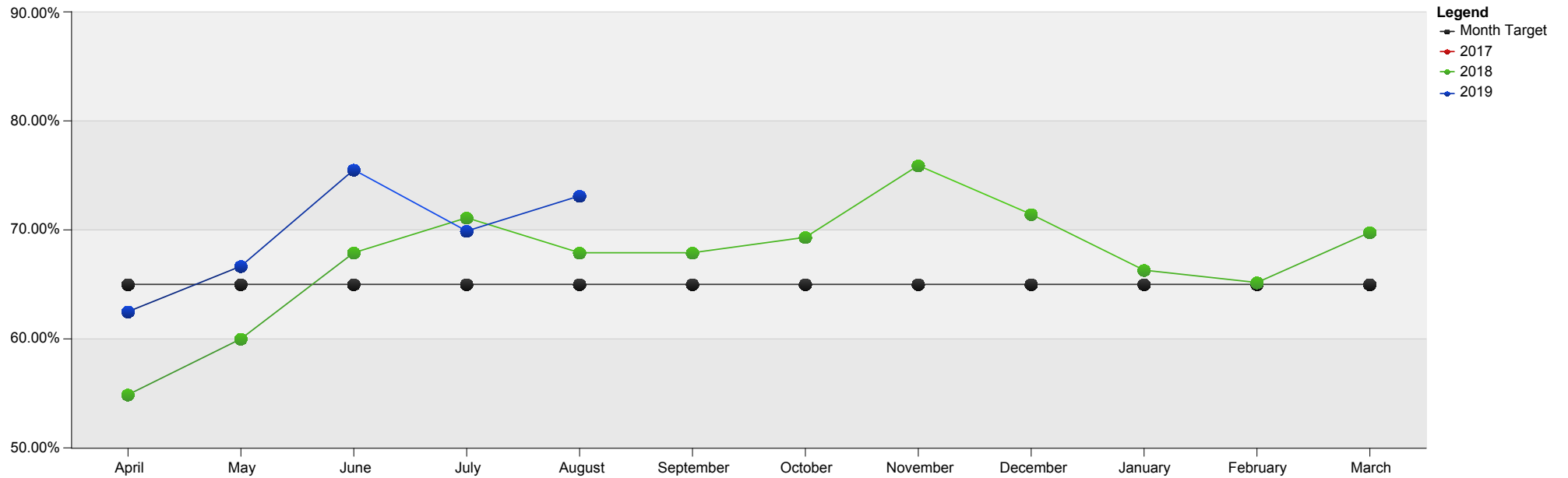
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	63.92%	63.75%	64.52%	63.69%	63.33%	63.12%	63.89%	64.09%				

**Narrative**

The Trust position for August 2019 is 63.92%, which is meeting the standard, however a deterioration to that reported in July 2019. This is an improvement to that reported in August 2018. All localities are meeting target for this indicator. Within this KPI an improvement in HONOS is shown by a decrease in the patient's actual HONOS score on PARIS. The change is identified by comparing the first HONOS score calculated on admission to TEWV, and the score on discharge. The work led by Dr Ruth Briel is continuing.

# Trust Dashboard Graphs for TRUST

7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	73.12%	69.70%	79.31%	67.31%	73.33%	72.34%	67.65%	69.70%				

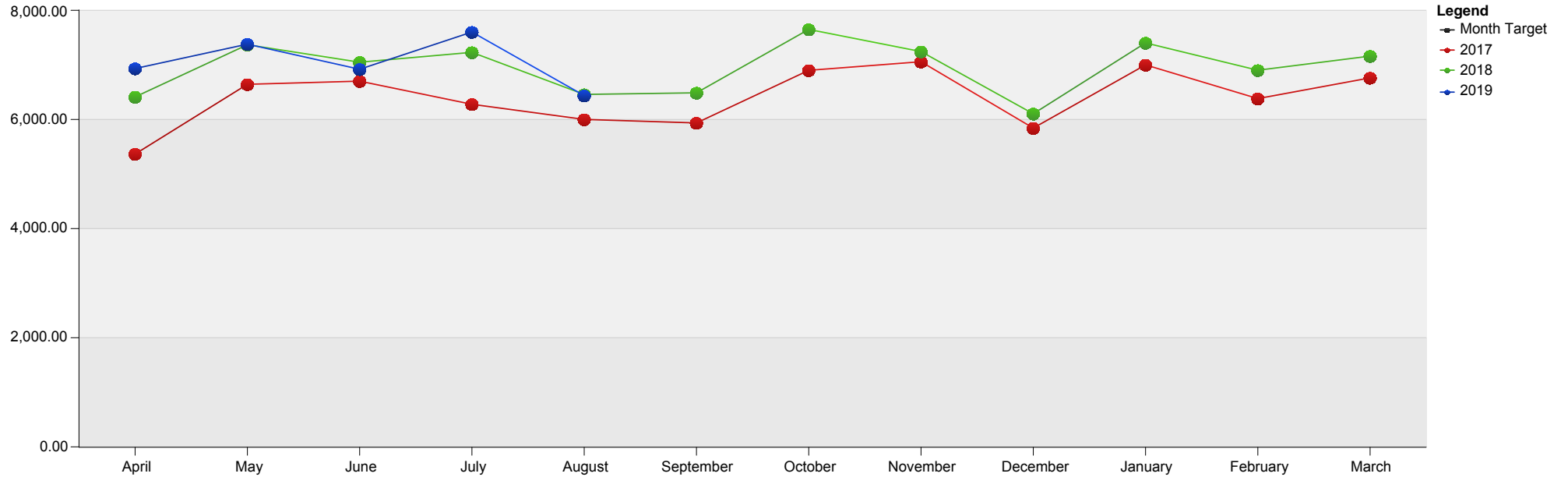
**Narrative**

The Trust position for August 2019 is 73.12%, which is meeting the standard and an improvement to that reported in July 2019 and on that reported in August 2018. Within this KPI, an improvement in SWEMWBS (which is a patient experience measure) is shown by an increase in the patient's actual SWEMWBS score. The change is identified by comparing the first SWEMWBS score calculated on admission, and the score on discharge. The work led by Dr Ruth Briel is continuing.



# Trust Dashboard Graphs for TRUST

## 8) Number of new unique patients referred



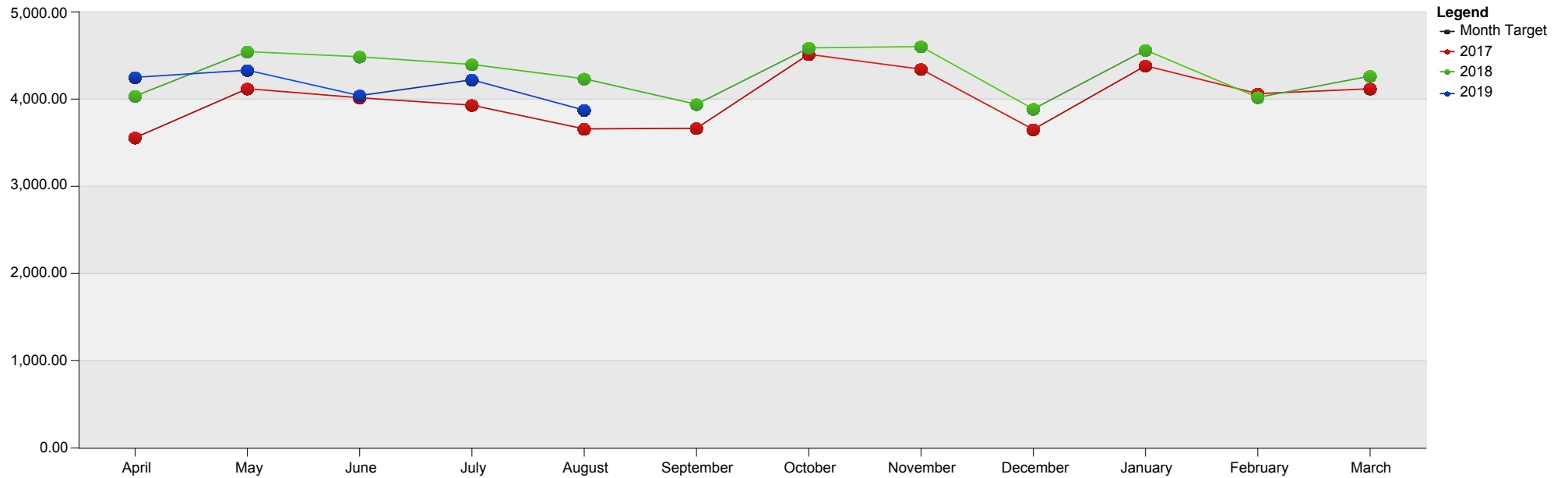
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Number of new unique patients referred	6,438.00	35,273.00	1,904.00	10,843.00	2,168.00	12,098.00	1,812.00	10,010.00	475.00	2,062.00		

### Narrative

The Trust position for August 2019 is 6,438 which is a decrease on the position reported for July 2019 and similar to that reported in August 2018. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

# Trust Dashboard Graphs for TRUST

## 9) The number of new unique patients referred with an assessment completed



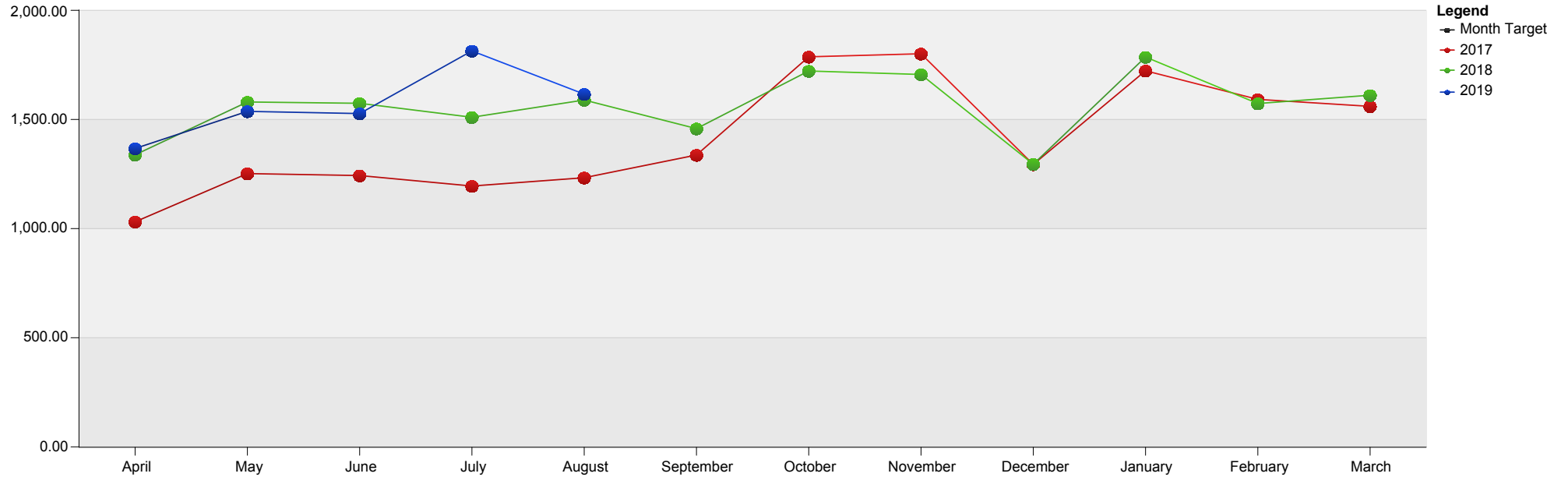
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The number of new unique patients referred with an assessment completed	3,873.00	20,714.00	1,081.00	6,175.00	1,396.00	7,378.00	1,136.00	6,063.00	243.00	1,076.00		

### Narrative

The Trust position for August 2019 is 3,873 which is a decrease on the position reported for July 2019 and that reported in August 2018. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

# Trust Dashboard Graphs for TRUST

## 10) Number of new unique patients referred and taken on for treatment



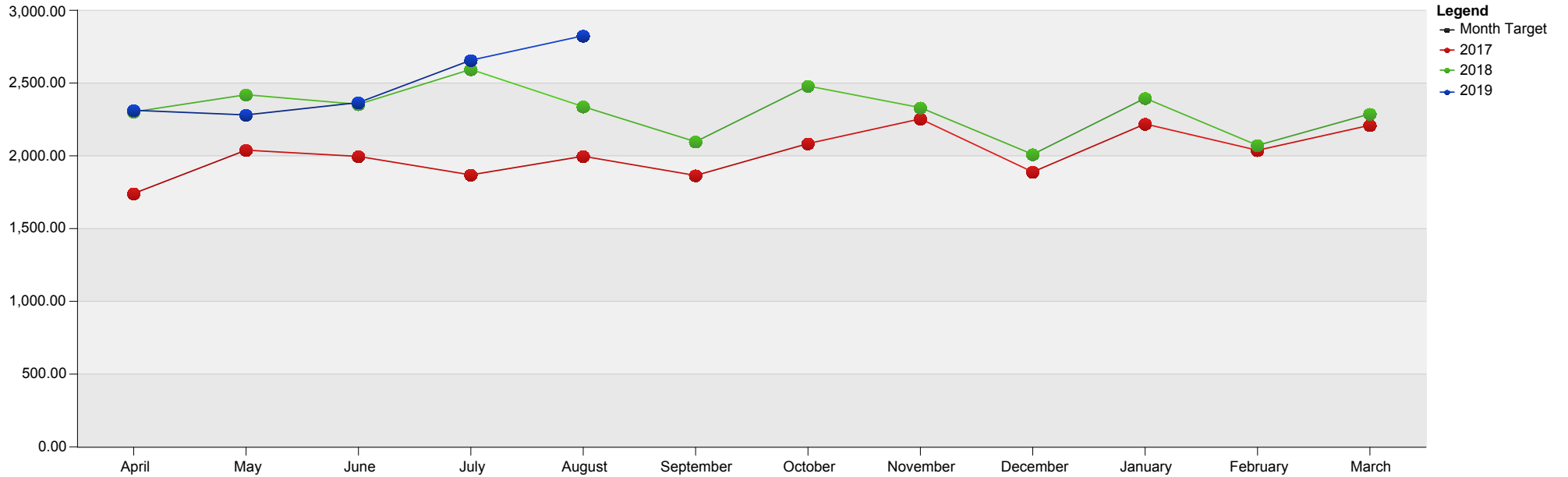
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Number of new unique patients referred and taken on for treatment	1,616.00	7,861.00	481.00	2,478.00	537.00	2,330.00	570.00	2,918.00	19.00	80.00		

### Narrative

The Trust position for August 2019 is 1,616 which is a decrease on the position reported for July 2019 and similar to that reported in August 2018. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

# Trust Dashboard Graphs for TRUST

## 11) Number unique patients referred who received treatment and were discharged



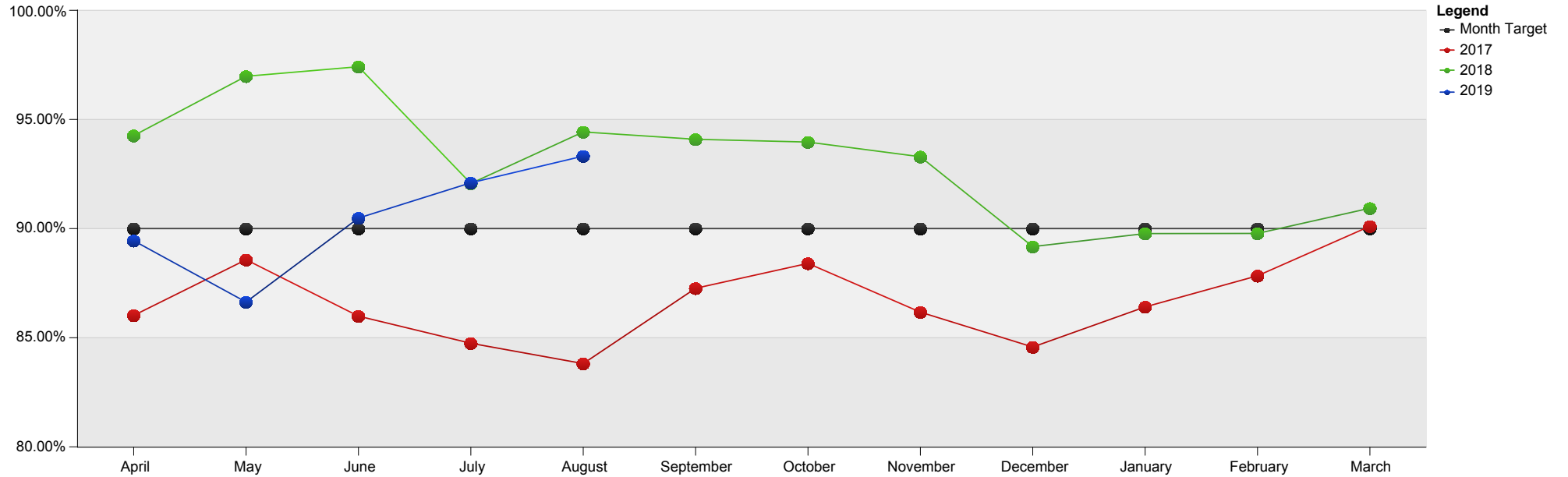
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number unique patients referred who received treatment and were discharged	2,825.00	12,442.00	847.00	3,913.00	999.00	3,931.00	929.00	4,439.00	49.00	152.00		

### Narrative

The Trust position for August 2019 is 2,825 which is an increase to that reported for July 2019 and to that reported in August 2018. This is also the highest number reported since 2016/17. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

# Trust Dashboard Graphs for TRUST

## 12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)



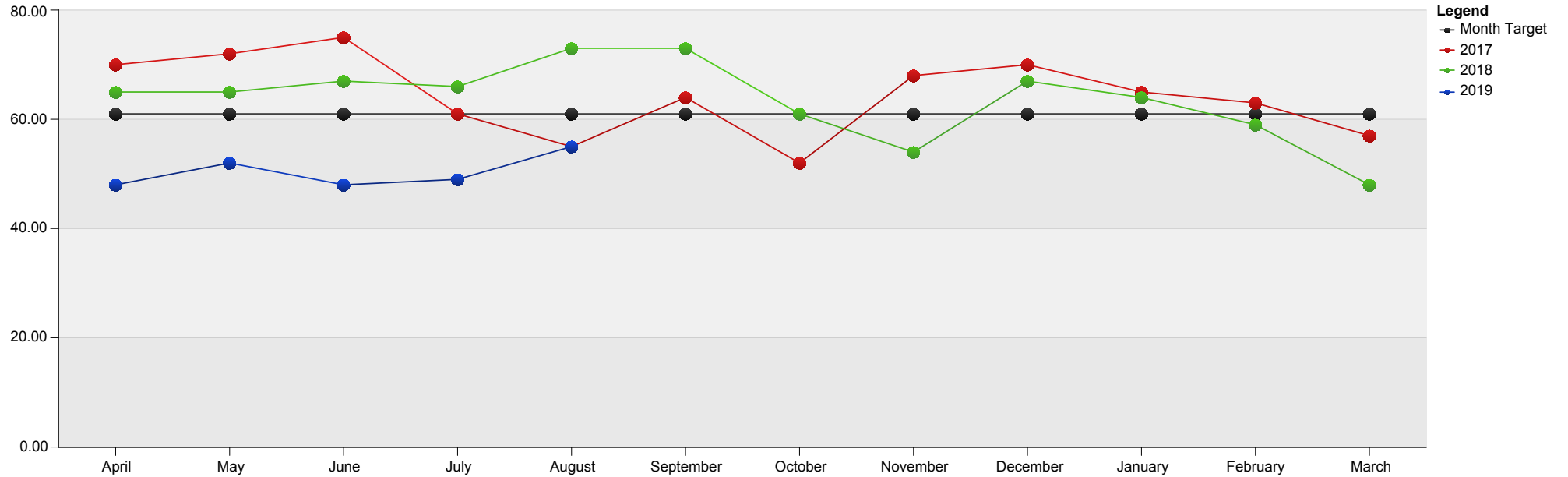
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	93.32%	90.40%	94.12%	93.28%	99.44%	96.93%	88.04%	82.74%	NA	NA		

### Narrative

The Trust position for August 2019 is 93.32% which is not meeting the standard and a deterioration in performance when compared to July 2019. Teesside report the poorest position at 99.44%, this is due to increased demand on beds within both AMH and MHSOP. Work is ongoing within AMH to understand and address any blockages to discharge for patients with a LOS of 30 days or more. Despite the increase in bed occupancy the number of out of area admissions has improved.

# Trust Dashboard Graphs for TRUST

13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot



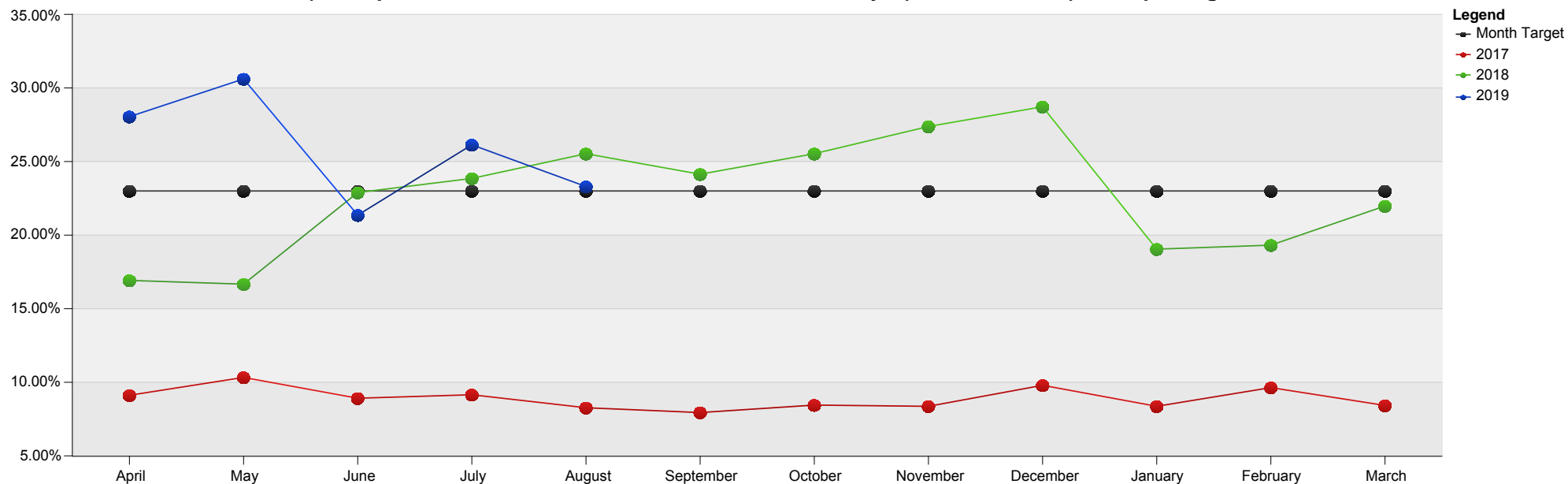
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	55.00	55.00	22.00	22.00	11.00	11.00	20.00	20.00				

**Narrative**

The Trust position for August 2019 is 55 which is meeting the standard however an increase to that reported in July 2019. This continues to be one of the lowest positions recorded since 2017/18. Durham and Darlington and Teesside localities are not meeting target for this indicator. Both localities report issues relating to complex patients and securing community placements as impacting on performance in this area. All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles.

# Trust Dashboard Graphs for TRUST

14) % of patients re-admitted to A&T wards within 30 days (AMH & MHSOP) - in reporting month



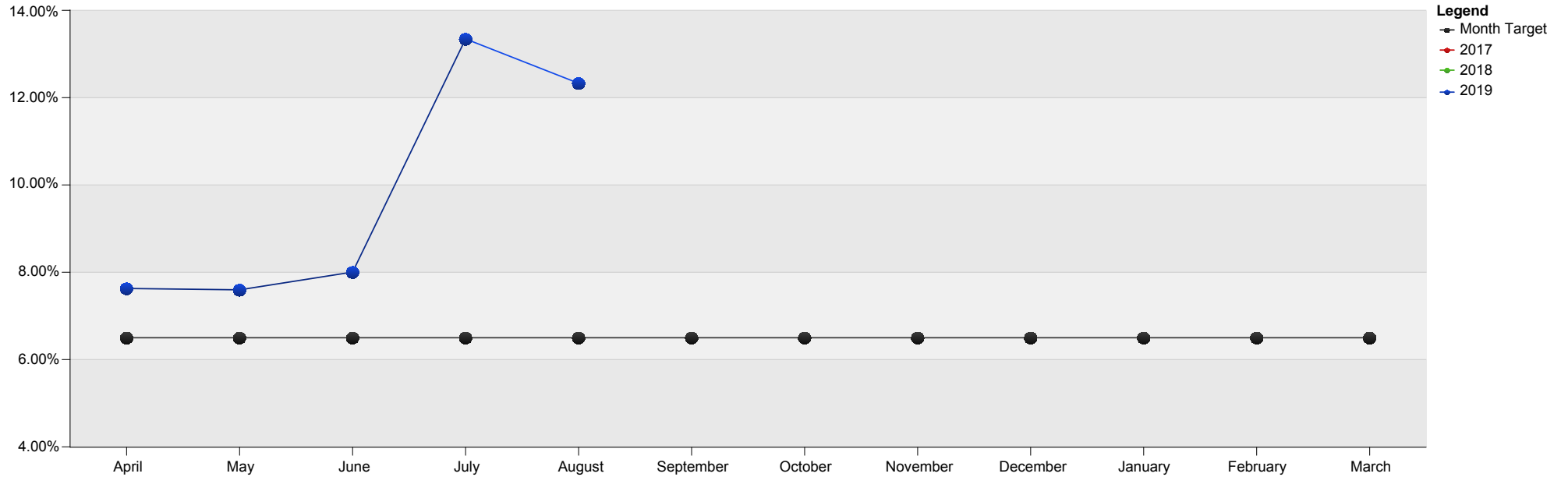
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.30%	25.74%	26.83%	25.73%	17.24%	26.12%	24.24%	24.38%				

**Narrative**

The Trust position for August 2019 is 23.30% which is not meeting the standard however an improvement to that reported in July 2019 and August 2018. This relates to 24 readmissions out of 103 readmissions that were within 30 days. Teesside is the only locality not meeting target. Further work has been completed to improve understanding of the issues impacting on performance for this indicator and is included in this report.

# Trust Dashboard Graphs for TRUST

## 15) Vacancy Rate (Healthcare Professionals only)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Vacancy Rate (Healthcare Professionals only)	12.33%	9.73%	16.28%	11.73%	8.94%	6.42%	13.99%	13.48%	7.37%	5.38%		

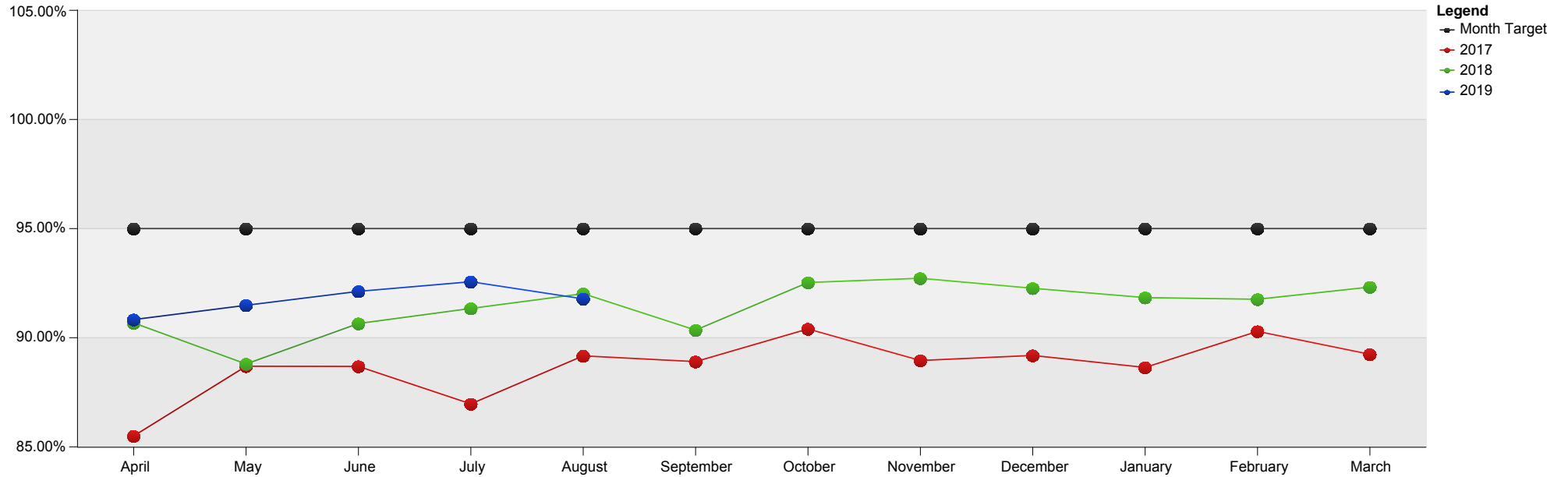
### Narrative

The position for August 2019 is 13.34% which is not meeting the standard and an improvement compared to that reported in July. This equates to 440.89 wte vacancies currently being actively being recruited to which represents a significant increase on the number of vacancies reported in June. A Right Staffing Agency dashboard is now in place to monitor the usage of agency staff; this will allow operational services to monitor vacancies more effectively. A vacancy census report on community vacancies has been produced and will be considered by EMT in September. This is a new indicator for 2019/20 therefore data relating to previous year's performance is not available.



# Trust Dashboard Graphs for TRUST

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



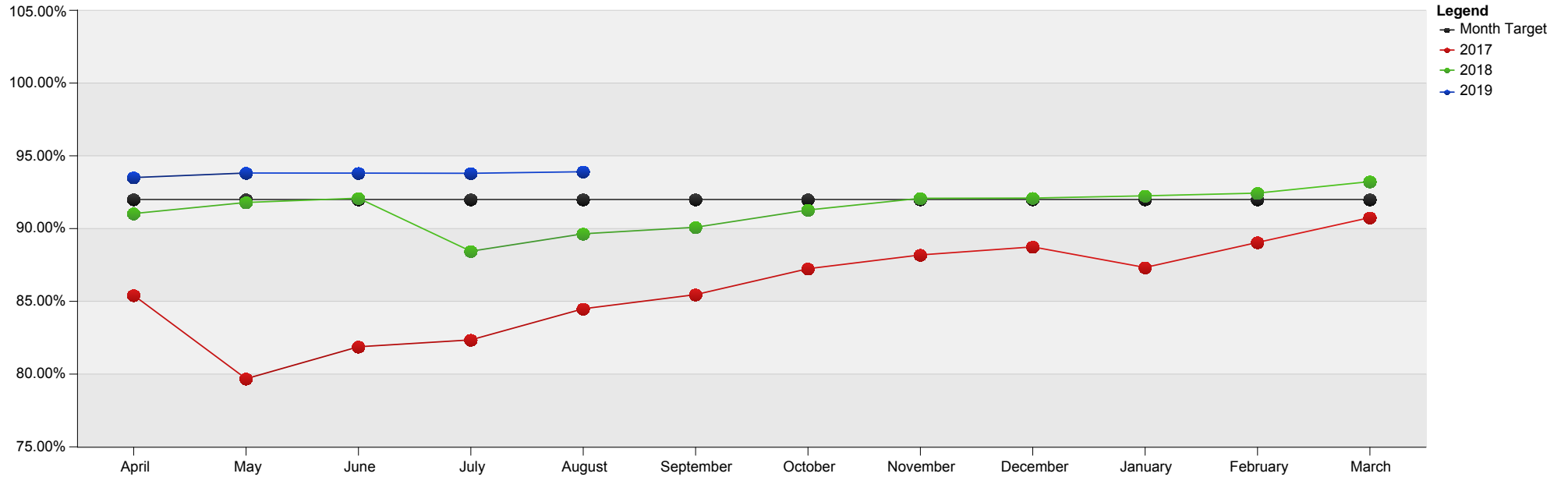
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	91.78%	91.78%	91.52%	91.52%	91.35%	91.35%	91.34%	91.34%	96.29%	96.29%		

Narrative

The Trust position for August 2019 is worse than the standard at 92.55% which relates to 471 members of staff out of 5730 that do not have a current appraisal. This is a deterioration to the position reported in July 2019 and a marginal deterioration to that reported in August 2018. Forensic Services are the best performing locality at 96.29%. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels. However issues such as vacancies and sickness, referred to within this report, impact on the ability to deliver appraisals.

# Trust Dashboard Graphs for TRUST

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



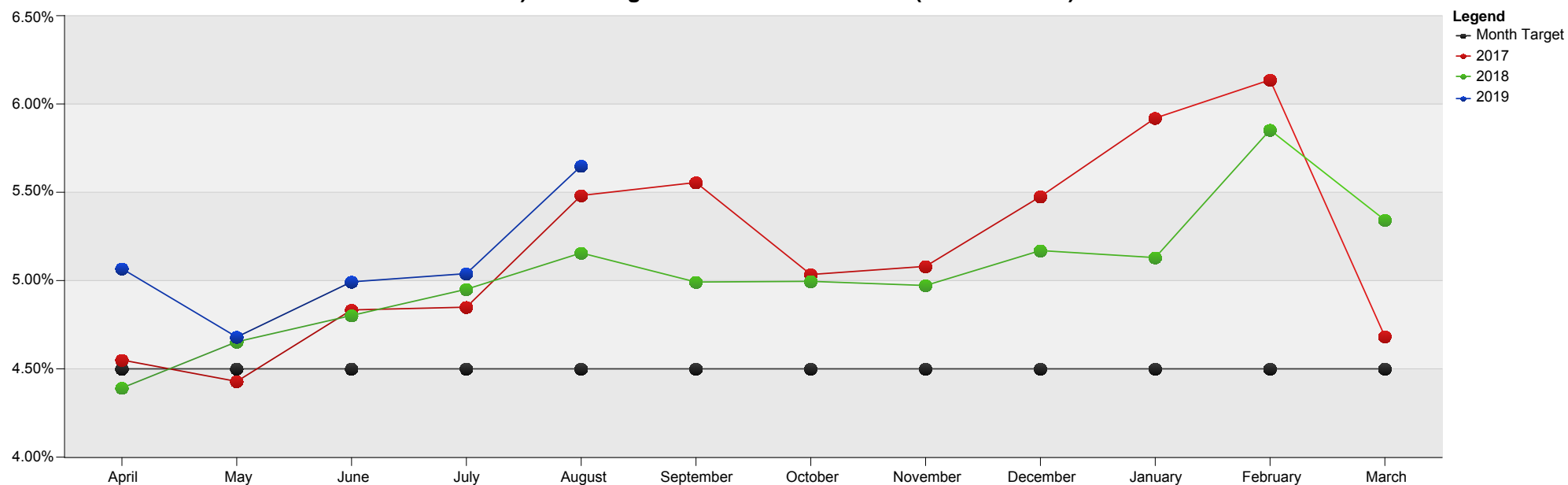
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	93.91%	93.91%	92.60%	92.60%	94.20%	94.20%	92.32%	92.32%	97.00%	97.00%		

### Narrative

The position for August 2019 is 93.91% and is a slight improvement to that reported for July 2019 and is achieving the standard. This is the best position reported since 2017/18. All localities are achieving the standard. The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh also allows a timelier update of accurate performance information to managers, enabling proactive action to take place.

# Trust Dashboard Graphs for TRUST

## 18) Percentage Sickness Absence Rate (month behind)



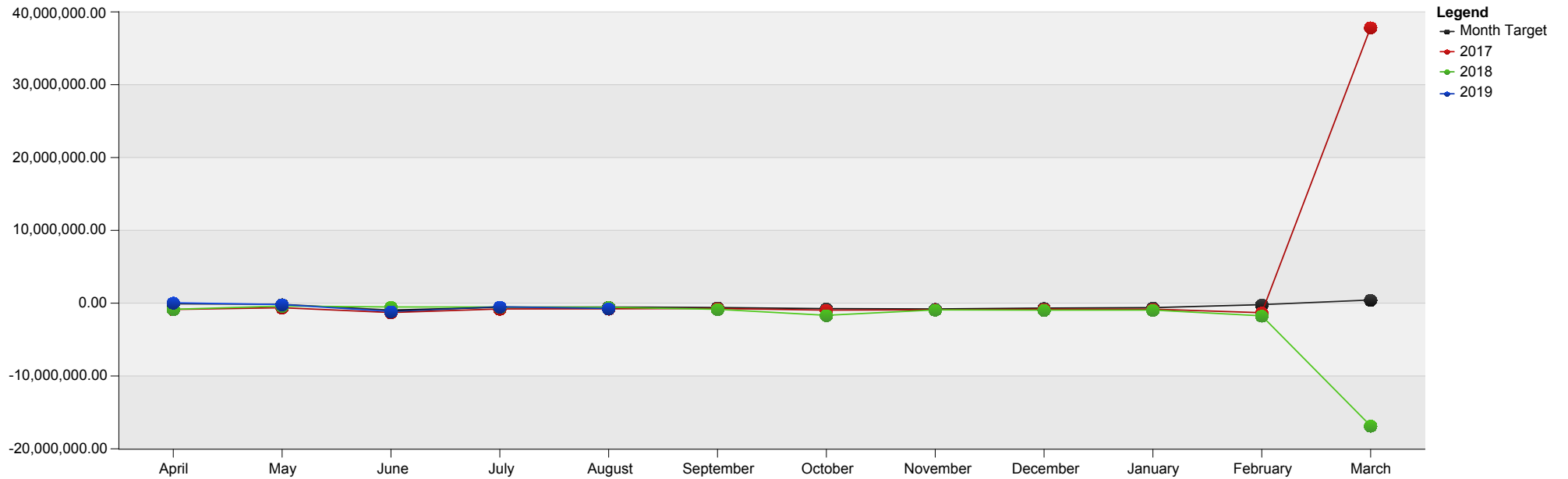
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	5.65%	5.09%	5.40%	5.05%	7.02%	5.86%	4.31%	4.12%	6.72%	6.44%		

### Narrative

The Trust position reported in August relates to the July sickness level. The Trust position reported in August 2019 increased to 5.65% which is not meeting the standard of 4.50% and an increase to the position reported in July 2019 and August 2018. North Yorkshire and York are the only locality to meet target. Teesside report the highest figure at 7.02%. This is due to exceptional circumstances within this locality that are being addressed by the Trust. Appropriate action is being taken to support both staff and patients. Improvements in the sickness position are anticipated. The Sickness Absence Management Procedure is currently being reviewed and a revised procedure is due to be agreed by December 2019.

# Trust Dashboard Graphs for TRUST

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



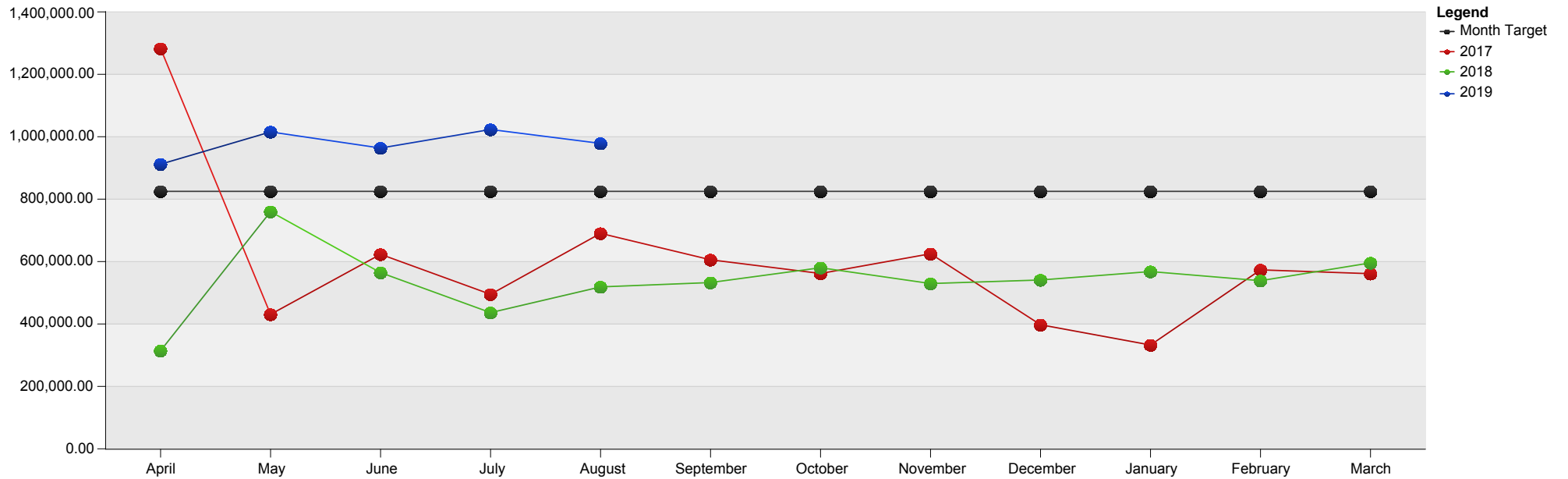
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Delivery of our financial plan (I and E)	-730,839.00	-2,490,510.00	-149,475.00	-301,928.00	422,554.00	1,772,861.00	1,420.00	654,571.00	5,401.00	117,831.00		

**Narrative**

The comprehensive income outturn for the period ending 31 August 2019 is a surplus of £2,4910k, representing -0.2% of the Trust's turnover and is £85k ahead of the NHSI plan.

# Trust Dashboard Graphs for TRUST

## 20) CRES delivery



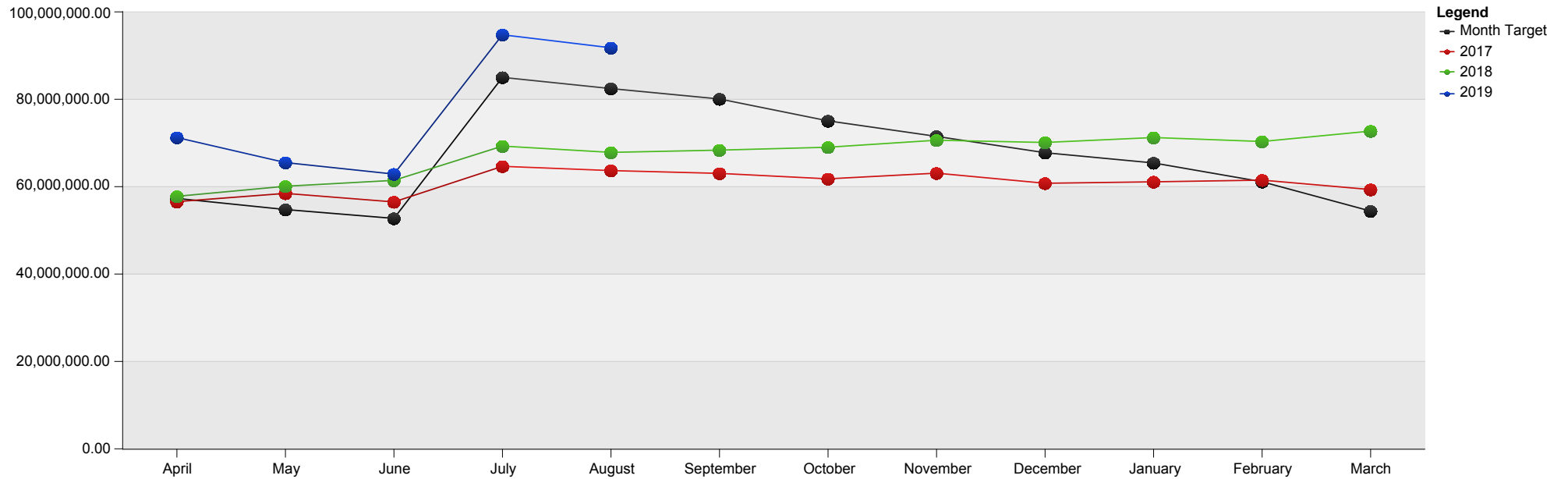
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	978,602.00	4,893,009.67	97,692.00	488,460.17	84,430.00	422,149.00	214,034.00	1,070,170.00	49,753.00	248,764.50		

### Narrative

Identified Cash Releasing Efficiency Savings at 31 August 2019 is £4,893k and is £768k ahead of plan for the year to date. The Trust is anticipating being ahead of plan (£1,844k) at the financial year end and continues to identify schemes for future years

# Trust Dashboard Graphs for TRUST

## 21) Cash against plan



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	91,781,645.00	91,781,645.00	NA	NA	NA	NA			NA	NA		

### Narrative

Total cash at 31 August 2019 is £91,782k which is £9,338k ahead of plan largely due to higher than anticipated creditor accruals where invoices have not been received by the Trust and underspends on the capital programme.

Trust Dashboard - Locality Breakdown for TRUST

	August 2019												April 2019 To August 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral		84.01%		82.40%		89.38%		76.75%		98.67%				84.20%		82.73%		89.47%		77.27%		98.68%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		61.80%		71.07%		55.32%		58.06%		94.92%				56.02%		60.57%		56.50%		53.11%		92.86%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		1,302.00		172.00		510.00		620.00						1,302.00		172.00		510.00		620.00				
4) Percentage of patients surveyed reporting their overall experience as excellent or good		90.82%		91.02%		92.11%		89.26%		90.40%				91.80%		91.89%		91.58%		92.25%		88.45%		
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		66.67%		60.00%		33.33%		100.00%						35.09%		53.33%		10.53%		43.48%				
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		63.92%		64.52%		63.33%		63.89%						63.75%		63.69%		63.12%		64.09%				
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		73.12%		79.31%		73.33%		67.65%						69.70%		67.31%		72.34%		69.70%				

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	August 2019												April 2019 To August 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
8) Number of new unique patients referred		6,438.00		1,904.00		2,168.00		1,812.00		475.00				35,273.00		10,843.00		12,098.00		10,010.00				2,062.00
9) The number of new unique patients referred with an assessment completed		3,873.00		1,081.00		1,396.00		1,136.00		243.00				20,714.00		6,175.00		7,378.00		6,063.00				1,076.00
10) Number of new unique patients referred and taken on for treatment		1,616.00		481.00		537.00		570.00		19.00				7,861.00		2,478.00		2,330.00		2,918.00				80.00
11) Number unique patients referred who received treatment and were discharged		2,825.00		847.00		999.00		929.00		49.00				12,442.00		3,913.00		3,931.00		4,439.00				152.00
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		93.32%		94.12%		99.44%		88.04%		NA		NA		90.40%		93.28%		96.93%		82.74%		NA		NA
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot		55.00		22.00		11.00		20.00						55.00		22.00		11.00		20.00				
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		23.30%		26.83%		17.24%		24.24%						25.74%		25.73%		26.12%		24.38%				



Trust Dashboard - Locality Breakdown for TRUST

5 - Workforce

	August 2019												April 2019 To August 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
15) Vacancy Rate (Healthcare Professionals only)		12.33%		16.28%		8.94%		13.99%		7.37%				9.73%		11.73%		6.42%		13.48%		5.38%		
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		91.78%		91.52%		91.35%		91.34%		96.29%			91.78%		91.52%		91.35%		91.34%		96.29%			
17) Percentage compliance with ALL mandatory and statutory training (snapshot)		93.91%		92.60%		94.20%		92.32%		97.00%			93.91%		92.60%		94.20%		92.32%		97.00%			
18) Percentage Sickness Absence Rate (month behind)		5.65%		5.40%		7.02%		4.31%		6.72%			5.09%		5.05%		5.86%		4.12%		6.44%			

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	August 2019												April 2019 To August 2019											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Delivery of our financial plan (I and E)		-730,839.00	NA	-149,475.00	NA	-422,554.00	1,420.00	NA	5,401.00				-2,490,510.00	NA	-301,928.00	NA	-1,772,861.00	654,571.00	NA	117,831.00				
20) CRES delivery		976,602.00		97,692.00		84,430.00	214,034.00		49,753.00				4,893,009.67		488,460.17		422,149.00	1,070,170.00		248,704.50				
21) Cash against plan		91,781,645.00	NA	NA	NA	NA		NA	NA				91,781,645.00	NA	NA	NA	NA		NA	NA				

**Trust Dashboard 2019/20 KPI Guide**

No.	KPI	Target	Definition
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90%	This measures, the number of patients who attend their first appointment in 4 weeks of their referral date out of the total number of people who attend their first appointment following their referral. This KPI has been amended for 2018/19 and the clock will now NOT restart if the patient DNAs or the patient cancels an appointment. This looks at patients with an external referral only. This excludes IAPT patients.
2	Percentage of patients starting "treatment" within 6 weeks of external referral	60%	This measures, the number of people starting treatment within 6 weeks of an external referral against number of people starting treatment. This looks at patients with an external referral only.
3	The total number of inappropriate OAP days over the reporting period (Rolling 3 months)	2,169	This measures, the total number of days patients have spent in an out of area bed inappropriately. In line with national reporting this measures a rolling 3 months' time frame
4	Percentage of patients surveyed reporting their overall experience as excellent or good	94%	Within all inpatient and community services, this measures: Of the number of people in the Patient Survey who answered the question: -"Overall how would you rate the care you have received?," the number of patients who have scored "excellent" or "good"
5	The percentage of Serious Incidents which are found to have a root cause or contributory finding	32%	This measure looks at the percentage of serious incidents that are investigated and found to have a root cause or contributory finding
6	The % teams achieving the agreed improvement benchmarks for HoNOS total score	60%	This measure relates to patients discharged from TEVV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total HoNOS scores are compared from first rating against the last. A reduction in total HoNOS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 40% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEVV not if they are

**Trust Dashboard 2019/20 KPI Guide**

No.	KPI	Target	Definition
			transferred to a different In Scope team.
7	The % teams achieving the agreed improvement benchmarks for SWEMWBS	65%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total SWEMWBS scores are compared from the first rating against the last. An increase in SWEMWBS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 50% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.
8	Number of new unique patients referred	N/A	This measure relates to the number of new individual patients referred (so a patient is only counted once and not open to any other team in the Trust). This excludes IAPT patients.
9	The number of new unique patients referred with an assessment completed	N/A	This measure relates to the number of new unique patients with an assessment completed (and is a subset of measure 8).
10	Number of new unique patients referred and taken on for treatment	N/A	This measure relates to the number of new unique patients referred, assessed and then taken on for treatment (and is a subset of measure 9).
11	Number unique patients referred who received treatment and were discharged	N/A	This measure relates to the number of new unique patients referred who were taken on for treatment and then discharged.
12	Bed Occupancy (AMH & MHSOP A & T Wards)	90%	This measures the number of days beds that are occupied out of the number of possible bed days available. (The calculation is on the number of beds available and the days in the month). This looks at AMH and MHSOP Assessment and Treatment wards only
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards (Snapshot)	61	This measures the number of patients occupying a bed with a length of stay longer than 90 days from the day they were admitted. This looks at AMH and MHSOP Assessment and Treatment wards only

No.	KPI	Target	Definition
14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	23%	This measures the number of patients who are readmitted onto a ward within 30 days of their last discharge. This looks at AMH and MHSOP Assessment and Treatment wards only
15	Vacancy Rate (Healthcare Professionals only)	6.50%	This measures the total number of advertised vacancies against the total number of budgeted staff
16	Percentage of staff in post more than 12 months with a current appraisal	95%	This measures the number of staff in post more than 12 months and of those how many have a current appraisal. For medical staff this is monitored against 13 months.
17	Percentage compliance with ALL mandatory and statutory training	92%	This measures the total number of courses completed by each member of staff for ALL mandatory and statutory training out of the number of courses due to be completed for each member of staff
18	Percentage Sickness Absence Rate	4.50%	This measures the number of days lost to sickness out of the number of days within the month
19	Delivery of our financial plan (I&E)	-524,000	This shows the Trusts surplus or deficit position (£). The target is the planned surplus position.
20	CRES delivery	824,916	This shows the CRES Identified against the planned amount
21	Cash against plan	82,444	This shows the actual cash held by the Trust against the amount of cash forecasted to be held

Data Quality Scorecard 2019/20 - Appendix C

	Data Source				Data Reliability					KPI Construct/Definition					KPI Amended / Tested					Total Score	Total Score as %	Notes		
	A (6)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	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	Unlisted 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	Tested within last 12 months and all associated risks identified on proforma have been accepted or mitigated	Tested within last 12 months and all associated risks identified on proforma	Tested within last 12 months	Tested between 12 and 24 months ago				Tested over 24 months ago	
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	5				5					5					5						20	100%	
2	Percentage of patients starting treatment within 6 weeks of external referral	5					4				5					5						19	95%	Some data quality issues have been reported in relation to the use of appropriate intervention/treatment codes. Guidance has been circulated to improve understanding and this under review in the report out process. Improvements are expected as awareness about appropriate codes included in this KPI improves.
3	Total number of inappropriate OAP days over the reporting period (rolling 3 months)		4			5					5					5						19	95%	Data is extracted electronically, validated manually and reuploaded into the system. Work is underway to amend PARIS to enable this to be recorded completely on the system, timescale to be confirmed
4	Percentage of patients surveyed reporting their overall experience as excellent or good.	5				5					5							3				18	90%	Data is collected via electronic devices for inpatient areas, on paper surveys for community teams as well as via kiosks in team bases where there are large footfalls. There is also a phone Application now where clinicians can send the survey to patients and carers phones via email or SMS. The Quality Data Team access the system to generate reports.
5	The percentage of Serious Incidents which are found to have a root cause or contributory finding				2	5					5					5						17	85%	Data is collated onto excel for manual process after retrieval from the Dataix system
6	The percentage of teams achieving the agreed improvement benchmarks for HoNOS total score		4			5					5					5						19	95%	
7	The percentage of teams achieving the agreed improvement benchmarks for SWEMWBS total score		4			5					5					5						19	95%	
8	Number of new unique patients referred	5				5					5					5						20	100%	
9	The number of new unique patients referred with an assessment completed	5				5					5					5						20	100%	
10	Number of new unique patients referred and taken on for treatment	5				5					5					5						20	100%	
11	Number unique patients referred who received treatment and were discharged	5				5					5					5						20	100%	
12	Bed Occupancy (AMH & MHSOP A&T wards)	5				5					5					5						20	100%	
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards)	5				5					5							3				18	90%	
14	Percentage of patients readmitted to Assessment and treatment wards within 30 days	5				5					5							3				18	90%	
15	Vacancy rate (score from old KPI)				2		4				5					5						16	80%	Data extracted electronically but processed manually
16	Percentage of staff in post more than 12 months with a current appraisal	5					4				5							3				17	85%	Issues with appraisal dates being entered to ESR have been reported. Compliance levels are effectively being monitored via monthly Huddle meetings and support is being provided where necessary to address ESR issues. A refresh of ESR guidance is being scheduled to improve accurate recording on the source system.
17	Percentage compliance with ALL mandatory and statutory training	5					4				5					5						19	95%	Issues with training compliance figures being reported have lessened - there appears to be greater confidence in the data being reported and this has been supported by scrutiny of issues in report out processes
18	Percentage Sickness Absence Rate (month behind)	5					4				5							3				17	85%	Sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR. There are some data quality issues concerned with failing to end sickness in a timely manner - this is picked up and monitored through sickness absence audits that the Operational HR team undertake.
19	Delivery of our financial plan (I and E)		4			5					5					5						19	95%	Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
20	CRES Delivery				2	5					5					5						17	85%	Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4			5					5					5						19	95%	An extract is taken from the system then processed manually to obtain actual performance.

**Detailed Analysis of Performance regarding KPI 14:**  
**Percentage of Patients Re-admitted to Assessment & Treatment Wards within 30 Days**  
**(AMH & MHSOP)**

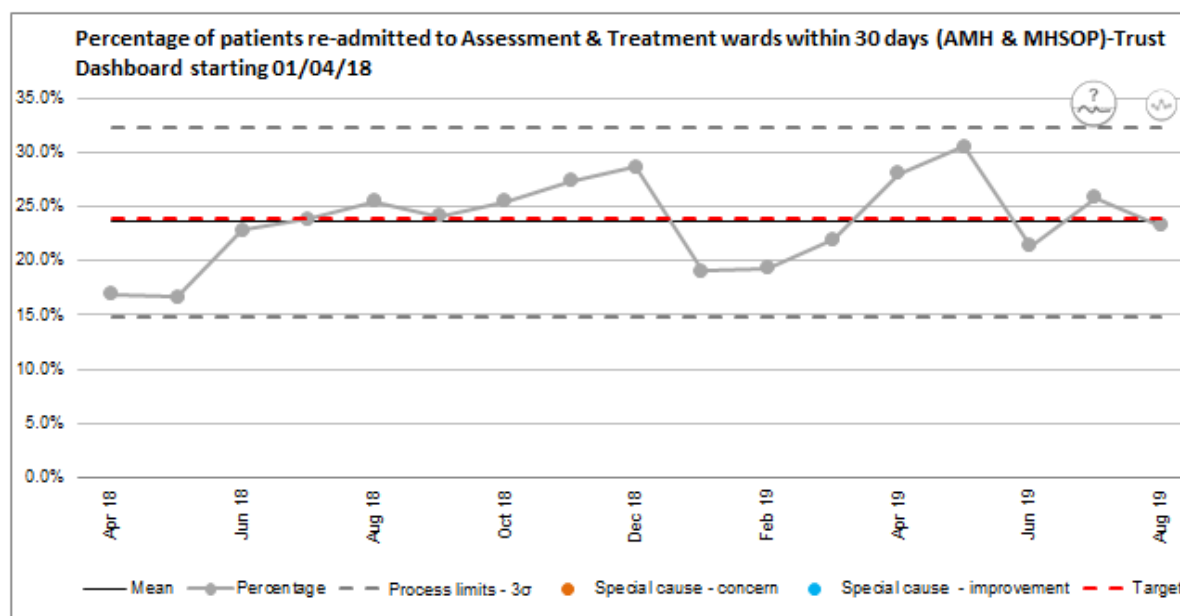
Definition

This report contains data relating to the key performance indicator 14 - percentage of patients re-admitted to assessment & treatment wards within 30 days (AMH & MHSOP).

This indicator calculates of those people who have been readmitted in the month the percentage where this is within 30 days of their last discharge. The calculation excludes planned admissions, transfers back from an acute trust and the MOD beds.

Overall Performance

The SPC chart below shows the performance since April 2018 to August 2019. This SPC chart shows that performance has remained within the expected control limits with any variation being common cause variation.



When considered as a percentage of all admissions the number of re admissions within 30 days is at 7.59% YTD, with North Yorkshire and York readmitting the highest number of people.

Diagnosis Analysis

The table below shows the most recent **primary** diagnosis for a snapshot of patients readmitted in Q1 2019 (April - June 2019). This table shows the following:

- The majority of patients readmitted have a current diagnosis of psychosis, personality disorder or non-psychotic mood disorder.
- North Yorkshire and York have a higher number of patients readmitted with a current diagnosis of psychosis and mood disorder (non psychotic) than the other localities.
- North Yorkshire and York have a lower number of patients readmitted with a current diagnosis of personality disorder

<b>Diagnosis Type:</b>	<b>DURHAM AND DARLINGTON</b>	<b>NORTH YORKSHIRE AND YORK</b>	<b>TEESSIDE</b>	<b>TOTAL</b>
Psychosis	7 (29.16%)	12 (48%)	9 (26%)	28 (37.84%)
Personality disorder	8 (33.33%)	1 (4%)	8 (32%)	17 (22.97%)
Mood disorder, non-psychotic	3 (12.5%)	8 (32%)	5 (20%)	16 (21.62%)
Other	3 (12.5%)	1 (4%)	2 (8%)	6 (8.11%)
Organic	1 (4.17%)	2 (8%)	1 (4%)	4 (5.40%)
Substance misuse	2 (8.33%)	1 (4%)	0 (0%)	3 (4.05%)
<b>Total</b>	<b>24</b>	<b>25</b>	<b>25</b>	<b>74</b>

### Intervention Analysis

Readmissions within 30 days between April and June 2019 have also been reviewed to assess if there were any common issues that could have prevented the readmission.

Analysis of the 74 readmissions between April and June 2019 is summarised below:

- 71.62% (53 out of 74) cases identified no specific additional action that could have been taken which it is felt would have prevented the admission.
- 28.37% (21 cases out of 74) recorded a reflection or learning that highlighted a gap in community interventions **or** discharge planning.
- Of the 21 readmissions that recorded a reflection or learning point:
  - The majority of cases (18) reported a gap or learning with regards to community interventions
  - Eight cases recorded a gap or learning with regards to discharge planning

Particular themes in terms of where potential gaps have been noted are highlighted below:

- 8 cases highlighted lack of involvement / potential for improvement in the involvement of the crisis team post discharge. Of the 8 cases three highlighted that home based treatment may have been beneficial to the patient
- 4 cases highlighted lack of involvement / potential for improvement in the involvement of the community mental health team
- 2 cases identified that a border line personality disorder plan may have been beneficial to the patient on discharge

The findings will be discussed by the QUAG's in each locality.

### Conclusion

- SPC analysis of the KPI Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) shows that variations in monthly performance are due to common cause variation.
- The majority of patients readmitted have a current primary diagnosis of psychosis, personality disorder or non-psychotic mood disorder.
- The majority of readmissions (71.62%) identified no specific action that could have been taken which it was felt would have avoided the admission.



- Of the identified 28.74% (21 out of 74) cases where a reflection or learning point was identified the majority of potential gaps lay in the support provided to the patient in the community post discharge. Key themes within the gaps in community provision were highlighted within crisis intervention post discharge and the CMHT.
- When considered as a proportion of all admissions for the financial year to date the percentage of readmissions is relatively low. When described as a percentage at Trust level the figure is consistently below 10%. However there is a higher proportion in North Yorkshire and York.

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	24 <sup>th</sup> September 2019
TITLE:	Strategic Direction Performance Report – Quarter 1 2019/20
REPORT OF:	Sharon Pickering, Director of Planning and Performance
REPORT FOR:	Assurance

<b>This report supports the achievement of the following Strategic Goals:</b>	✓
<i>To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing</i>	✓
<i>To continuously improve the quality and value of our work</i>	✓
<i>To recruit, develop and retain a skilled, compassionate and motivated workforce</i>	✓
<i>To have effective partnerships with local, national and international organisations for the benefit of the communities we serve</i>	✓
<i>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.</i>	✓

#### Executive Summary:

The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 1 (30<sup>th</sup> June 2019). **It does not include any information on issues that have arisen since the 30<sup>th</sup> June 2019, as these will be included in the quarter 2 report due to come to Board in November.**

At the Board Meeting on the 19<sup>th</sup> July 2018, the Board agreed to revise the KPIs for the Strategic Direction Scorecard. This report reflects the new key performance indicators that were agreed against which we will monitor and report progress against the Trust's 5 year strategic direction in conjunction with the Trust Business Plan and other forms of intelligence.

Whilst quarter 1 performance reports 5 out of 15 metrics being red, 3 (60%) of those have reported an improvement compared to quarter 4; 6 metrics in total have reported an improvement on quarter 4. In addition, progress against the Business Plan and qualitative intelligence supports the strong performance on the KPIs. However, there does remain a concern with the Business Plan element of Strategic Goal 5, which has not delivered any actions in quarter 1 and the CQC Notice of Decision at West Lane Hospital received on the 25<sup>th</sup> June 2019 is of concern in terms of us achieving our Strategic Direction.

#### Recommendations:

Board of Directors is asked to:

- Consider and approve the increase of trajectory for KPI 9 detailed in 3.4.1.
- Consider and approve the suggested change to KPI 21 detailed in 3.6.4.
- Note the changes to the Trust Business Plan that require Board approval in Appendix 1.

<b>MEETING OF:</b>	<b>BOARD OF DIRECTORS</b>
<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Strategic Direction Performance Report – Quarter 1 2019/20</b>

**1. INTRODUCTION & PURPOSE:**

- 1.1 The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 1 (30<sup>th</sup> June 2019). It does not include any information on issues that have arisen since the 30<sup>th</sup> June 2019, as these will be included in the quarter 2 report due to come to Board in November.

**2. BACKGROUND INFORMATION AND CONTEXT:**

- 2.1 This report demonstrates progress against the Strategic Direction via progress against the agreed KPI Scorecard, the Trust Business Plan and other forms of qualitative intelligence.
- 2.2 The current KPIs for the Trust Strategic Direction Scorecard were agreed by the Board on the 19<sup>th</sup> July 2018, with the majority of targets being agreed at the October 2018 Board meeting.
- 2.3 The Strategic Direction Scorecard is shown under each strategic goal with proposed changes to the Business Plan requiring approval, by exception, detailed in Appendix 1.

**3. KEY ISSUES:**

**3.1 Trust Strategic Direction Scorecard**

The Strategic Direction Scorecard is shown under each strategic goal.

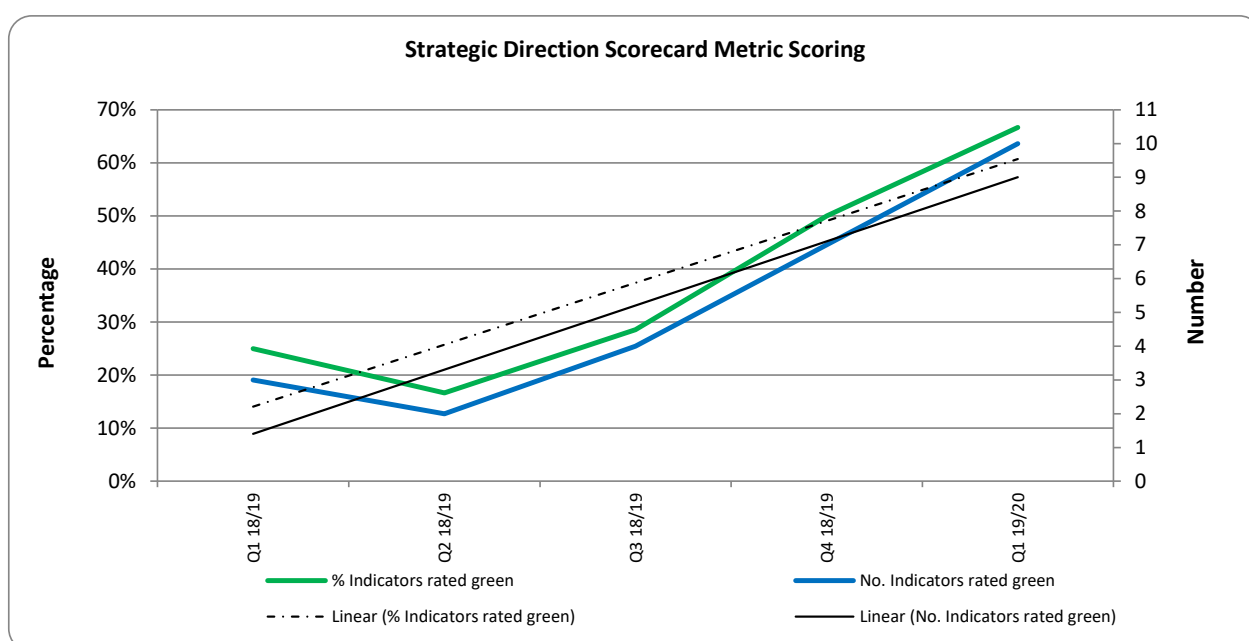
The following table provides a summary of the RAG ratings at quarter 1 compared to the position in the previous quarters. The Trust is not meeting some of its high ambitions given the number of reds (5) against stretching metrics.

Quarter 1 has reported an overall improvement with 67% (10) of the metrics reporting green compared to 50% (7) in quarter 4. Of the 33% (5) metrics reporting red, 3 have reported an improvement compared to quarter 4.

There remains a number (8) that are not being rated as they are not required to be reported in this quarter or are still under development.

SDS	Q4 2018/19		Q1 2019/20	
	No	%*	No.	%*
Indicators rated green	7	50%	10	67%
Indicators rated red	7	50%	5	33%
<b>Indicators rated</b>	<b>14</b>		<b>15</b>	
Indicators with no target agreed				
Indicators currently under development/being finalised	7		7	
Indicators where data is not yet available or not applicable in qtr	1		1	
Metric will not be possible to report and we are identifying a further indicator	1			

The graph below shows the improving trend in the percentage of greens since the metrics were introduced in 2018/19.



### 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 all metrics are performing better than target, which is an improvement on the quarter 4 2018/19 position, which reported 2 metrics red. However, it must be noted that we have reduced the targets on the two metrics that have changed from red to green for 2019/20; improvement benchmarks for HoNOS and SWEMWBS. These reductions are in line with the Trust Performance Dashboard and were implemented to recognise the focus required to increase the number of patients with a timely

paired outcome, which may reduce achievement of improvement benchmarks in the short term. All KPIs under this strategic goal are reporting a deterioration compared to the quarter 4 2018/19 report.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20									
Indicator	Q1 Target 2019/20	Quarter 1 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20	
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 teams achieving the agreed improvement benchmarks for HoNOS total score	60.00%	62.50%	↓	60.00%	62.50%	59.41%	44.00%	60.00%
2	Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS	65.00%	68.48%	↓	65.00%	68.48%	67.38%	50.00%	65.00%
3	Number of patients who said we helped them achieve the goals they set	TBC	Metric currently under development	N/A	N/A	Metric currently under development	N/A	N/A	TBC
4	Percentage of carers that report feeling listened to and heard	76.20%	77.12%	↓	76.20%	77.12%	76.45%	76.08%	76.20%

There are no concerns for the indicators reported above.

### 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 69% (25 out of 36) compared to 76% (26 out of 34) in quarter 1 2018/19. 75% of the priorities under Strategic Goal 1 are reporting that there is no significant risk to the overall completion on time of the priority. There are 16% of priorities that have a moderate risk of failure to deliver the final milestone or benefits on time. Proposed changes to the Business Plan requiring approval, by exception, are detailed in Appendix 1.

However, there are 4 (9%) priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget:

- 1 priority (1.13.70) **Tees Rehabilitation** – Tees Rehab EMT paper received and approved in May 2019 and needs to go through Board, Partnership arrangements and discussions with OSCs. Therefore Board are requested to approve the extension of time to Q3 19/20.
- 1 priority (1.101) **Implement agreed future delivery model (Harrogate)** There has been a delay in starting the public engagement linked to the local elections. The engagement events commenced in June and will run until 13<sup>th</sup> September. EMT has approved an extension to Q3 2019/20.
- 1 priority (1.13.2) **Employment of people with a LD/Autism** - Preparation work is continuing though issues of clearance have been identified. EMT has approved an extension to Q3 2019/20.
- 1 Priority (1.7.1 – 1.7.6) **Implement the transforming care agenda (Adult Learning Disabilities/Forensic Learning Disabilities)** – work has been delayed as it has not been possible to make the anticipated reductions due to clinical need, demand on beds and lack of appropriate placements. There are ongoing issues with agreeing funding and legal restrictions, therefore discussions continue with NHSE and the private sector to understand and resolve these issues.

There are 4 priorities reporting Grey on the basis that they have not been completed on time and/or benefits realised due to external factors:

- **Configuration of West Lane Site** – A combination of the West Lane CQC feedback and provider collaborative work has meant delays to the progression of this priority. It is therefore felt that further time is required to progress. EMT has approved an extension to Q3 until the outcome of the provider collaborative is known and the developments following CQC feedback are resolved.
- **CYP Eating Disorders** - A combination of the West Lane CQC feedback and provider collaborative work has meant delays to the progression of this priority. It is therefore felt that further time is required to progress. EMT has approved an extension to Q3 19/20 until the outcome of the provider collaborative is known and the developments following CQC feedback are resolved.
- **AMH IAPT** - A Market engagement event took place on 24th June. Further details for the tender and submission date are currently awaited.
- **HMP Haverigg Procurement** - The Procurement process has not been launched by the commissioners.

There are also 6 metrics that require Board approval to remove them from the business plan, change to wording and timescales noted in the table attached in Appendix 1.

### 3.2.3 Other Qualitative Intelligence

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

- **Crisis resolution and home treatment team, Cross Lane Hospital, Scarborough** have been successful in achieving the Home Treatment Accreditation Scheme (HTAS), which aims to work with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers.
- **Talking Changes in County Durham**, has been accredited by the Royal College of Psychiatrists for their high standards of patient care. The service was recognised for the number of pathways in place to assist referrals and improving access to mental health services for underrepresented groups.
- **Hambleton and Richmond mental health services for older people (MHSOP) community mental health team (CMHT)** have successfully delivered the 7 day working model. The new ways of working have had a positive impact on service users, carers and other services internal and external.
- **All age liaison and diversion team**, Middlehaven Police Station, Middlesbrough has been shortlisted in the Nursing in Mental Health

category of the Nursing Times Awards 2019.

- **Occupational therapy** staff attended the 'gardening for health' forum at the Chelsea Flower Show's, where they were invited to share their experiences of using gardening as an intervention to improve health and wellbeing.

#### 3.2.4 Other points to note:

- **KPI 1 - Percentage of teams achieving the agreed improvement benchmarks for HoNOS total score** – the target has been reduced from 67.25% to 60.00%, in line with the Trust Performance Dashboard.
- **KPI 2 - Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS** – the target has been reduced from 78.25% to 65.00%, in line with the Trust Performance Dashboard.
- **KPI 3 - Number of patients who said we helped them achieve the goals they set** – Following consultation with the Recovery College, Experts by Experience and the Patient Experience Group the wording of the metric was amended to "Did/do staff help you to achieve what was/is important to you?" The survey was implemented on 1 May in Adult, MHSOP and Recovery inpatient services and 1 June in Secure Inpatient Services. It was felt that further consultation was needed in Children & Young People Services and Adult Learning Disability services, which is being undertaken by the Recovery College. Plans are progressing to roll out the changes to community services surveys over the coming months and processes are currently being explored to facilitate reporting in quarter 2.

3.2.5 In conclusion, overall a positive position is presented in terms of this strategic goal and the services we provide to patients and carers. Whilst there are four priorities/service developments at high risk of failure to deliver on time or within budget, all three reportable metrics are green and there is a significant amount of positive qualitative intelligence.

### 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 two indicators rated red, which is consistent with the quarter 4 2018/19 position; however one metric was not available for quarter 4. Of the two metrics reporting red, one has reported an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20									
Indicator	Q1 Target 2019/20	Quarter 1 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20	
Strategic Goal 2 (To continuously improve the quality and value of what we do)									
5	Percentage of staff reporting that they can contribute towards improvement at work (reported a quarter behind)	87.00%	82.30%	N/A	87.00%	82.30%	81.50%	81.59%	87.00%
6	Percentage of patients who report feeling supported by staff to feel safe	65.20%	65.59%	↑	65.20%	65.59%	61.53%	65.63%	65.20%
7	Percentage of patients who report their overall experience as excellent or good	94.00%	92.12%	↑	94.00%	92.12%	91.41%	90.68%	94.00%

### Indicators of concern are:

- KPI 5 - Percentage of staff reporting that they can contribute towards improvement at work** – this metric is reported a quarter behind; the quarter 1 data therefore relates to the quarter 4 survey. The Trust position reported in quarter 1 is 82.30% which relates to 429 members of staff out of 2424 who stated they did not feel they contribute towards improvements at work. This is 4.7% below the target of 87%.

All areas are reporting below target:

- Durham & Darlington report 79.22% which is consistent with quarter 3 (78.94%)
- Forensics report 83.74% which is better than quarter 3 (80.41%).
- North Yorkshire report 82.14% which is better than quarter 3 (76.29%).
- Teesside report 83.12% which is slightly worse quarter 3 (84.78%).
- York & Selby report 82.74% which is better than quarter 3 (76.97%).
- Corporate services report 83.59%; no comparison is available to quarter 3 as data was not extracted at that level at that point in time.

This metric was not available in quarter 4.

The recent crowdsourcing exercise highlighted concerns from staff that they felt they could not raise ideas and contribute to change. A response has been provided and the information collated is being used to inform further engagement. It is expected that this will impact positively on future scores, but this is likely to take time.

- KPI 7 - Percentage of patients who report their overall experience as excellent or good** – The Trust position for quarter 1 is 92.12% which relates to 355 patients out of 4503 patient survey responses that report their overall experience other than excellent or good. This is 1.88% below the target of 94% and is consistent with the quarter 4 position.

All localities are reporting below target:

- Durham & Darlington report 92.64% which is consistent with quarter 4 (92.72%)
- Forensics report 89.02% which is consistent with quarter 4 (88.56%).
- North Yorkshire & York report 92.57% which is better than quarter 4 (NY 91.04% and Y&S 88.98%).



- Teesside report 91.95% which is worse quarter 4 (93.59%).

Work is being undertaken within the localities to monitor and improve completion rates and any narrative produced by patients is reviewed in Quality Assurance Groups and localities to identify any areas of concern. There has also been a Deep Dive undertaken recently by the Executive Management Team to identify any particular issues.

### 3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 1 were rated green; 92% compared to 75% in quarter 1 2018/19. 33% of the priorities under Strategic Goal 2 are reporting that there is no significant risk to the overall completion on time of the priority. There are 67% of priorities that have a moderate risk of failure to deliver the final milestone or benefits on time.

### 3.3.3 Other Qualitative Intelligence

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

- The Care Quality Commission (CQC) attended West Lane Hospital for an unannounced inspection of the children and young people's service. This inspection took place from 20- 24 June and identified concerns about recording of observations, risk assessments and staffing levels given the acuity of patients. As a result, the CQC served a Notice of Decision on the 25<sup>th</sup> June 2019, requiring the Trust to undertake some immediate and urgent actions to address these concerns. New admissions to the wards at West Lane Hospital were suspended. Significant work is required to address the concerns raised by the CQC.
- **Paul Blenkiron**, consultant, Huntington house, York had his paper 'Patient-reported outcome measured in community mental health teams: pragmatic evaluation of PHQ-9, GAD-7 and SWEMWBS.' published in BJPsych Bulletin.

3.3.5 In conclusion, the position against this Strategic Goal is disappointing. Whilst performance against the Business Plan is progressing well, two KPIs are performing below target and the CQC Notice of Decision at West Lane Hospital is a significant concern.

## 3.4 **Strategic Goal 3 - *To recruit, develop and retain a skilled, compassionate and motivated workforce***

### 3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red as at quarter 1 out of a possible 3 that could be rated; two have reported an improvement on quarter 4 2018/19.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20									
Indicator	Q1 Target 2019/20	Quarter 1 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20	
Strategic Goal 3 - To recruit, develop and retain a skilled, compassionate and motivated workforce									
8	Percentage rolling 12 month TEWV labour turnover rate	9.00%	10.35%	↑	9.00%	10.35%	10.44%	N/A	10.00%
9	Percentage rolling sickness absence rate	4.50%	5.03%	↑	4.50%	5.03%	5.17%	N/A	4.50%
10	Percentage staff recommending TEWV as a place to work	76.00%	70.72%	↓	76.00%	70.72%	74.04%	70.95%	76.00%
11	Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified.	TBC		N/A	N/A		N/A	N/A	TBC

**Indicators of concern are:**

- KPI 8 - Percentage rolling 12 month TEWV labour turnover rate** - The Trust position for quarter 1 is 10.35% which relates to 711 leavers out of 6869 total staff. This is 1.35% outside the target of 9% and is slightly lower than the 10.44% reported for quarter 4.

The target has been reduced from 10% to 9%, in line with the Workforce Strategy.

Labour turnover in North Yorkshire and York remains the highest at 12.67%, but has decreased on the figure of 14.6% at end of March 2019. The figures reported exclude doctors in training. The labour turnover rate for Durham and Darlington has increased in the last quarter from 9.87% to 10.45%. 35% (55) are attributable to retirement, 9 of whom are returning under the Trust flexible retirement scheme.

Analysis of reasons for leaving highlights retirement continues to be the most prevalent reason for leaving across the Trust. The figure has increased from 26.6% to 29.0% in the last quarter. 48 staff opted to retire and return to work within the Trust. Work life balance as a reason for leaving has continued to decrease in the last quarter from 8.6% to 8.0%.

- KPI 9 - Percentage rolling sickness absence rate** - The Trust position for quarter 1 is 5.03% which relates to 110442 days lost to sickness out of 2196565 available working days for the Trust. This is 0.53% above the target of 4.50% and is consistent with the previous quarters.

The target for this metric has been maintained at 4.50% in line with the Trust Dashboard; however, this is different to the 4.40% target that was agreed for the Workforce Strategy. Board approval is sought to increase the trajectory within the Workforce Strategy to 4.50% for 2019/20, and all subsequent years to be amended in line with this increase.

A review of the approach to managing sickness absence has recently been concluded. This has been considered by the Business Disability Forum for

their views and this feedback is being considered by the Policy Working Group. Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 months.

- **KPI 10 - Percentage staff recommending TEWV as a place to work** - The Trust position for quarter 1 is 70.72% which relates to 573 members of staff out of 1957 that responded they would not recommend TEWV as a place to work. This is 5.28% below the target of 76% and is worse than the position reported last quarter of 80.60%.

The target has been increased from 73% to 76%, in line with the Workforce Strategy.

The response rate for this quarter was one of our lowest response rates and this could be due to it coinciding with the first crowdsourcing conversation.

Organisational Development regularly meet with teams to review the reasons for their responses. Themes reported by staff as to why they would not recommend the Trust are reviewed but as surveys are anonymous it can be difficult to identify areas to undertake more focussed work.

#### 3.4.2 Trust Business Plan

The majority of the business plan actions due to be completed by the end of quarter 1 were rated green 80%. There are 2 business plan priorities assigned to Strategic Goal 3 which are both currently reporting amber green due to there been a moderate risk of failure to deliver the final milestone or benefits on time.

There is 1 metric in the Right Staffing Programme that requires Board approval to remove the action from the business plan. New Actions are currently been developed for the rostering procurement work.

#### 3.4.3 Other Qualitative Intelligence

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

- Results for the quarter 4 2018/19 staff friends and family test are now available. Overall, in all areas surveyed, staff rated the **Trust** as excellent or good, particularly commenting on high standards of patient care and supportive management. However concerns were raised around waiting times, staffing levels and staff health and wellbeing. In the coming weeks the Trust will be looking into this information in more detail to identify areas of good practice and where improvements may be needed.
- **Diane Smyth**, support worker, HMP Holme House, Stockton has been shortlisted for the RCNi Nurse Awards 2019 in the 'health care assistant' category.
- **Claire Bainbridge**, consultant psychologist in health and justice services, forensic services has been awarded the 2019 British Psychological Society

Division of Forensic Psychology - Excellence in Forensic Psychology Practice Award.

- **Sabrina Leigh-Hunt**, consultant psychiatrist, mental health services for older people (MHSOP), Ryedale community, Princess Road Clinic, York has won the Faculty Tutor of the Year at the Medical Education Awards.
- The first **Trust-wide** conversation via Crowdsourcing has taken place with 1,264 staff taking part, generating 8,661 ideas, comments and votes about how we can improve the well-being and the voice of staff. All have been independently analysed and findings have enabled the Trust to draft a series of actions to be taken forward, which we are having a further conversation with staff on.
- **Jo Smith**, professional head, dietetic services has been shortlisted in the AHP Public Health Champion category of the NHS England - Chief Allied Health Professions Officer's Awards 2019.
- **TEWV ThinkON**, Trustwide has been shortlisted in the Best Coaching and Mentoring Initiative category of the CIPD People Management Awards 2019.

#### 3.4.4 Other points to note:

- **KPI 11 - Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified** – The first programme is due to be completed in December 2019, after which baseline data will be available. Dates for cohort 1 have been agreed with Tees and discussions have started about providing sessions 1 and 3/4 as stand-alone modules in partnership with the Recovery Programme team; content is almost finalised.

3.4.5 In conclusion, performance against this Strategic Goal is mainly positive. Whilst all three metrics are reporting red, two have improved compared to last quarter. Progress against the Business Plan and the significant amount of qualitative intelligence is encouraging for the recruitment, development and retention of our workforce.

### 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 all metrics are performing better than target out of a possible 3 metrics that can be rated. This is an improvement on the quarter 4 2018/19 position, which reported 1 metric red.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20									
Indicator	Q1 Target 2019/20	Quarter 1 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20	
Strategic Goal 4 - To have effective partnerships with local, national and international organisations for the benefit of the communities we serve									
12	Percentage joint bids with CCGs that are successful	80%		N/A	80%		70.83%	N/A	80%
13	Percentage of mental health and learning disability budget covered by a ring-fenced budget	85%	91.90%	↑	85%	91.90%	77.17%	N/A	85%
14	Percentage delayed transfers of care due to non Trust issues	3.5%	2.68%	↓	3.5%	2.68%	3.01%	N/A	3.50%
15	Percentage of e-letters developed against the total number of GP letters required	100%	100.00%	N/A	N/A	100.00%	N/A	N/A	100%

There are no concerns for the indicators reported above.

### 3.5.2 Trust Business Plan

There are no business plan priorities assigned to Strategic Goal 4.

### 3.5.3 Other Qualitative Intelligence

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

- **Jayne Finch**, clinical psychologist, Stockton affective disorders team, **Adam Freear**, research assistant, **Haydee Cochrane**, clinical psychologist, Harrogate community mental health team and **the Cognitive Analytic Therapy (CAT) Network** have offered five session CAT care planning to service users and staff and collated outcome measures. This was a multi-site study with CAT colleagues from Sheffield, Rotherham and Leeds and showed that five session CAT care planning led to service users feeling significantly less fragmented whilst offering improvements for staff also.
- The Trust has started engagement with local people over a 12 week period to obtain views on proposals about the future development of community mental health services for adults and older people across **Harrogate and Rural District**. The approach focuses on increasing the capacity of community services to support people at home wherever possible and has been developed by the Trust, in partnership with NHS Harrogate and Rural District Clinical Commissioning Group (CCG) and NHS Leeds CCG.
- The **planning** team have worked with commissioners and operational managers to develop a range of urgent care proposals. These have now been submitted to regional NHS panels for consideration prior to national decisions on whether to release the money.
- The **Trust** is working in partnership with the British Institute for Human Rights exploring ways to empower service users to know and claim their rights.

- **TEWV** and our partner NTW via the New Care Model for Secure Services submitted a bid for LD Transforming Care Partnership (TCP) Funding to develop the role of Accommodation Pathway Development Leads to focusing on the accommodation needs of patients post discharge which can often prove difficult and lead to delays.
- The procurement for healthcare services across the 7 North East Prisons commenced 25<sup>th</sup> April; this will be progressed with **TEWV** as a sub-contractor to Spectrum as the lead provider.

#### 3.5.4 Other Points to Note

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

- **KPI 12 - Percentage joint bids with CCGs that are successful** – The Trust has submitted 9 joint bids with CCGs during quarter 1; however as at the 30<sup>th</sup> June we had not received notification as to whether any were successful.
- **KPI 15 - Percentage of e-letters developed against the total number of GP letters required** – Following Board approval, this metric has now replaced the Percentage referrals received from GPs using the standard electronic referrals template relevant for the speciality. The target has been set at 100% as defined in the Digital Transformation Strategy. All letters are developed in PARIS; however PARIS is unable to email them/send them electronically at this current time. A way forward has been identified but this relies on CITO being implemented.

3.5.5 In conclusion performance against this strategic goal indicates work with our partners is strong. All three of the reportable metrics are green and these are supported by a significant amount of qualitative intelligence.

### 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 all metrics are performing against target, which is consistent with the quarter 4 2018/19 position.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20									
Indicator	Q1 Target 2019/20	Quarter 1 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20	
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									
16	Delivery of control total in full as per NHSI financial plan	-£1,345,000.00	-1,267,392	N/A	-£1,345,000	-1,267,392	-£26,766,868	n/a	
17	Achieve an NHSI SOF rating of 1 (reported one quarter behind)	1	1	↔	1	1	1	N/A	1
18	All clinical teams to be able to access pathology results via PARIS and order test by PARIS	25.00%	63.68%	↑	25.00%	63.68%	24.30%	N/A	100.00%
19	All service users being able to access care plan online or digitally	TBC		N/A	N/A		N/A	N/A	TBC
20	100% clinical pathways developed and in use within PARIS	100%		N/A	100%		N/A	N/A	100%
21	Placeholder: Digital Transformation Strategy			N/A	N/A		N/A	N/A	TBC
22	Placeholder: E&D Strategy			N/A	N/A		N/A	N/A	TBC
23	Placeholder: E&D Strategy			N/A	N/A		N/A	N/A	TBC

There are no concerns for the indicators reported above.

### 3.6.2 Trust Business Plan

No actions have been delivered on time within quarter 1.

There are two business plan priorities assigned to Strategic Goal 5. One priority is to identify and reduce waste and the other one is to deliver our Digital Transformation Strategy which are both currently reporting Red.

For Digital Transformation much progress is being made but there are some delays to some projects caused by a combination of supplier issues, staffing capacity and technical issues. CITO is progressing well and continues to have high levels of clinical engagement. Planning and development are taking longer than expected because of this engagement but this makes it more likely that the new system will be implemented smoothly and meets service and patient needs.

There are 5 metrics that require Board approval to approve new timescales in to 2020/21 financial year noted in the table attached in Appendix 2.

### 3.6.3 Other Qualitative Intelligence

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

- Commissioners have requested the Trust implement the new **IAPT** service model in Durham and Darlington from the 1<sup>st</sup> April. This is for 12 months and a key focus is achievement of the access target with discussions ongoing to confirm the trajectory from 19%-22% by end March 2020, and improve engagement and responsiveness to GPs.

- **Peppermill Court** in York has been chosen to contribute to a project to improve access to green spaces for inpatients. It has been awarded green beacon site status after submitting an application to the green walking project to get involved with their work to promote the importance of green spaces to aid recovery.

#### 3.6.4 Other points to note:

- **KPI 19 - All service users being able to access care plan online or digitally** – data is not available as yet. The plan is that Care Planning will be built in CITO and patients will receive an electronic copy alongside access to a Patient Portal where they can access the plan online. CITO rollout is being managed and the plan is that MHSOP will be aiming to go live in Autumn.
- **KPI 20 - 100% clinical pathways developed and in use within PARIS** - data is not available as yet. Version 2.3 of CITO includes workflow functionality to allow development of pathways. The plan is that the pilot teams for CITO will include this high level pathways/workflow functionality. CITO rollout is being managed and the plan is that MHSOP will be aiming to go live in Autumn 2019.
- **KPI 21 - All Trust clinicians to have access to their key service/team/patient information in near to real time** – As approved last quarter, the Head of Information Services – IT and Systems and Head of Information Systems propose this metric be replaced by “All clinicians to have access to the following six pieces of information in near to real-time:
  - Datix Incidents
  - Datix Risks
  - Datix Complaints
  - Clinical Caseload
  - Clinical Huddle Dashboard
  - Bed Management View”

The proposal clarifies what is classified as “key” information and provides an indicator that is measurable against delivery. It is anticipated that Datix information will be reportable from quarter 3, with the remaining elements following. **Board approval is sought for this metric.**

- **KPI 22/23 - E&D Strategy metrics** – these metrics are not yet finalised. At the July meeting, the Resources Committee agreed that the Equality & Diversity Strategy will now go to the November meeting.

3.6.5 In conclusion performance against this Strategic Goal is mixed. Whilst all three reportable KPIs are green, no Business Plan actions have been delivered this quarter.

## 4. **IMPLICATIONS:**



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

There are no issues of compliance with the CQC fundamental standards. The report includes the CQC visit in June and subsequent action regarding West Lane Hospital.

**4.2 Financial/Value for Money:**

The report highlights that none of the Sustainability metrics are below target.

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

There are no direct legal or constitutional implications from this paper.

**4.4 Equality and Diversity:**

There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled'.

**4.5 Other implications:**

There are no other implications associated with this paper.

**5. RISKS:**

There are no identified risks associated with this paper.

**6. CONCLUSIONS:**

Whilst quarter 1 performance reports 5 out of 15 metrics being red, 3 (60%) have reported an improvement with quarter 4; 6 metrics in total have reported an improvement on quarter 4. In addition, progress against the Business Plan and qualitative intelligence supports the strong performance on the KPIs. However, there does remain a concern with the Business Plan element of Strategic Goal 5, which has not delivered any actions in quarter 1 and the CQC Notice of Decision at West Lane Hospital is a significant risk.

**7. RECOMMENDATIONS:**

Board of Directors is asked to:

- Consider and approve the increase of trajectory for KPI 9 detailed in 3.4.1.
- Consider and approve the suggested change to KPI 21 detailed in 3.6.4.
- Note the changes to the Trust Business Plan that require Board approval in Appendix 1.

**Sharon Pickering**  
**Director of Planning, Performance & Communications**

**Background Papers:**

**Appendix 1**

Appendix – Requests to the Board of Directors for a Change to the Business Plan

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
1.13.42	Trailblazers - wave 2	D&D	CYP (all)	If bid successful to implement waiting time pilot	Pilot in place and evaluation to measure impact	Q1 19/20	Donna Sweet	GY	The waiting time pilot was not part of this wave of bids. <b>Therefore Board are requested to remove this action.</b>
1.13.57	Crisis Service Provision	D&D	AMH	Evaluate impact of the implementation of single crisis service/approach	Evaluation completed	Q3 19/20	Fran Bergin		Due to the delay and lack of available car parking space offered by CDDFT. The timescales for the establishment of a hub at APH has been extended to October which has an impact on this action and timescales <b>Therefore Board are requested to extend to Q1 2020/21</b>
1.12.2	Improve the physical environment at Roseberry Park Hospital	Tees	AMH	Relocation of Inpatient Services - Identification of staff and stakeholder engagement process	Requirements identified	19/20 Q4	Elspeth Devanney / Joanne Hodgen		A meeting structure is in place involving clinical and operational staff within each speciality with an overarching joint speciality meeting to ensure continuity, communication and joint working wherever possible. The meetings report via Tees governance structures including the escalation of any perceived risks. The two

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
									speciality groups have formulated action plans that include staff and stakeholder communication and engagement with named leads to coordinate and ensure completion. The timescales associated with this action were developed prior to the current updated timetable. <b>As a result of this, Board are requested to approve an extension of this action to Q2 21/22.</b>
1.12.3	Improve the physical environment at Roseberry Park Hospital	Tees	AMH	Relocation of Inpatient Services - Engagement process carried out as identified	Engagement process complete	19/20 Q4	Elspeth Devanney / Joanne Hodgen		As above. <b>As a result of this, Board are requested to approve an extension of this action to Q2 21/22.</b>
1.12.6	Improve the physical environment at Roseberry Park Hospital	Tees	AMH	Relocation of Inpatient Services - Relocate wards from RPH to allow rectification works be completed	Wards relocated	20/21 Q1	Elspeth Devanney / Joanne Hodgen		Current scheme timetable is for completion of works to Block 5 in May 2020 followed by a commissioning period. Tees MHSOP services will then transfer back to RP. Enabling works will then take place at Sandwell Park to ensure the environment meets the requirements of AMH patients. Work has commenced to identify requirements in order that

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
									information for tendering processes is prepared in advance. The scheme timetable for AMH relocation is end July 2020. <b>As a result of this, Board are requested to approve an extension of this action to Q2 20/21.</b>
1.13.70	Rehabilitation	Tees	AMH	Complete decant of services at Roseberry Park to Lustrum Vale	Decant complete	Q4 18/19	Clare Cuthbertson	R	This action has been carried forward from the 18/19 business plan. Tees Rehab EMT paper received and approved in May 2019 and needs to now go through Partnership arrangements and discussions with OSCs. <b>Therefore Board are requested to approve the extension of time to Q3 19/20</b>
3.3.3	Ensure we have the right staffing for our services now and in the future	N&G	All	Complete Phase 1 of community-based roster roll-out	Phase 1 completed	Q1 19/20	Joe Bergin	R	Following agreement to proceed to full procurement episode for rostering / job planning solution within all teams the requirement for this pilot has been superseded - <b>therefore Board are requested that this action be removed</b> New Actions and project plan are currently been developed for the the rostering/procurement work

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
5.5.3	Deliver our Digital Transformation Strategy		MHSOP	Fully implement CITO for MHSOP	All MHSOP teams using CITO for all day-to-day clinical work	19/20 Q3	Richard Yaldren		It is expected that the go-live for Cito and full implementation will take place in Q1 of 20/21 <b>Board are requested to extend to Q1 20/21 for Phase 2 to include full CITO functionality</b>
5.5.4	Deliver our Digital Transformation Strategy	Info	CYP (all)	Design CITO to support CYP services	CITO development and "live" testing for all key agreed CYP pathways / processes commenced	19/20 Q3	Richard Yaldren		It is expected that the go-live for Cito and full implementation will take place in 20/21 <b>Board are requested to extend to Q1 20/21</b>
5.5.5	Deliver our Digital Transformation Strategy	Info	AMH	Fully implement CITO for AMH	All AMH teams using CITO for all day to day clinical work	19/20 Q4	Richard Yaldren		It is expected that the go-live for Cito and full implementation will take place in 20/21 <b>Board are requested to extend to Q1 20/21 for Phase 2 to include full CITO functionality</b>
5.5.7	Deliver our Digital Transformation Strategy	Info	CYP (all)	Fully implement CITO for CYP	All CYP teams using CITO for all day to day clinical work	20/21 Q4	Richard Yaldren		It is expected that the go-live for Cito and full implementation will take place in 20/21 <b>Board are requested to extend to Q1 20/21</b>
5.5.8	Deliver our Digital Transformation	Info	ALD	Fully implement CITO for ALD	All CYP teams using	20/21 Q4	Richard Yaldren		It is expected that the go-live for Cito and full

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
	Strategy			services	CITO for all day to day clinical work				implementation will take place in 20/21
5.5.9	Deliver our Digital Transformation Strategy	Info	AMH	Develop Crisis Dashboard	Crisis Dashboard in place	19/20 Q3	Richard Yaldren		It is expected that the go-live for Cito and full implementation will take place in 20/21 <b>Board are requested to extend to Q1 20/21</b>
5.5.2 2	Deliver our Digital Transformation Strategy	Info	All	pilot the new patient portal	patient portal pilot commenced	19/20 Q3	Richard Yaldren		The GNCR is looking to implement a region wide patient portal. The Trust is going to be actively engaged in this project, but it is unclear what the timelines are going to be but the original estimation of deliver will be pushed back to meet the regions timescales.
5.5.2 3	Deliver our Digital Transformation Strategy	Info	All	pilot the new patient portal	patient portal pilot complete	19/20 Q4	Richard Yaldren		The GNCR is looking to implement a region wide patient portal. The Trust is going to be actively engaged in this project, but it is unclear what the timelines are going to be but the original estimation of deliver will be pushed back to meet the regions timescales.
5.5.2 4	Deliver our Digital Transformation Strategy	Info	All	Roll-out patient portal to all services	Roll out to all services commences	19/20 Q4	Richard Yaldren		The GNCR is looking to implement a region wide patient portal. The Trust is going to be actively engaged

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q1 Metric Status	Comment and requests for decisions
									in this project, but it is unclear what the timelines are going to be but the original estimation of deliver will be pushed back to meet the regions timescales.

Please note that if approved, future monitoring will be against the amended timescale

FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Board Committees – Annual Review</b>
<b>REPORT OF:</b>	<b>Phil Bellas, Trust Secretary</b>
<b>REPORT FOR:</b>	<b>Decision</b>

<b>This report supports the achievement of the following Strategic Goals:</b>	✓
<i>To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing</i>	
<i>To continuously improve the quality and value of our work</i>	
<i>To recruit, develop and retain a skilled, compassionate and motivated workforce</i>	
<i>To have effective partnerships with local, national and international organisations for the benefit of the communities we serve</i>	
<i>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.</i>	✓

**Executive Summary:**

The purpose of the report is to enable the Board to undertake its annual review of its committee arrangements.

The report includes proposals:

- (a) To disestablish the Commercial Oversight Committee in view of regulatory changes and in response to the reduction in the Committee’s activities arising from NETS Ltd and TEWV EFM Ltd becoming dormant.
- (b) To incorporate the functions of the Commercial Oversight Committee into the terms of reference of the Resources Committee.
- (c) To retitle the Audit Committee as the “Audit and Risk Committee” and amend its terms of reference to provide greater oversight of, an assurance on, risk management in the Trust.
- (d) To amend the terms of reference of the Nomination and Remuneration Committee to enable it to approve locally determined terms and conditions of service for all TEWV staff employed on national medical terms and conditions and all staff paid at AFC Band 8 and above, in addition to Very Senior Managers.

Board Members will be aware that, arising from discussions on the results of the Board Performance Evaluation Scheme in 2018/19, it was suggested that a separate Workforce Committee should be established. This is not proposed, at this time, as it is considered that the objective of providing sufficient consideration of both workforce and financial matters should be able to be achieved by undertaking a review of reporting on the former matters to the Resources Committee, together with improved agenda management/focus, rather than through structural change.

No changes are proposed to the terms of reference of:

- (a) The Mental Health Legislation Committee as they are considered to remain appropriate.
- (b) The Quality Assurance Committee as discussions on its operational arrangements, which will include learning from the recent regulatory action taken in regard to West



Lane Hospital, are ongoing.

The terms of reference of the Board's Committee, as amended to reflect the above proposals, are appended to the report.

**Recommendations:**

The Board is asked to:

- (1) Approve the disestablishment of the Commercial Oversight Committee from 30<sup>th</sup> September 2019
- (2) Approve the amendments to the terms of reference of the Audit and Risk Committee, the Nomination and Remuneration Committee and the Resources Committee (attached as Annexes 1, 3 and 5 to this report) to come into effect on 1<sup>st</sup> October 2019.
- (3) Agree that a separate Workforce Committee should not be established and support the proposed review of workforce reporting to the Resource Committee.
- (4) Note that any changes to the terms of reference of the Quality Assurance Committee, arising from ongoing discussions, will be presented to the Board in due course.

<b>MEETING OF:</b>	<b>The Board of Directors</b>
<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Board Committees - Annual Review</b>

**1. INTRODUCTION & PURPOSE:**

1.1 The purpose of this report is to enable the Board to undertake its annual review of its committee arrangements.

**2. BACKGROUND INFORMATION AND CONTEXT:**

2.1 The approval of the terms of reference, including their reporting arrangements, of all committees established by the Board is a reserved matter under the Constitution.

2.2 The terms of reference of the Board's committees are reviewed annually taking into account, amongst other matters, the findings of the Board Performance Evaluation Scheme.

2.3 Although there is assurance from the external governance review (2017) and the Board Performance Evaluation Scheme 2018/19 that the Board's committees generally operate well, certain changes, both nationally and locally, suggest that it would be beneficial to amend the terms of reference of the Audit, Resources and Nomination and Remuneration Committees. These are explored in Section 3 below.

**3. KEY ISSUES:**

**Audit (and Risk) Committee**

3.1 It is considered that there would be benefits from expanding the role of the Audit Committee to provide greater oversight of, and assurance on, organisational risk management in the Trust.

3.2 It is, therefore, proposed that:

- (a) The Committee should be renamed the "Audit and Risk Committee".
- (b) The full Board Assurance Framework (BAF) should be scrutinised by the Committee, on a quarterly basis, to provide assurance to the Board on its coverage and comprehensiveness and on the appropriate and effective mitigation of each principal risk.
- (c) The Corporate Risk Register (CRR) should be reported, by exception, together with the BAF, to support the Committee's oversight of risk management systems and processes.

3.3 The proposed changes are intended to:

- (a) Enable the delivery of the Internal Audit recommendation, arising from the review of risk management (assignment ref. 04/19), for a committee or group to be identified that has overall responsibility for the effectiveness and robustness of risk management arrangements.
- (b) Support compliance with para. 2.1 of the Committee's terms of reference in regard to reviewing the "establishment and maintenance of an effective

system of integrated governance, risk management and internal control, across the whole of the organisation's activities ..."

- (c) Improve the provision of assurance to the Board.
- (d) Increase awareness of the importance of organisational risk management in the Trust.

3.4 Terms of reference for the Audit and Risk Committee, which reflect the above proposals, are attached as Annex 1 to this report for approval.

### **Commercial Oversight Committee**

3.5 It is proposed that the Commercial Oversight Committee should be disestablished.

3.6 The Committee was formed in 2014 in response to the establishment of Positive Independent Proactive Support Ltd (PIPS) and in anticipation that the number of Trust subsidiaries/trading vehicles would increase. The portfolio of subsidiaries/trading vehicles subsequently expanded with the creation of NETS Ltd and TEWV Estates and Facilities Management Ltd.

3.7 Board Members will be aware that the position has now changed as a result of:

- (a) the tightening of regulatory controls relating to subsidiaries by NHS Improvement; and
- (b) NETS Ltd and TEWV EFM Ltd becoming dormant.

3.8 In view of the above changes, having a separate Committee with the sole function of overseeing a single, now well established, subsidiary appears to be excessive.

3.9 If the proposal to disestablish the Commercial Oversight Committee is approved it is considered that its functions should be transferred to the Resources Committee (see below).

### **Mental Health Legislation Committee (MHLC)**

3.10 Board Members will recall that the Board Performance Evaluation Scheme 2018/19 provided assurance on the improvements made to the operational arrangements of the MHLC following significant work being undertaken over the last couple of years.

3.11 In view of these improvements, and the appointment of a new Chairman of the Committee following the retirement of Mr. Simpson, it is considered that no changes should be made to the terms of reference of the Committee at this time.

3.12 The present terms of reference of the MHLC are attached as Annex 2 to this report for information.

### **Nomination and Remuneration Committee**

- 3.13 Board Members will be aware of NHS pension tax issues as reported in the national media.
- 3.14 Some Trusts have sought to respond to these issues by way of locally determined pay and conditions approved by their Nomination and Remuneration Committees. This approach is not available in the Trust and any changes to pay and conditions would require the approval of the Board of Directors.
- 3.15 To provide flexibility going forward, it is proposed to amend the terms of reference of the Nomination and Remuneration Committee to enable it to agree locally determined terms and conditions of service for all TEWV staff employed on national medical terms and conditions and all staff paid at, or above, AFC Band 8.
- 3.16 Changes to the terms of reference of the Committee to effect the above proposal are highlighted in Annex 3 to this report.

### **Quality Assurance Committee**

- 3.17 Discussions on the operational arrangements and potential amendments to the terms of reference of the Quality Assurance Committee (attached as Annex 4 to this report for information) are ongoing and, it is recognised that these will need to take into account any learning from the recent regulatory action taken by the CQC at West Lane Hospital.
- 3.18 It is therefore proposed that no changes should be made to the Committee's terms of reference at this time but a separate report on this matter should be presented to the Board in due course.

### **Resources Committee**

- 3.19 The terms of reference of the Resources Committee (Annex 5 to this report) have been amended to include the relevant functions of the Commercial Oversight Committee (see above).
- 3.20 Board Members will recall the feedback under the Board Performance Evaluation Scheme about whether the scope of the Resources Committee is too broad and whether a separate committee should be established to ensure sufficient consideration of both workforce and financial matters within the committee structure.
- 3.21 It is recognised that the establishment of a separate Workforce Committee could have benefits, particularly the additional focus on matters of both national and local significance within the governance structure; however, it would also have implications in terms of: the loss of the holistic oversight provided by the present Resources Committee; the future treatment of

equality and diversity issues within the committee structure; and the capacity required to support the new committee.

- 3.22 On balance, it is considered that a separate Workforce Committee should not be established; however, in response to the issues raised, a review of reporting on workforce matters to the Resources Committee and improved agenda management/focus should be undertaken.

#### **4. IMPLICATIONS:**

- 4.1 **Compliance with the CQC Fundamental Standards:** The effectiveness of structures, including committee arrangements, in supporting the delivery of the Trust's strategy and good quality, sustainable services falls within the CQC's well-led domain.

#### **4.2 Financial/Value for Money:**

- (a) The proposed changes to the Board's committee arrangements, outlined in this paper, should not result in additional financial costs.
- (b) The establishment of a Workforce Committee would incur additional costs and exacerbate capacity issues within the Trust Secretary's Department.

- 4.3 **Legal and Constitutional (including the NHS Constitution):** Amendments will be required to the Constitution, in due course, if the proposed change to the title of the Audit Committee and the disestablishment of the Commercial Oversight Committee are approved.

- 4.4 **Equality and Diversity:** The position of equality and diversity within the Board's Committee structure would need to be reviewed if a separate Workforce Committee was established.

- 4.5 **Other implications:** None identified.

#### **5. RISKS:**

- 5.1 There are no new risks arising from this report.

#### **6. CONCLUSIONS:**

- 6.1 The proposed changes to the committee structure and the terms of reference of individual committees are considered to be beneficial in response to national and local circumstances and support good governance in the Trust.

#### **6. RECOMMENDATIONS:**

- 6.1 The Board is asked to:
- (a) Approve the disestablishment of the Commercial Oversight Committee from 30<sup>th</sup> September 2019.
  - (b) Approve the amendments to the terms of reference of the Audit and Risk Committee, the Nomination and Remuneration Committee and the Resources

Committee and (attached as Annexes 1, 3 and 5 to this report) to come into effect on 1<sup>st</sup> October 2019.

- (c) Agree that a separate Workforce Committee should not be established and support the proposed review of workforce reporting to the Resource Committee.
- (d) Note that any changes to the terms of reference of the Quality Assurance Committee, arising from ongoing discussions, will be presented to the Board in due course.

## AUDIT AND RISK COMMITTEE

### TERMS OF REFERENCE

#### 1 CONSTITUTION AND PURPOSE

- 1.1 The **Audit and Risk** 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 **organisational** 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, **organisational** 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 organisational 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;
- **systems and processes for risk management in the Trust, in accordance with the Organisational Risk Management Policy, including those for the development and review of the Board Assurance Framework (BAF) and the Corporate Risk Register;**
- **the Board Assurance Framework (BAF)** and the underlying processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal organisational risks; and the appropriateness of the above disclosure statements;

*(The Committee will undertake detailed monitoring and review of the BAF on a quarterly basis and provide assurance to the Board with regard to its coverage and comprehensiveness and the appropriate and effective mitigation of each principal risk)*

- 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 section 24 of the NHS Standard Contract and as required by NHS Counter Fraud Authority.

### **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 and Risk** 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 NHS Improvement.

- 2.16 To review the Trust's Quality Account/Report prior to inclusion in the Annual Report and submission to the Board of Directors to determine its completeness, integrity and accuracy. This review will include but is not limited to:
- Compliance with directions received from the Department of Health and NHS Improvement.
  - The accuracy of mandatory and local performance indicators
  - Any issues raised by stakeholders
- 2.17 To review all systems of accounting and financial reporting, including those of budgetary control, in order to provide assurance on the completeness and accuracy of information provided to the Board.

### Other

- 2.18 To review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. NHS Improvement, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

- 2.19 To review the work of other committees within the organisation and the Executive Management Team (*including recommendations from EMT and the other Committees*) whose work can provide relevant assurance to the Committee's own scope of work on the appropriateness, robustness and operation of the Trust's governance arrangements. This will particularly include the Quality Assurance Committee.

In reviewing the work of the Quality Assurance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

- 2.20 To review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ("The Whistle Blowing Policy").

In undertaking the review the Committee's objective will be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

- 2.21 To review the Trust's systems and processes for the prevention of bribery and receive reports on non-compliance.

- 2.22 To request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 2.23 To request and review specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.
- 2.24 To commission and review value for money studies of the Trust's services and functions and to make recommendations to the Board accordingly.

### **3 MEMBERSHIP**

- 3.1 The Committee shall be appointed by the Board from amongst the Non - Executive Directors/ Associate Non-Executive Directors of the Trust and shall consist of not less than four members. At least one Member of the Committee shall have recent and relevant financial experience.
- 3.2 The Chairman of the Committee shall be appointed by the Board of Directors.
- 3.3 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman. Nominated deputies may be appointed when appropriate.

### **4 ATTENDANCE**

- 4.1. The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. .
- 4.2 The Chairman of the Trust shall not be a member of the Committee but may attend as an observer at the invitation of the Committee.
- 4.3 Any Non-Executive Director of the Trust may attend meetings should they wish and participate in discussions on all matters before the Committee. All Non-Executive Directors will receive Audit **and Risk** 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 **and Risk** Committee the process for assurance that supports the Annual Governance Statement.
- 4.6 A Governor, nominated by the Council of Governors, shall be invited to attend the special meeting of the Committee to consider the draft Annual Report and Accounts, and the External Auditors' reports relating to them in an observer capacity.
- 4.7 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 Following every meeting the Chairman of the Committee shall report to 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.
- **To provide assurance on the adequacy of the Board Assurance Framework and the effective management of the Trust's strategic risks.**
- To draw to the Board's attention any issues that require disclosure to the full Board or where executive action is required.
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

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 NHS Improvement and/or the Care Quality Commission.

- 8.3 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.

## **MENTAL HEALTH LEGISLATION COMMITTEE**

### **TERMS OF REFERENCE**

#### **1 CONSTITUTION**

- 1.1 The Mental Health Legislation Committee is established under Standing Order 6 of the Board of Directors
- 1.2 The Standing Orders of the Board of Directors, as far as they are applicable and with appropriate alterations, shall apply to meetings of the Committee.
- 1.3 All meetings of the Committee will be held in public.

#### **2 FUNCTIONS**

- 2.1 To provide assurance to the Board on the Trust's compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005, including any statutory Codes of Practice relating thereto, by:
  - (a) reviewing activity and performance with appropriate comparisons and trends; and
  - (b) identifying common themes arising from the findings of the Care Quality Commission following visits to the Trust's services

and to escalate risk and propose mitigating actions to the Board where assurance is lacking.

(NOTE: Oversight and monitoring of actions in response to recommendations received from the Care Quality Commission falls within the remit of the Quality Assurance Committee).

- 2.2 To consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to make recommendations, as required, for changes to the Trust's policies, procedures and practice.
- 2.3 To ensure appropriate arrangements are in place for the appointment and appraisal of associate managers and oversee managers' hearings.
- 2.4 To consider other matters at the request of the Board of Directors.

#### **3 MEMBERSHIP**

- 3.1 The Committee will comprise:
  - A Non-Executive Director as the Chairman of the Committee
  - Two other Non-Executive Directors/ Associate Non-Executive Directors
  - The Chairman of the Trust
  - The Director of Nursing and Governance

- The Medical Director
- The Chief Operating Officer
- A Public Governor or an Expert by Experience as a service user representative\*
- A Public Governor or an Expert by Experiences as a carer representative\*

(\* Note: The agreement of arrangements for filling any vacancies amongst the service user and carer representatives shall be at the discretion of the Chairman of the Trust).

- 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 Assurance Framework 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 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 (including any risks which the Committee considers should be escalated to the Board Chapter of the Integrated Assurance Framework and Risk Register).
  - 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.  
(October 2018)



## **NOMINATION AND REMUNERATION COMMITTEE OF THE BOARD OF DIRECTORS**

### **TERMS OF REFERENCE**

#### **1 CONSTITUTION**

- 1.1 The Nomination and Remuneration 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**

##### **Nominations**

- 2.1 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.
- 2.2 To be assured that arrangements are in place to support succession planning for Executive Director roles.
- 2.3 To be responsible for appointing Executive Directors and other Directors reporting directly to the Chief Executive.
- 2.4 To be responsible for appointing the Chief Executive subject to the approval of the Council of Governors.
- 2.5 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**

- 2.6 To be responsible for reviewing and determining 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

- 2.7 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).
- 2.8 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.
- 2.9 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.
- 2.10 To be responsible for reviewing and deciding locally determined terms and conditions of service for all Trust staff employed on national medical terms and conditions and all staff paid at, or above, AFC Band 8.

### Miscellaneous

- 2.11 To be responsible for authorising applications to NHS Improvement and HM Treasury for permission to make a special severance payment to an employee or former employee.
- 2.12 To consider the engagement or involvement of any suitably qualified adviser to assist with any aspect of its responsibilities.

### 3 DELEGATED AUTHORITY

- 3.1 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.
- 3.2 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)

- 3.3 The approval of the remuneration and terms and conditions of service of the Executive Directors and other Directors (where these are not determined nationally).
- 3.4 The approval of any annual uplifts in Trust determined pay structures.
- 3.5 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.
- 3.6 **The approval of locally determined terms and conditions of service for all Trust staff employed on national medical terms and conditions and all staff paid at, or above, AFC Band 8.**
- 3.7 The approval of applications to NHS Improvement and HM Treasury for permission to make a special severance payment to an employee or former employee.

#### **4 MEMBERSHIP**

- 4.1 The Committee shall comprise the Chairman of the Trust and all Non-Executive Directors.
- 4.2 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.
- 4.3 The Chairman of the Trust shall be the Chairman of the Committee.
- 4.4 A quorum shall be at least three Members of the Committee.
- 4.5 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.

#### **5 ATTENDANCE AT MEETINGS**

- 5.1 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
- 5.2 The Trust Secretary shall be the secretary of the Committee.

#### **6 FREQUENCY OF MEETINGS**

6.1 Meetings shall be held as and when required on dates and at times agreed by the Chairman.

## **7 MINUTES AND REPORTING PROCEDURES**

7.1 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.

7.2 The Nomination and Remuneration Committee will report to the Board of Directors after each meeting.

7.3 Matters pertaining to the work of the Nomination and Remuneration shall be reported, as required by NHS Improvement, in the Annual Report.

## **8 REVIEW**

8.1 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.

## QUALITY ASSURANCE COMMITTEE

### TERMS OF REFERENCE

#### 1 CONSTITUTION

- 1.1 The Quality Assurance 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,
- 1.3 The Committee exists to provide assurance to the Board to enable it (“the Board”) to fulfil its responsibilities.

#### 2 FUNCTIONS

- 2.1 To provide assurance to the Board that the Trust is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008 (“the Act”).
- 2.2 To gain and provide assurance to the Board on:
  - a. The Trust’s compliance with regulation requirements enabling it to maintain registration with the Care Quality Commission to undertake regulated activities at each location;
  - b. The Trust is compliant with the Regulator’s standards of quality and safety as set out in the Health and Social Care Act 2008 (Registration requirements) Regulations 2009 and the fundamental standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014;
  - c. The delivery of the strategic quality objectives in the Trust’s Quality Strategy and its supporting Frameworks;
  - d. The delivery of the Quality Account priorities and escalate risks of achievement to the Board;
  - e. That effective processes are in place in the Trust to ensure that lessons are learned and that good practice is shared and implemented across the Trust.

And to escalate risk to the Board where assurance is lacking.
- 2.3 To make recommendations about priorities in the Trust’s Annual Quality Account for the following year.
- 2.4 To commission and monitor projects/programmes of work to assist the Trust to maintain CQC registration and/or discharge its duty of quality and safety.

- 2.5 To co-operate fully with all Board Committees and to support those Committees achieving their objectives.
- 2.6 To develop an annual programme of work to ensure the functions of the Committee are achieved.
- 2.7 To agree in consultation with the Audit Committee, an annual Clinical Audit programme (aligned to the key clinical risks of the Trust); and to monitor that programme and liaise with the Audit Committee as appropriate.
- 2.8 To monitor that the risks relevant to the Committee within the Risk Registers 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**

#### **3.1 Voting Members**

Chairman of the Committee (a Non-Executive Director)  
 Trust Chairman  
 Three Non-Executive Directors / Associate Non-Executive Directors  
 Director of Nursing and Governance  
 Medical Director  
 Chief Operating Officer  
 Chief Executive  
 Director of Quality Governance

#### **3.2 In attendance (whole meeting)**

- The Deputy Medical Directors and Directors of Operations whose LMGB reports are being considered.
- Deputy Director of Nursing
- Associate Directors of Nursing

*The Trust Secretary, or an officer appointed by him/her, shall be the secretary of the Committee.*

### 3.2 **Other**

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**

- 5.1 The Committee will meet 10 times a year usually from 14:00 – 17.00 on the 1st Thursday of the month (except in January and August).

## 6 **RELATIONSHIP WITH THE BOARD AND OTHER COMMITTEES**

- 6.1 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.
- 6.2 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 Assurance Framework 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**

- 7.1 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.
- 7.2 The Committee has delegated authority, subject to consultation with the Audit Committee, to approve an annual programme of clinical audit.

## 8 **REPORTING ARRANGEMENTS**

- 8.1 Following every meeting the Chairman of the Committee shall report to 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 (including any risks which the Committee considers should be escalated to the Board Chapter of the Integrated Assurance Framework and Risk Register).
- 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 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.



## RESOURCES COMMITTEE (INCLUDING CHARITABLE FUNDS)

### TERMS OF REFERENCE

#### 1 CONSTITUTION

- 1.1 The Resources 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.
- 1.3 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.

#### 2 FUNCTIONS

- 2.1 To provide assurance to the Board that the resources available to the Trust (both financial and non-financial) to deliver its Operational/Business Plan are appropriate, sufficient and deployed effectively.
- 2.2 To provide assurance to the Board (in the context of paragraph 2.1 above) on the robustness and alignment of the following strategies and plans:
- The Financial Strategy
  - The Capital Plan
  - The Investment Strategy and Plan
  - The Workforce Strategy and Plan
  - The Digital Transformation-Strategy
  - Equality Strategy and WRES/WDES Action Plans
- 2.3 To review proposals (including evaluating risks) for major business cases and their respective funding sources and provide assurance to the Board.
- 2.4 To monitor, review progress and provide assurance to the Board on the delivery of:
- (a) The strategies and plans (set out in paragraph 2.2 above) particularly in relation to the achievement of commissioner investment in the service priorities.
- (b) Major investments/service changes and new models of care.
- (Note: The monitoring of progress on the delivery of the Operational/Business Plan shall be undertaken directly by the Board)*
- 2.5 To oversee and provide assurance to the Board on the performance of the Trust’s Subsidiaries including that they:

- (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) remain financially solvent and provide a positive financial return to the Trust;
- (e) have appropriate insurance in place.

2.6 To keep under review potential changes in the external environment in the medium to longer term and to draw any material risks to the sustainability of the Trust to the Board's attention.

2.7 To provide oversight of the management and administration of Charitable Funds held by the Trust.

### **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 The provision of guidance 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.

3.6 Approval of applications for financial assistance from the Trust's Charitable Trust Funds.

3.7 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 / Associate Non-Executive Directors
  - The Chairman of the Trust
  - The Chief Executive
  - The Director of Finance and Information\*
  - The Chief Operating Officer
- 4.2 The Chairman of the Committee shall be appointed by the Board of Directors.

## 5 ATTENDANCE AT MEETINGS

- 5.1 All Board Members are invited to attend and participate in meetings of the Committee (but not to vote). To facilitate this, copies of all agendas and papers for meetings will be provided to them.
- 5.2 Executive Directors are expected to attend meetings of the Committee when matters within their portfolios are being considered.
- 5.3 The Committee may require:
- (a) Directors or senior post holders of Subsidiaries;
  - (b) the Trust's shareholder representative;
  - (c) internal or external auditors;
  - (d) any other relevant third parties
- to attend its meetings, as it considers appropriate, to gain assurance on a Subsidiary's business plans, operations, activities and performance.
- 5.4 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.
- 5.5 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary of the Committee.

## 6 QUORUM

- 6.1 A quorum shall be not less than two Non-Executive Directors, one of which will chair the meeting and one Executive Director.

## 7 FREQUENCY OF MEETINGS

- 7.1 The Committee shall meet at least once each quarter.

## **8 REPORTING**

- 8.1 Following every meeting the Chairman of the Committee shall report to 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 (including any risks which the Committee considers should be escalated to the Board Assurance Framework).
  - 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 Resources Committee shall be reviewed at least annually.

FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Appointment of the Non-Executive Chairmen and Members of Committees of the Board of Directors</b>
<b>REPORT OF:</b>	<b>Miriam Harte, Chairman of the Trust</b>
<b>REPORT FOR:</b>	<b>Decision</b>

<b>This report supports the achievement of the following Strategic Goals:</b>	✓
<i>To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing</i>	
<i>To continuously improve the quality and value of our work</i>	
<i>To recruit, develop and retain a skilled, compassionate and motivated workforce</i>	
<i>To have effective partnerships with local, national and international organisations for the benefit of the communities we serve</i>	
<i>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.</i>	✓

**Executive Summary:**

The appointment of members to the Board's Committees is a reserved matter under Annex 8 of the Constitution.

This report seeks the appointment of Non-Executive Directors as the chairmen and members of the Board's committees in accordance with their terms of reference, and to participate in reviews of serious incidents, as set out in the attached schedule.

**Recommendations:**

The Board is asked to approve the appointments set out in the schedule attached to this report with effect from 1<sup>st</sup> October 2019.

**Non-Executive Director Committee and SUI Panel Membership from 1<sup>st</sup> October 2019**

	<b>Audit Committee</b>	<b>Resources Committee</b>	<b>Mental Health Legislation Committee</b>	<b>Quality Assurance Committee</b>	<b>SUI Panel</b>
<i>Maximum Number of Non-Executive Director seats (excluding Chair of the Committee and Ex Officio Members)</i>	3	2	2	3	-
<b>Miriam Harte</b>		<b>Ex Officio Member</b>	<b>Ex Officio Member</b>	<b>Ex Officio Member</b>	<b>Ex Officio Member</b>
<b>Dr. Hugh Griffiths</b>	✓			<b>Chair</b>	✓
<b>Marcus Hawthorn</b>	✓	<b>Chair</b>			
<b>Prof. Pali Hungin</b>			✓	✓	✓
<b>David Jennings</b>	<b>Chair</b>	✓			✓
<b>Paul Murphy</b>	✓		<b>Chair</b>		✓
<b>Shirley Richardson</b>		✓		✓	✓
<b>Bev Reilly</b>			✓	✓	✓

(Note: All Non-Executive Directors are members of the Board Nomination and Remuneration Committee)

FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Board Business Cycle 2020</b>
<b>REPORT OF:</b>	<b>Phil Bellas, Trust Secretary</b>
<b>REPORT FOR:</b>	<b>Decision</b>

<b>This report supports the achievement of the following Strategic Goals:</b>	✓
<i>To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing</i>	
<i>To continuously improve the quality and value of our work</i>	
<i>To recruit, develop and retain a skilled, compassionate and motivated workforce</i>	
<i>To have effective partnerships with local, national and international organisations for the benefit of the communities we serve</i>	
<i>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.</i>	✓

**Executive Summary:**

The business cycle sets out the matters to be considered by the Board at its formal meetings and seminars taking into account key corporate processes.

Appended to the report are:

- (1) A calendar of meetings for the Board and its Committees.
- (2) A schedule of reports to be provided to each Board meeting.

The Board is asked to note that:

- (1) In general, the meeting arrangements follow the same pattern of previous years.
- (2) The key change is that the Board meeting in July 2020 will not be held in the same week as the Annual General Meeting.
- (3) The dates of the Audit Committee and Board meetings in May 2020 should be regarded as provisional as NHS Improvement has not yet published the timetable for the submission of the Annual Report and Accounts. The meeting dates will be confirmed once the guidance has been received.
- (4) Although the suggested dates of the Board Seminars are included in the meeting calendar, a detailed programme of the topics to be discussed at each event has not been prepared. It has been decided to maintain flexibility as there are a number of key reports which are due to be considered at Board Seminars (e.g. those relating to West Lane Hospital, the outcome of the CQC inspection, etc) where the date of receipt cannot yet be timetabled.

A detailed meeting schedule will be distributed to Board Members once the arrangements have been approved.

**Recommendations:**

The Board is asked to approve its indicative business cycle for 2020 (as set out in Annexes 1 and 2 to this report) noting that changes might be required to meeting arrangements during the period.



<b>MEETING OF:</b>	<b>The Board of Directors</b>
<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Board Business Cycle</b>

**1. INTRODUCTION & PURPOSE:**

- 1.1 To enable the Board to consider its meeting arrangements and business cycle for 2020.

**2. BACKGROUND INFORMATION AND CONTEXT:**

- 2.1 The business cycle sets out the matters to be considered by the Board at its formal meetings and seminars.
- 2.2 It takes into account:
- The need for the provision of timely assurance to the Board to support achievement of the Trust's strategic goals and regulatory compliance.
  - The delivery of key corporate processes.
  - The reporting requirements of the Board's committees as set out in their terms of reference.
- 2.3 The Board's present meeting arrangements are based on the following approach:
- All formal meetings being held in public as required by the Health and Social Care Act 2012.
  - Formal ordinary meetings being held, generally, on the last Tuesday of each month except that:
    - The Board meeting in May might need to be held earlier in the month due to the submission date for the Annual Report and Accounts.
    - No meetings being held during August.
    - The Board meeting in December being held early in the month combined with a Seminar.
    - Other changes as may be required and agreed by the Board.
  - Board meetings being held at West Park Hospital, Darlington except that end of quarter meetings are usually held in one of the Trust's geographical Localities. For North Yorkshire, the meeting venues alternate, annually, between Scarborough and Harrogate.
  - Eight private Board seminars being held each year usually on the second Tuesday of the month.
  - Board Business Planning Events being held in October (two days) and January (one day).
- 2.4 The business cycle is only indicative and the matters to be included on the agenda for each Board meeting are agreed by the Chairman following consultation with the Executive Management Team.

### 3. KEY ISSUES:

#### Formal Board Meetings

- 3.1 A proposed calendar of Board and committee meeting dates for the year is attached as Annex 1 to this report.

*(Note: the calendar might need to be amended in response to the Board's discussions on its committee arrangements under agenda item 18).*

- 3.2 A schedule of the reports due to be considered at each Board meeting is attached as Annex 2 to this report.
- 3.3 The Board is asked to note that, in general, the meeting arrangements remain the same as in previous years; however:
- The Board meeting in July 2020 has been moved in order to avoid the same week as the Annual General Meeting.
  - The dates of the Board and Audit Committee meetings in May will be confirmed following receipt of the timetable for the submission of the Annual Report and Accounts from NHS Improvement.

#### Board Seminars

- 3.4 The proposed dates of the Board Seminars are included in Annex 1 to this report.
- 3.5 In usual circumstances a programme of the topics for each Board Seminar would be provided; however, this year, it has been decided to maintain flexibility as there will be a number of key reports (those relating to West Lane Hospital, the outcome of the CQC inspection, etc) which will require in-depth consideration by the Board but where the dates of receipt are, at present, unknown.
- 3.6 The Board is asked to note that, at present, the topics due for consideration at Board Seminar during 2020 include:
- (a) Briefings on the work of each Specialty Development Group.
  - (b) Review of the Business Plan
  - (c) Raising concerns
  - (d) Restrictive Interventions
  - (e) Future purpose and business model of the Trust
  - (f) Assurance
  - (g) Service user and carer involvement and engagement
  - (h) Reports relating to West Lane Hospital
  - (i) CQC well led report
  - (j) Lone working procedures
- 3.7 Board Members are also invited to suggest any additional topics for the Seminars at the meeting.

**4. IMPLICATIONS:**

- 4.1 **Compliance with the CQC Fundamental Standards:** The Board business cycle seeks to ensure that assurances are available to the Board on the Trust's compliance with the CQC's Fundamental Standards.
- 4.2 **Financial/Value for Money:** The Board business cycle seeks to ensure that assurances are available to the Board on the Trust's compliance with its financial and value for money obligations.
- 4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.
- 4.4 **Equality and Diversity:** Equality and diversity are covered in the meeting reporting schedule.
- 4.5 **Other implications:** None identified.

**5. RISKS:**

- 5.1 There are risks that the Board might be unsighted on significant issues if its reporting and assurance processes are not robust.

**6. CONCLUSIONS:**

- 6.1 The report supports good governance in the Trust.

**7. RECOMMENDATIONS:**

- 7.1 The Board is asked to:
- (a) Approve the calendar and indicative reporting schedule (as set out in Annexes 1 and 2 to this report) noting that changes might be required to meeting arrangements during the period.
  - (b) Agree the topics for inclusion in the Board Seminar programme based on the list provided in para. 3.6 above and those proposed at the meeting.

**Phil Bellas, Trust Secretary**

<b>Background Papers: None</b>
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## Draft Meeting Calendar 2020

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
1										QuAC		
2				QuAC			QuAC					
3									COC/QuAC			COC/QuAC
4						COC/QuAC						
5			COC/QuAC								QuAC	
6		QuAC								Bus Planning		
7	Bus Planning				QuAC					Bus Planning		
8									RC/Seminar			
9							CoG special					
10			RC/Seminar						Audit		RC/Seminar	Audit
11		Seminar										
12		CoG			RC/Seminar							
13												
14	RC			Seminar	Audit		Seminar					
15												Board + Seminar (West Park)
16									CoG			
17												
18												
19			Audit		COG						CoG	
20												
21							MHLC			MHLC		
22	MHLC			MHLC	Audit		AGM					
23												
24											Board (West Park)	
25		Board (West Park)										
26					Board (West Park)							
27										Board (York)		
28	Board (Durham)			Board (Harrogate)			Board (Boro)					
29									Board (West Park)			
30						Board (West Park)						
31			Board (West Park)									

 Non Day  
 Bank Holiday



## Tees, Esk and Wear Valleys NHS Foundation Trust

## Schedule of Board Business (Jan 2020 - December 2020)

Meeting Date	Lead	2020											
		28-Jan	25-Feb	31-Mar	28-Apr	26-May	30-Jun	28-Jul	29-Sep	27-Oct	24-Nov	15-Dec Special	
Tees Rehab Service Changes (Dates to be determined)	COO												
Business Cases (via RC) (Dates to be determined)	DoF&I/COO												
Roseberry Park Updates	DoF&I	√	√	√	√	√	√	√	√	√	√	√	√
<b>5 Performance</b>													
Performance Dashboard	DoPP&C	√	√	√	√	√	√	√	√	√	√	√	*
Finance Report	DoF&I	√ (x2)	√	√	√ (x2)	√	√	√ (x2)	√	√ (x2)	√	√	*
Strategic Direction Performance Report	DoPP&C		√			√			√		√		
<b>6 Governance/Regulatory</b>													
Register of Directors' Interests	TS								√				
Board Business Cycle	TS								√				
Annual Review of Board Committee's terms of reference	TS								√				
NED Committee Membership Review	Chair								√				
NHSI Governance Certificates (via AC)	TS					√							
Annual Report (including the Annual Governance Statement and Quality Report/Account) and Accounts together with the External Auditors' Reports (via AC)	CEO/DoF&I					√							
Charitable Funds Annual Report and Accounts (via AC)	DoF&I								√				
Board Assurance Framework	TS	Summary	Summary	Summary	Summary	Summary	Summary	Full	Summary	Summary	Summary	Summary	Full
NHS Oversight Framework Report	TS/ DoPP&C	√			√			√		√			
Information Governance Toolkit	DoN&G			√ (Annual Submission)					√ (Half year progress report)				
Annual Report on Research and Development	MD					√							
Annual Report of the Responsible Officer for Medical Revalidation	MD								√				
Medical Education Annual Report	MD									√			
Annual Claims Report	DoN&G							√					
Core standards on emergency preparedness, resilience and response (via AC)	DoF&I								√				
Integrated Governance Framework (via AC)	TS			√									
Annual Board Performance Evaluation Scheme Report	TS					√							
Gender Pay Gap Report	DoHR&OD									√			
<b>7 Other Standing Committee Reports</b>													
Audit Committee Report	Cttee Chair	√		√			√		√				Verbal Update
Resources Report	Cttee Chair/ DoF&I	√		√			√		√		√		
Board Nomination and Remuneration Committee Report (as and when required)	Chair												
<b>8 For Information</b>													
Register of Seals (as and when required)	CEO	√	√	√	√	√	√	√	√	√	√	√	
Policies and Procedures	CEO	√	√	√	√	√	√	√	√	√	√	√	

(Note:\* indicates report to be circulated under separate cover outside the meeting)

FOR GENERAL RELEASE

BOARD OF DIRECTORS

<b>DATE:</b>	<b>24<sup>th</sup> September 2019</b>
<b>TITLE:</b>	<b>Register of Interests of the Board of Directors</b>
<b>REPORT OF:</b>	<b>Phil Bellas, Trust Secretary</b>
<b>REPORT FOR:</b>	<b>Information</b>

<b>This report supports the achievement of the following Strategic Goals:</b>	✓
<i>To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing</i>	
<i>To continuously improve the quality and value of our work</i>	
<i>To recruit, develop and retain a skilled, compassionate and motivated workforce</i>	
<i>To have effective partnerships with local, national and international organisations for the benefit of the communities we serve</i>	
<i>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.</i>	✓

**Executive Summary:**

The Trust is required to have a Register of Interests of the Board of Directors under the NHS Act 2006 and the Constitution.

This report presents the updated version of the Register of Interests following the annual review.

The Register is:

- (a) A public document which is published on the Trust's website and publicised in the Annual Report.
- (b) Formally reviewed, at least, on an annual basis.

**Recommendations:**

The Board is asked to receive and note the Register of Interests of the Board of Directors as at September 2019.

**Tees, Esk and Wear Valleys NHS Foundation Trust**

**Register of Interests of Members of the Board of Directors**

Date: September 2019

Note: 1 - This Register has been established in accordance with the National Health Service Act 2006 (as amended) and the Constitution

Note: 2 - Descriptions of the types of interests are provided in NHS England Guidance "Managing Conflicts of Interests in the NHS" (Publications Gateway Number 06419) and the Trust's Conflicts of Interest Policy

Note: 3 - (B) denotes that the Director is a voting member of the Board of Directors

Note: 4 - Changes of interest should be recorded as notified

Note: 5 - The Register should be refreshed at least annually

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Miriam Harte	Chairman (B)	<b>Yes</b> Non-Executive Director/Committee Member at Thirteen Housing Group	<b>None</b>	<b>None</b>	<b>None</b>
Dr Hugh Griffiths	Deputy Chairman (B)	<b>Yes</b> Director of Hugh Griffiths Associates Ltd Associate contract with GE Finnamore Healthcare	<b>Yes</b> Fellow of the Royal College of Psychiatrists	<b>None</b>	<b>Yes</b> Wife is an Improvement Director with NHS Improvement
Marcus Hawthorn	Senior Independent Director (B)	<b>None</b>	<b>Yes</b> Director of NRCPD	<b>None</b>	<b>None</b>
Prof. Pali Hungin	Non-Executive Director (B)	<b>None</b>	<b>None</b>	<b>None</b>	<b>None</b>



Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
David Jennings	Non-Executive Director (B)	None	None	None	None
Paul Murphy	Non-Executive Director (B)	Yes Ad hoc consultancy work for City of York Council, North Yorkshire County Council and East Riding Council	None	Yes Chair of Trustees at the York and North Yorkshire Benefits Unit Member of the Board of Trustees at the National Centre for Early Music	Yes Daughter is Head of Office for the Office of the National Director, Operations and Information, NHS England until 30th September 2019. From 7th October 2019 she will be Head of Healthcare Policy (EMEA) for Amazon Web Services
Shirley Richardson	Non-Executive Director (B)	None	None	Yes Chairman of Carers Together Foundation, a charity which carries out carers' assessments and gives advice and support to carers in Middlesbrough, Redcar and East Cleveland <i>(Note: whilst the Carers Together Foundation does receive funding from the NHS, Mrs. Richardson's role is unpaid and no expenses are claimed)</i>	None
Bev Reilly	Non-Executive Director (B)	None	Yes Member of the Royal College of Nursing	None	None

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Colin Martin	Chief Executive (B)	None	Yes Director of North East Transformation System (NETS) Ltd	None	None
Ruth Hill	Chief Operating Officer (B)	None	Yes Director of North East Transformation System (NETS) Ltd	None	Yes Sister in law works for East Durham College which is subcontracted by TEVV for training services
Dr Ahmad Khouja	Medical Director (B)	None	None	None	None
Patrick McGahon	Director of Finance and Information (B)	None	Yes Chairman Carlisle College (part of NCG Group)	None	None
Elizabeth Moody	Director of Nursing and Governance & Deputy Chief Executive (B)	None	None	None	Yes Husband is employed as a clinical manager in forensic services by Northumberland, Tyne and Wear NHS Foundation Trust

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
David Levy	Director of Human Resources and Organisational Development	None	Yes Director of Achieving Real Change for Communities (CIC) Ltd	None	None
Sharon Pickering	Director of Planning, Performance and Communications	None	None	None	Yes Husband employed by Durham Dales Easington and Sedgefield CCG and Darlington CCG as Chief Finance Officer

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

<b>DATE:</b>	<b>24 September 2019</b>
<b>TITLE:</b>	<b>Policies Ratified by the Executive Management Team</b>
<b>REPORT OF:</b>	<b>Colin Martin</b>
<b>REPORT FOR:</b>	<b>Information</b>

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

**Executive Summary:**

The policy paper contains the following information:

- 3 policies that underwent full revision and required ratification:
  - IT-0032-v3 Maintenance of IT Systems Policy
  - CORP-0026-v6.1 Records Management Policy
  - CLIN-0027-v7 Safeguarding Children Policy
  
- 2 policies that underwent minor amendment and required re-ratification:
  - CLIN-0012-v7.5 Admission Transfer and Discharge Policy
  - CLIN-0014-v8 Rapid Tranquillisation Policy
  
- 1 policy that had the review date extended:
  - FIN-0005-v4 Lease Car Policy
  
- 1 strategy that has been withdrawn:
  - Records Lifecycle Management Strategy

**Recommendations:**

The Board are asked to ratify the decisions made by EMT at the meetings held on 28 August 2019.

<b>DATE:</b>	<b>24 September 2019</b>
<b>TITLE:</b>	<b>Policies and Procedures Ratified by the Executive Management Team</b>
<b>REPORT OF:</b>	<b>Colin Martin</b>
<b>REPORT FOR:</b>	<b>Information</b>

**1. INTRODUCTION & PURPOSE:**

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

**2. BACKGROUND INFORMATION AND CONTEXT:**

- 2.1** It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.
- 2.2** Following the last revision of the Trust’s Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies.
- 2.3** Each policy ratified by the Executive Management Team will have gone through the Trust’s consultation process.
- 2.4** Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

**3. KEY ISSUES:**

- 3.1** The following policies have undergone full review and required ratification:

<b>Ref and Title</b>	IT-0032-v3 Maintenance of IT Systems Policy
<b>Review date</b>	24 August 2022
<b>Reviewed by</b>	Ahmad Khouja
<b>Approved by</b>	Digital Transformation and Safety Board
<b>Description of change</b>	The policy has undergone full review with minor changes to job titles, legislation and governance groups and processes.

<b>Ref and Title</b>	CORP-0026-v6.1 Records Management Policy
<b>Review date</b>	16 June 2021
<b>Reviewed by</b>	David Levy
<b>Approved by</b>	Digital Transformation and Safety Board
<b>Description of change</b>	Section 4.16 has been added identifying the rights of the individual under the Data Protection Act 2018 (GDPR), bringing this policy in line with the Requests for Information Procedure.

<b>Ref and Title</b>	CLIN-0027-v7 Safeguarding Children Policy
<b>Review date</b>	28 August 2022
<b>Reviewed by</b>	Phil Bellas
<b>Approved by</b>	Safeguarding and Public protection subgroup
<b>Description of change</b>	Changes to the policy are summarised as:- <ul style="list-style-type: none"> <li>• Removal of reference to Pre caf as no longer applicable</li> <li>• Updated in relation to Working Together guidance 2018</li> <li>• Links added throughout the document to relevant other documents and safeguarding toolkit</li> <li>• Additional context added regarding safeguarding issues to be considered</li> <li>• Contact details updated for the safeguarding team</li> </ul>

**3.2** The following have undergone minor amendment and required re-ratification:

<b>Ref and Title</b>	CLIN-0012-v7.5 Admission Transfer and Discharge Policy
<b>Review date</b>	02 November 2019
<b>Reviewed by</b>	Colin Martin
<b>Approved by</b>	SDG for AMH 16 May 2019, SDG for MHSOP 16 May 2019, SDG for LD 20 June 2019
<b>Description of change</b>	Section 7 has been added regarding transfers between Trust wards. This does not include Forensic services who are developing their own transfer summary.

<b>Ref and Title</b>	CLIN-0014-v8 Rapid Tranquillisation Policy
<b>Review date</b>	28 August 2022
<b>Reviewed by</b>	Elizabeth Moody
<b>Approved by</b>	Drugs and Therapeutics Committee 12 August 2019

<b>Description of change</b>	The policy has undergone full revision with minor amendments throughout. (Please note hyperlinks will be added where highlighted prior to publication)
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**3.3** The following required an extension to the review date.

<b>Ref and Title</b>	FIN-0005-v4 Lease Car Policy
<b>Review date</b>	01 April 2020
<b>Comments</b>	The Travel and Subsistence Policy is currently being revised. This will impact on the Lease Car Policy and so an extension is required to enable this review to be completed.

**3.4** The following has been withdrawn:

<b>Ref and Title</b>	Records Lifecycle Management Strategy
<b>Comments</b>	The requirements of this strategy have been superseded with the introduction of the Digital Transformation Strategy. The Records Lifecycle Management Strategy has therefore been withdrawn and archived.

## **4. IMPLICATIONS:**

### **4.1 Compliance with the CQC Fundamental Standards:**

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

### **4.2 Financial/Value for Money:**

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

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

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

**4.4 Equality and Diversity:**

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

**4.5 Other implications:**

None identified

**5. RISKS:**

None identified

**6. CONCLUSIONS:**

The decisions detailed above made at the EMT meetings on 28 August 2019 have been presented for ratification.

**7. RECOMMENDATIONS:**

The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

**Author: Colin Martin**  
**Title: Chief Executive**