# AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 4th JULY 2017
# VENUE: THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON
# AT 9.30 A.M.

**PLEASE NOTE THE CHANGE OF VENUE**

Apologies for Absence

Standard Items (9.30 am)

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| **Item 1** | To approve the public minutes of the last ordinary meeting held on **23rd May 2017** and the special meeting held on **13th June 2017**. | | **Attached** |
| **Item 2** | Public Board Action Log. | | **Attached** |
| **Item 3** | Declarations of Interest. | | |
| **Item 4** | Chairman's Report. | **Chairman** | **Verbal** |
| **Item 5** | To consider any issues raised by Governors. | **Board** | **Verbal** |

Quality Items (9.45 am)

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| **Item 6** | To receive a briefing on key issues in the Tees Locality. | **David Brown to attend** | **Presentation** |
| **Item 7** | To receive the report of the Quality Assurance Committee. | **HG/JI** | **Attached** |
| **Item 8** | To consider the monthly Nurse Staffing Report. | **JI** | **Attached** |
| **Item 9** | To receive and note a report on the staffing situation in the North Yorkshire Locality. | **Tim Cate to attend** | **Attached** |

Strategic Items (10.50 am)

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| **Item 10** | On the recommendation of the Resources Committee to approve the Finance Strategy. | **DK** | **Attached** |

Performance (11.00 am)

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| **Item 11** | To consider the Finance Report as at 31st May 2017. | **DK** | **Attached** |
| **Item 12** | To consider the Trust Performance Dashboard as at 31st May 2017. | **SP** | **Attached** |

Items for Information (11.15 am)

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| **Item 13** | To receive and note a report on the use of the Trust's seal. | **CM** | **Attached** |
| **Item 14** | Policies and Procedures ratified by the Executive Management Team. | **CM** | **Attached** |

**Item 15** To note that the next meeting of the Board of Directors will be held on Thursday **20th July 2017** in the Board Room, West Park Hospital Darlington at 9.30 am.

Confidential Motion (11.20 am)

**Item 16** **The Chairman to move:**

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

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

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

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

*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***

**Mrs. Lesley Bessant**
**Chairman**
**28th June 2017**

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

# MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 23RD MAY 2017 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 9.30 AM

**Present:**
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. J. Tucker, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. B. Kilmurray, Chief Operating Officer and Deputy Chief Executive
Mr. D. Kendall, Interim Director of Finance and Information
Dr. N. Land, Medical Director
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. Fletcher, Grant Thornton UK LLP
Mr. P. Bellas, Trust Secretary
Mrs. J. Illingworth, Director of Quality Governance (representing Mrs. Moody)
Mrs. J. Jones, Head of Communications
Mrs. K. Ord, Deputy Trust Secretary

## 17/120 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs. E. Moody, Director of Nursing and Governance.

## 17/121 MINUTES

***Agreed*** *– that, subject to the replacement of "North Yorkshire" with "York and Selby" in minute 17/97, the public minutes of the last meeting held on 25th April 2017 be approved as a correct record and signed by the Chairman.*

## 17/122 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

## 17/123 DECLARATIONS OF INTEREST

There were no declarations of interest.

## 17/124 CHAIRMAN'S REPORT

The Chairman reported on her activities since the last meeting which included:

(1) Presenting a "Living the Values" Award to the staff of Ceddesfeld Ward.

(2) Attending a meeting of the Northern Chairs Network in Leeds on 4th May 2017.

The Board noted that:

(a) Discussions at the meeting had focussed on health improvement and the financial challenges faced by Trusts.

(b) A special meeting of the Network, on the topic of mental health, was due to be held on 23rd June 2017.

(3) Commencing a round of attendance at meetings of the Locality Management and Governance Boards (LMGBs).

## 17/125 GOVERNOR ISSUES

No issues were raised.

## 17/126 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 6th April 2017 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 4th May 2017.

Mr. Tucker, the Acting Chairman for the meeting held on 4th May 2017, drew attention to the following matters:

(1) The difficulties being experienced in recruiting consultants for CAMHS in North Yorkshire, as included in the LMGB's report to the meeting, and in York and Selby.

(2) The Committee's discussions on the support provided by the Trust to patients in Hope House in Hartlepool together with assurances that this was not impacting on clinical standards.

Board Members raised the following issues:

(1) The assurances to be provided to the Quality Assurance Committee, and the Board, that the planned regular communications to staff on common themes identified following MHA visits were being effective in preventing non-compliance issues.

Mrs. Illingworth explained that, as a first step, a Quality Compliance Group had recently been established with the aim of taking a whole Trust approach to sharing and spreading improvements to address recurring issues. This would include aligning the Trust's response to findings from CQC inspections with those from MHA visits into a single process.

(2) The levels of cleanliness in facilities in the York and Selby Locality which had been raised in the Infection, Prevention and Control report to the meeting.

Mr. Kilmurray reported that:

(a) Anecdotal feedback had been received that the cleanliness of some facilities in the Locality were not to the standard expected by the Trust.
(b) Discussions to seek improvements had been held with NHS Property Services Ltd, in relation to the state of the buildings, and the Trust's housekeepers.
(c) In the short-term, action had been taken to address the difficulties being experienced in recruiting housekeeping staff by engaging agency workers and transferring staff from other Localities. The Trust was also reviewing its recruitment plans to seek a longer term solution.
(d) Following the QuAC meeting, he had visited Acomb Garth and had gained assurance that cleanliness standards were being maintained but had also noted the staffing pressures and difficulties arising from the condition of the estate.

(3) The support being provided by the community team to patients placed in Hope House.

With regard to this matter the Board noted:

(a) The challenges arising from the Transforming Care agenda and the impact of CQC regulation on independent providers.
(b) That, by providing support, the Trust was seeking to ensure placements were successful.

Mr. Martin informed the Board that, following the inspection in January 2017, he and Mrs. Moody had been asked, by the CQC, for their views on the standard of commissioning of learning disability services.

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

(1) The draft policy on responding to deaths would be presented to the Board for approval.

Mr. Hawthorn informed the Board that the Audit Committee had received a very useful briefing from Mazars LLP on the involvement of families in investigations of deaths and the use of social media.

(2) The QuAC would continue to receive aggregate data on seclusions.
(3) The lack of guidance for staff on self-harm, highlighted in section 4.9 of the report, related to reporting issues only.

**17/127 NURSE STAFFING REPORT**

The Board received and noted the exception report on nurse staffing for April 2017 as required to meet the commitments of "Hard Truths", the Government's response to the Public Inquiry into Mid Staffordshire NHS Foundation Trust (the "Francis Review").

The focus of discussions was on the development and benefits of the severity scores (as included in Appendix 4 to the report).

In response to questions it was noted that:

(1) Although the severity scores had been used for approximately six months, the Head of Data Quality had advised that a longer period of time was needed to enable meaningful trends to be identified.

(2) The severity scores had not highlighted any new issues, to date, but were useful in providing a comprehensive picture of the impact of recruitment issues, clinical pressures and acuity on wards.

(3) Work was being undertaken to develop differential weightings for the elements underpinning the severity scores but further data was needed to support this approach.

The Chairman advised that work was also being undertaken to improve the assurances available to the Board that staffing issues highlighted by serious incidents had been addressed.

With regard to the severity scores for individual wards:

(1) Dr. Land:

(a) Considered that thought needed to be given to how to sustain staff on Sandpiper Ward in view of it having had the highest severity scores for some months and providing care to very complex patients.

(b) Asked for the situation in Lustrum Vale to be checked in response to the increase in the severity score for the ward in the last month.

**Action: Mr. Kilmurray**

(2) The Non-Executive Directors sought reassurance that support was being provided to Acomb Garth in view of its severity score (the 10th highest for the month) and the cleanliness issues highlighted by the Quality Assurance Committee (minute 17/126 refers).

It was noted that the ward, as part of the MHSOP in York and Selby, was included in the list of services to be receive intensive support.

In addition, the Board also discussed the use of agency staff by the Trust. In relation to this matter:

(1) Mr. Levy advised that the Trust prioritised the use of bank staff but a shortage of nurses made this difficult in the York and Selby and North Yorkshire Localities.

(2) It was noted that the discrepancy between agency usage, included in the nurse staffing report, and expenditure of agency staff, included in the Finance report, arose from the latter report covering both medical locums and agency nurses.

(3) Mr. Kilmurray advised that, in considering whether the level of agency usage was reasonable, the requirement to maintain safe staffing levels and the difficulties experienced in recruiting staff to some services needed to be taken into account. He assured the Board that overall agency usage in the Trust was low compared to other Trusts but was kept under review.

## 17/128 RECRUITMENT AND RETENTION ACTION PLAN

Further to minute 16/286 (29/11/16) the Board received and noted a progress report on the Recruitment and Retention Action Plan.

The Board discussed the following matters:

(1) The reasons why it had been decided not to proceed with the Derbyshire responsive workforce model as it was suggested that, if tailored to the Trust's needs, it might help address some of the staffing issues which had been raised with Directors during their visits to community teams.

Mr. Levy explained that, following a review, the Heads of Nursing considered that the need for longer term cover, as provided through the model, was not an issue for the Trust and the preferred approach was a remodelled version of the Trust's staff bank arrangements.

In relation to this matter:

(a) The Chairman highlighted that difficulties in recruiting to the staff bank (e.g. in York and Selby) would impact on the implementation of the approach suggested by the Heads of Nursing.

(b) Mr. Kilmurray informed the Board that over booking of bank staff at West Park Hospital and in forensic services had helped address requirements for staff at short notice.

(2) The extension of the staff bank to cover community teams.

It was noted that:

(a) There was no financial provision to extend the staff bank to cover community teams.

(b) Discussions had been held on monitoring staffing issues in community teams from serious incident reports.

(c) A process was in place to escalate staffing issues from community teams on a daily basis and there was evidence that staff were being used flexibly in response to need.

In view of the continuing increases in referrals and being mindful of the resilience of staff, the Board considered that:

(a) A report should be presented to a future meeting on the actions being taken to address temporary staffing requirements in community teams.

**Action: Mr. Levy**

(b) To improve visibility, information on staffing in community teams should be included, occasionally, in the Nurse Staffing reports.

**Action: Mr. Levy and Mrs. Moody**

(3) The benefits of encouraging mature entrants to the nursing profession.

Mr. Levy acknowledged that, through learning from the approach taken by Northumbria Healthcare NHS Foundation Trust, it was hoped to attract a broader

mix of entrants to the nursing profession but the end of the bursary might make this more difficult to achieve.

(4) The actions being taken to address the unattractiveness of band 7 roles; an issue which had been raised during Directors' visits.

The Board noted that:

(a) Work was being undertaken to look at role design taking into account the broader leadership arrangements in teams linked to daily lean management.
(b) Discussions were being held on how to minimise the financial losses for staff taking band 7 roles as a result of loss of enhancements.
(c) Work was also being undertaken to provide additional support to staff taking these roles e.g. through the leadership and management programme.
(d) The issue was likely to remain for the foreseeable future but it was hoped that some progress would be made in addressing the issues in the next couple of years.

(5) Whether the destination of newly qualified nurses was being mapped to mitigate the risks of having too many inexperienced staff in one place.

Mr. Levy assured the Board that this work had been undertaken and, whilst there was unease about the proportion of newly quality staff in some services, he was encouraged by the work to support them as well as to retain experienced staff.

(6) The overbooking of bank staff in forensic services and its importance in providing safe staffing levels.

Mr. Levy advised that:

(a) The initiative had been developed in response to awareness that difficulties in providing bank staff at short notice led to lower fill rates.
(b) Overall, the model had worked very well in forensic services and this had led to its extension into the Durham and Darlington Locality.
(c) Further information on the initiative would be included in the report on bank staffing which was due to be presented to the Board at its meeting to be held on 20th July 2017.

(7) The late delivery of exit questionnaires to staff leaving the Trust.

Mr. Levy acknowledged that work needed to be undertaken to improve the timeliness of notification of staff leaving the Trust so that the exit questionnaires could be provided earlier.

(8) The numerator and denominator used for the graph on recruitment in Appendix B to the report.

Mr. Levy explained that this graph showed the fill rate and undertook to include additional narrative on this matter in future reports.

**Action: Mr. Levy**

***Agreed –*** *that a progress report on the Recruitment and Retention Action Plan be provided to the Board meeting to be held on 28th November 2017.*

**Action: Mr. Levy**

## 17/129 REPORT OF THE MENTAL HEALTH LEGISLATION COMMITTEE

The Board received and noted the report of the Mental Health Legislation Committee including:

(1) The confirmed minutes of its meeting held on 19th January 2017 (Annex 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 20th April 2017.

Mr. Simpson, the Chairman of the Committee, highlighted the discussions, at the latter meeting, on the potential impact of amendments to the Mental Health Act arising from the Police and Crime Act 2017 which had been escalated to the Executive Management Team.

He also advised that he was working with the Trust Secretariat to further develop the operation of, and the provision of assurance to, the Committee.

In response to a question, it was noted that an escalation process was being developed to provide assurance that where professional differences arose within multidisciplinary teams, regarding decisions to discharge, this did not adversely impact on the care of the service user.

## 17/130 COMPOSITE STAFF ACTION PLAN

Consideration was given to the report on:

(1) Progress made on the delivery of the Composite Staff Action Plan and locality action plans for 2016 (Appendix 1 to the covering report) following the update provided to the Board meeting held on 29th November 2016 (minute 16/288 refers).

(2) A proposed Composite Staff Action Plan (Appendix 2 to the covering report) developed in response to the 2016 annual staff survey opinion results (as reported to the Board Seminar held on 14th March 2017) and the Staff Friends and Family Test (FFT) results.

Board Members, noting that the action plan did not mention all related activities (e.g. it omitted the TEWV way priority, IiP re-accreditation, etc), suggested that the version of the report published on the Trust's website should be amended to provide greater visibility on the broader context of staff engagement in the Trust.

This was taken on board.

**Action: Mr. Levy**

In response to points raised by Board Members, Mr. Levy:

(1) Acknowledged the difficulties in gauging the effectiveness of actions included in the Composite Staff Action Plan as a result of the short time between its agreement and the next staff survey.

He considered that it was more appropriate to track the impact of actions over a period of two to three years.

(2) Advised that there had been difficulties in directly engaging with staff from black and minority ethnic (BAME) backgrounds in relation to their experience of bullying and harassment (an issue raised in the staff survey a couple of years ago) but efforts to do this were continuing through the establishment of a working group .

(3) Assured the Board that the issues raised during discussions on the Freedom to Speak Up Guardian's report (minute 17/62 - 28/3/17 refers), on inappropriate management behaviour were being addressed through the proposed Trustwide anti bullying and harassment procedure and actions under the TEWV Way Business Plan priority.

***Agreed –*** *that the Composite Staff Action Plan (as set out in Appendix 2 to the above report) be endorsed.*

**Action: Mr. Levy**

## 17/131 ANNUAL REPORT AND ACCOUNTS 2016/17

On the recommendation of the Audit Committee consideration was given to the approval of the draft Annual Report, including the Quality Report/Account, and Accounts 2016/17 and Letter of Representation 2017.

Revised copies of page 19 of the Annual Report and Appendix 1 to the Quality Report/Account, which reflected comments received from the External Auditors following the publication of the documents, were tabled at the meeting.

With regard to the above matters the Board took into account:

(1) The External Auditors' Audit Completion Report (ISA 260) and subsequent letter on the resolution of outstanding matters dated 17th May 2017.

The Board noted that, subject to its approval, the External Auditors intended to issue an unqualified opinion on the Annual Report and Accounts.

(2) The External Auditors' draft report on the contents and indicators included in the Quality Report 2016/17 and their limited (scope) Assurance Opinion.

(3) The report of the Director of Finance noting that the Trust had adopted the "going concern" basis for the preparation of the accounts at its meeting held on 28th March 2017 (minute 17/C/83 refers).

(4) The report of the Chairman of the Audit Committee on the Committee's review of the Quality Account/Report, the Annual Report and Accounts, and related matters, and the reports of the External Auditors at its meetings held on 11th and 18th May 2017.

Mr. Hawthorn, the Chairman of the Audit Committee, reported that in reviewing the above documents the Committee had:

(a) Paid particular attention to the Annual Governance Statement and had suggested some modifications to its tone and contents which had been taken on board.

(b) Considered that careful thought should be given to how the Trust should communicate its positive year-end financial position as its normalised surplus, excluding non-recurrent items (e.g. the receipt of incentive funding for good financial performance from NHS Improvement) remained relatively consistent with previous years.

Mr. Kendall advised that the availability of resources to support the capital programme, arising from the Trust's surplus position, would be emphasised at the meeting of the Council of Governors held on 25th May 2017 and the Annual General/Annual Members' Meeting.

***Agreed –***

*(1) that the Annual Report 2016/17, including the Quality Report, be approved;*

*(2) that the Annual Accounts 2016/17 be adopted;*

*(3) that the Chairman, the Chief Executive and the Interim Director of Finance and Information be authorised to sign, as appropriate, the Annual Report, the Accounts, the Statement of Financial Position, the Annual Governance Statement, the Remuneration Report, the Statement of the Chief Executive as Accounting Officer, the Chief Executive's Statement on the Quality Report/Account, the Statement on the Responsibilities of Directors for preparing the Quality Report/Account, the Letter of Representation and any other necessary statements and certifications;*

**Action: Mrs. Bessant, Mr. Martin and Mr. Kendall**

*(4) that the Annual Report 2016/17 including the Annual Accounts and the Quality Report be submitted to NHS Improvement and Parliament; and*

**Action: Mr. Kendall and Mr. Bellas**

*(5) that the Quality Account 2016/17 be submitted to the Department of Health.*

**Action: Mrs. Pickering**

**17/132 ANNUAL REPORT AND ACCOUNTS OF THE CHARITABLE TRUST FUNDS 2016/17**

Consideration was given to the Annual Report and Accounts of the Charitable Trust Funds 2016/17 taking into account:

(1) The recommendation from the Audit Committee, arising from its meeting held on 18th May 2017, that the above documents should be approved.

It was noted that at this meeting the Committee had discussed:

(a) The balance of the charitable funds which was fairly stable.
(b) Administrative charges to the funds.
(c) The promotion and utilisation of the funds to ensure their lifespans could be extended in a meaningful way.

(2) The report of the Director of Finance.

(3) The summary report of the findings arising from the External Auditors' independent examination of the Annual Report and Accounts.

The Board noted the Independent Examiner's statement made for and on behalf of Mazars LLP that:

*"In connection with my examination, no matter has come to my attention:*

*(1) which gives me reasonable cause to believe that in any material respect the requirements to keep accounting records in accordance with section 130 of the 2011 Act; and to prepare accounts which accord with the accounting records and comply with the accounting requirements of the 2011 Act have not been met; or*

*(2) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached."*

***Agreed -***

*(1) that the Annual Report and Accounts for the Charitable Trust Funds 2016/17 be approved;*

*(2) that the Statement of Trustee Responsibilities and the Balance Sheet within the Charitable Trust Fund Accounts be signed and dated on behalf of the Board; and*

**Action: Mrs. Bessant and Mr. Martin**

*(3) that the Annual Report and Accounts of the Charitable Trust Funds 2016/17 be submitted to the Charities Commission.*

**Action: Mr. Kendall**

**17/133 ANNUAL BOARD CERTIFICATES**

Consideration was given to the confirmation and sign off of the annual Board certificates required by NHS Improvement:

It was noted that:

(1) At its meeting held on 11th May 2017 the Audit Committee, following an assurance review, had recommended to the Board that the certificates should be confirmed.

(2) It had not been practicable to seek the views of the Council of Governors on the proposed confirmation of the certificates, as required by NHS Improvement, as guidance on the certification process had only been published on 21st April 2017.

Taking these matters into account it was:

***Agreed -***

*(1) that, subject to no material issues being raised by the Council of Governors at its meeting to be held on 25th May 2017:*

*(a) The certificate of compliance with Condition G6 of the Licence be confirmed in the following form:*
*"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution;"*

*(b) The Corporate Governance Statement required under Condition FT4 of the Licence (as set out in Annex 1 to the report) be approved based on the confirmation of each component;*

*(c) The certificate on the training of Governors in accordance with S. 151 of the Health and Social Care Act 2012 be confirmed in the following form:*
*"The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S.151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role;"*

*(d) that the certificate on compliance with Condition CoS7 of the Licence be confirmed in the following form:*
*"After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate;"*

*(e) that the statement of matters taken into account by the Board in confirming the certificate under Condition CoS7 of the Licence be approved as follows:*
*"In making the above declaration of compliance with Condition CoS7 of the Licence the Board has taken into account:*

- *The Trust's approved NHSI Operational Plan and Business Plan.*
- *The contracts agreed and signed off with all Commissioners as part of the planning round.*

- *The approved budget, signed off by the Board, including the capital programme and CRES programme (based on quality assurance processes).*
- *The control total agreed with NHSI.*
- *Its decision, based on an assurance review, that the Trust remains a "going concern".*
- *The Trust's workforce plans and measures being taken to increase recruitment and retention of clinical staff."*

*(2) that the Chairman and Chief Executive be authorised to agree any changes to the self-certifications, if required, following consultation with the Council of Governors.*

**Action: Mr. Bellas**

## 17/134 FINANCE REPORT AS AT 30TH APRIL 2017

The Board received and noted the Finance Report as at 30th April 2017.

The discussions focused on the following matters:

(1) Progress on identified CRES schemes, which was behind plan, and the actions being taken to rectify this position.

On this matter:

(a) It was noted that regular meetings were held between the Finance Department and the Localities to review and seek assurance on the delivery of CRES schemes.

(b) Mr. Martin advised that a significant proportion of the Trust's CRES requirements was due to be delivered by the PPCS programme. Through the Trust's Quality Impact Assessment process, confirmation was required that services could operate safely with the proposed revised establishments and deliver the efficiency requirements. Although there was some confidence that the targets would be achieved, a cautious approach to implementation was being taken with an emphasis on maintaining quality rather than seeking to achieve the planned savings profile.

The Chairman considered that the delivery of CRES provided a risk to the Trust and the Board would need to keep this matter under review as the year progressed.

(2) Agency expenditure which was higher than the capped target for the Trust.

Dr. Land advised that the position on medical agency expenditure reflected the increase in the cost of locums, nationally, as a result of changes made by the Government (e.g. with regard to the application of IR35) and recruitment difficulties; however, the Trust's requirements were comparatively less than other Trusts and a process for agreeing the engagement of locums had been put in place.

The Board also discussed the risks that medical staff might move to those Trusts paying higher rates.

Dr. Land advised that the Trust, not being immune to these risks, was taking forward a range of actions to seek to mitigate them including promoting "retire and return" arrangements; reconfiguring the workforce; and exploring overseas recruitment. However, he considered that further changes (e.g. the reduction in agency expenditure of £400k sought by NHS Improvement and the potential implications of a new consultant contract) would be very difficult to deliver and would have a significant impact on patient care.

In addition, in response to a question, Mr. Kendall advised that the loan from the Independent Trust Financing Facility was due to be paid off by the end of 2019/20.

**17/135 PERFORMANCE DASHBOARD REPORT AS AT 30TH APRIL 2017**

Consideration was given to the Performance Dashboard Report as at 30th April 2017 which included, further to minute 17/101 (25/4/17), proposed targets for the two outstanding metrics.

A revised version of the narrative of the report was tabled at the meeting.

The Chairman and Non-Executive Directors sought clarity on the following matters:

(1) The Trust's performance in comparison to other providers on the IAPT recovery indicator as there were indications that many were struggling to achieve the national target.

In response it was noted that:

(a) The Trust's performance at 49.5% for April 2017 was slightly below the national target of 50%.
(b) There were significant variations in performance against the indicator across the Trust.
(c) Further information on the Trust's position on the indicator, compared to others, would be available once the mental health dashboard for Quarter 4, 2016/17, had been published by NHS England.

(2) The top three reasons for cancelled appointments.

Mrs. Pickering:

(a) Advised that these were staff absence, sickness absence and vacancies.
(b) Undertook to provide additional narrative on this matter in future reports.

**Action: Mrs. Pickering**

(3) The tolerances for the "money" indicators.

Mrs. Pickering undertook to bring forward proposals on this matter following discussions with the finance department.

**Action: Mrs. Pickering**

***Agreed*** *– that the following targets be approved for the 2017/18 Board Performance Dashboard:*

| *No.* | *KPI Description* | *Trust Target* | *Green* | *Amber* | *Red* |
|---|---|---|---|---|---|
| *TD4* | *Number of current inpatients with a length of stay of greater than 90 days (AMH & MHSOP A&T wards)* | *75* | *75 or less* | *76-79 (within 5% of target)* | *80 or more (exceeds 5% of target)* |
| *TD9* | *The percentage of inappropriate Out of Area Placements (AMH/MHSOP A&T/PICU)* | *20%* | *20% or less* | *20.01% -25% (within 5% of target)* | *More than 25% (more than 5% of target)* |

**Action: Mrs. Pickering**

## 17/136 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report for Quarter 4, 2016/17 including proposals to:

(1) Change to the Trust Business Plan as shown in Appendix 1 to the report.

(2) Establish a target for KPI 24 (Percentage of indicators in the NHS Staff Survey for which there was no noticeable or sufficient difference in responses of those who identified themselves as disabled, compared to those who did not identify themselves as disabled") following the Board's decision to amend the definition of the metric .

The Board noted that the report provided a mixed picture with good progress being made on Strategic Goals 1, 4 and 5 but less so on Strategic Goals 2 and 3. However, the positions on the delivery of the business plan priorities and other quality intelligence provided a more positive picture than suggested by the metrics supporting the latter Strategic Goals.

In view of this the Board discussed the appropriateness of the KPIs for measuring progress on the strategic goals.

In response to questions on individual metrics it was noted that:

(1) The variation in performance on waiting times between that shown in the report (KPI 2) and the Performance Dashboard was due to different reporting periods.

Mrs. Pickering undertook to provide additional narrative in future reports where such variations occurred.

**Action: Mrs. Pickering**

(2) The position on KPI 25 ("Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above") at 32% against the target of 50% was due to the limited supply of internal candidates as a result of the number of internal appointments made in recent years.

The Non-Executive Directors highlighted previous discussions on the introduction of a development programme so that staff were better prepared to take on band 7 roles.

Mr. Levy responded that discussions on this matter, including establishing a pool of band 5 and 6 nurses, were at an early stage. There were also difficulties in generating interest of these staff in talent management conversations and the approach to this might need to be refreshed.

Mr. Martin reported that:

(a) He held talent management conversations with Mr. Kilmurray and Mrs. Brown (Head of Organisational Development) on a monthly basis.
(b) There had been internal appointments to all the band 7 nursing posts filled in April 2017.
(c) He considered that the position on this indicator linked to the previous point made about the appropriateness of the metrics included in the report.

(3) Although the performance against KPI 7 (Number of outstanding action points for more than 31 days for Level 5 SIs and action points for safeguarding serious case reviews and domestic homicide reviews) was rated "red", significant work was continuing to be undertaken by the corporate team to gather the assurances required to close off the remaining, mostly longstanding, action points.

In addition, Mrs. Pickering sought the views of Board Members on whether the level of detail provided in the report was appropriate.

The Chairman considered that, due to its quarterly cycle, the reports were likely to be lengthy and the narrative, particularly the qualitative intelligence, made an important contribution to the overall assurances provided to the Board.

***Agreed –***

*(1) that the amendments to the Trust Business Plan (detailed in Appendix 1 to the above report) be approved; and*
*(2) that the target for KPI 24 be >93.75% for 2017/18.*

**Action: Mrs. Pickering**

**17/137 EQUALITY ACT 2010 – PUBLICATION OF INFORMATION**

Consideration was given to the report which sought:

(1) The ratification of the equality data documents (Appendices A and B to the covering report) and authority to publish them on the Trust's website as required by the Equality Act 2010.
(2) Approval of changes to the Locality equality objectives (as set out in Appendix A to the covering report).
(3) The Board's comments on the Trust's workforce race equality standard (WRES) 2017 and accompanying action plan (as set out in Appendix C to the covering report).

The Chairman informed the Board that the principal purpose of the report was to approve the publication of the information required by the Equality Act. Time would be set aside at a future meeting or seminar for the Board to have a full discussion on the data based on a proper analysis.

**Action: Mr. Levy**

The Non-Executive Directors raised the following matters in relation to the equality data documents:

(1) The inclusion of those individuals where their status against the protected characteristics was unknown in the denominators for the calculation of the statistics included in the report.
(2) The appropriateness of using the term "deterioration" to describe the changes in the data (e.g. changes in data completeness on the previous year) particularly as the information would be published on the website.
(3) The high level of lesbian, gay and bisexual staff reporting harassment, bullying or abuse and whether sufficient action was being taken to address this.

With regard to the above points, Mr. Levy:

(1) Reported that the information had been compiled based on advice received from a statistician to seek to ensure that the data was aligned to that published by the Office of National Statistics.
(2) Advised that, due to the incompleteness of the data, it was difficult to draw any firm conclusions; however, further work would be undertaken to seek to understand the reasons for significant differences reported by protected groups.

In addition, Board Members:

(1) Asked for the Locality equality objectives to be reviewed to provide a coherent approach to tackling Trustwide issues.
(2) Highlighted that the CQC, during its inspection in January 2017, had commented that the Trust had not published its Public Sector Equality Duty report.

    Mr. Levy advised that the regulator had been informed that the delay in the publication of the report was due to changes to the reporting period so that it was aligned to the financial year.

Taking into account the matters raised during the discussions it was:

***Agreed*** –

*(1) that the equality data documents (Appendices A and B to the above report) be ratified and be published on the Trust's website as required by the Equality Act 2010;*
*(2) that the changes to the Locality equality objectives (as set out in Appendix A to the above report) be approved;*
*(3) that the intention to present the final iteration of the Workforce Race Equality Standard and action plan to the Board meeting on 20th July 2017 for sign off be noted.*

**Action: Mr. Levy**

## 17/138 USE OF THE TRUST SEAL

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

## 17/139 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

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

## 17/140 DATE OF NEXT MEETING

It was noted that:
(1) A special meeting of the Board was due to be held on 13th June 2017.
(2) The next ordinary meeting of the Board of Directors would be held at 9.30 am on Tuesday 4th July 2017 at Roseberry Park, Middlesbrough.

## 17/141 CONFIDENTIAL MOTION

***Agreed*** *– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*
*Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.*

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

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

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

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

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

# MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 13TH JUNE 2017 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 12.30 PM

**Present:**
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. J. Tucker, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. B. Kilmurray, Chief Operating Officer and Deputy Chief Executive
Mr. D. Kendall, Interim Director of Finance and Information
Dr. N. Land, Medical Director
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. Fletcher, Grant Thornton UK LLP
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Mrs. M. Pears, Partner, Ward Hadaway LLP

## 17/151 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs. E. Moody, Director of Nursing and Governance.

## 17/152 CONFIDENTIAL MOTION

***Agreed*** *– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below: Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.*

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

*The amount of any expenditure proposed to be incurred by the Trust under any particular contract for the acquisition of property or the supply of goods or services.*

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 2.15 pm.

**ITEM NO. 2**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **4th July 2017** |
| **TITLE:** | **Board Action Log** |
| **REPORT OF:** | **Phil Bellas, Trust Secretary** |
| **REPORT FOR:** | **Information/Assurance** |

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

**Executive Summary:**

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

**Recommendations:**

The Board is asked to receive and note this report.

# Board of Directors Action Log

**RAG Ratings:**

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

| Date | Minute No. | Action | Owner(s) | Timescale | Status |
|---|---|---|---|---|---|
| 27/09/2016 | 16/218 | Automatic reporting of seclusion from the PARIS system to be urgently addressed | DK | Jun-17 | Completed |
| 29/11/2016 | 16/286 | A more refined approach to nurse recruitment focussed on experience as well as numbers to be looked into | DL | 20/07/2017 | Information to be previded in the next Quarterly Workforce report |
| 29/11/2016 | 16/289 | A report to be provided to the Board on the proposed values consultation in early summer 2017 prior to its launch | DL | 20/07/2017 | |
| 29/11/2016 | 16/289 | A report on the findings of the values consultation exercise to be provided to the Board | DL | Mar-18 | |
| 29/11/2016 | 16/289 | Team based culture metrics reports to be introduced | DL | Nov-17 | |
| 29/11/2016 | 16/290 | Subject to the EMT being assured that sufficient resources are available to support the process, the Trust seek re-accreditation under the Investors in People scheme | DL | Nov-17 | |
| 29/11/2016 | 16/293 | A briefing to be provided to a Board Seminar on Teepa Snow's "Positive Approach to Care for people living with Dementia" | CM | Jun-17 | Completed |

| Date | Minute No. | Action | Owner(s) | Timescale | Status |
|---|---|---|---|---|---|
| 20/12/2016 | 16/312 | A report to be provided to the QuAC detailing the proportion of experienced nursing staff versus those on preceptorship on each ward in forensic services | EM | Jun-17 | See agenda item 7 |
| 20/12/2016 | 16/313 | The operation of the Resources Committee to be reviewed in 12 months or sooner if issues arise | PB | Dec-17 | |
| 31/01/2017 | 17/07 | A briefing to be provided to the Board on the Trust's position against the Stirling dementia design guidelines and the programme of work to address the gaps identified | BK | 20/07/2017 | |
| 31/01/2017 | 17/09 | A further report on waiting times in CAMHS, including the Trust's position against the national reporting requirements being introduced by NHS England, to be presented to the Board | BK | 20/07/2017 | |
| 31/01/2017 | 17/12 | A review of the Trust Performance Dashboard targets to be undertaken | SP | Jul-17 | |
| 31/01/2017 | 17/13 | A stock take of recruitment activity, including in relation to AHPs and medical staff, to be undertaken | DL | 20/07/2017 | Information to be previded in the next Quarterly Workforce report |
| 28/02/2017 | 17/36 | Report to be provided to the Board on the outcome of the comprehensive analysis of vacancies and staffing pressures being undertaken in the North Yorkshire Locality | EM | 04/07/2017 | See agenda item 9 |
| 28/02/2017 | 17/36 | To review the staffing establishment and skill mix at The Orchards compared to other rehabilitation units | EM | 04/07/2017 | See agenda item 9 |
| 28/03/2017 | 17/62 | The potential for expanding the proposed managers' tool, for recording concerns raised to the Freedom to Speak Up Guardian to cover all concerns raised by staff, to be explored | DL | Jul-17 | |
| 28/03/2017 | 17/64 | Wards with bank usage above planned establishment levels to be highlighted in nurse staffing reports | EM | 20/07/2017 | |

| Date | Minute No. | Action | Owner(s) | Timescale | Status |
|---|---|---|---|---|---|
| 28/03/2017 | 17/64 | The staffing position in the Forensic Services Locality to be reviewed and the outcome included in the Forensic Services LMGB report to the QuAC | EM | Jun-17 | Completed (see agenda item 7) |
| 25/04/2017 | 17/95 | Briefing to be provided to a Board Seminar on the Perinatal Service | CM/PB | Sept-17 | |
| 25/04/2017 | 17/98 | Report to be provided to the Board on bank staffing arrangements | DL | 20/07/2017 | |
| 25/04/2017 | 17/98 | To look into the development of an "app" to support staff book onto bank shifts | DL | Jul-17 | |
| 25/04/2017 | 17/102 | Changes to the reporting of workforce performance metrics to be implemented in the next quarterly workforce report | DL | 20/07/2017 | |
| 25/04/2017 | 17/104 | Further progress report on the York and Selby Quality Governance Action Plan to be presented to the Board | PB | 20/07/2017 | |
| 23/05/2017 | 17/127 | The situation at Lustrum Vale to be checked in view of the increase in the ward's severity score during April 2017 | BK | 30/09/2017 | |
| 23/05/2017 | 17/128 | A report to be presented to the Board on the action being taken to address temporary staffing requirements in community teams | DL | Oct-17 | |
| 23/05/2017 | 17/128 | To note that information on staffing in community teams should be included occasionally in the Nurse Staffing Reports | DL/EM | - | To note |
| 23/05/2017 | 17/128 | Additional narrative to be provided on the graph on recruitment in future reports on the Recruitment and Retention Action Plan | DL | 28/11/2017 | |
| 23/05/2017 | 17/128 | A progress report on the Recruitment and Retention Action Plan to be presented to the Board | DL | 28/11/2017 | |
| 23/05/2017 | 17/130 | A revised version on the Composite Staff Action Plan report, incorporating additional information on staff engagement, to be published on the website | DL | Jul-17 | |
| 23/05/2017 | 17/131 | Approval of the Annual Report, including the Quality Report, and Accounts and authorisation to sign the Letter of Representation and the required reports, statements and certificates | Chairman, CM & DK | - | Approved |

| Date | Minute No. | Action | Owner(s) | Timescale | Status |
|---|---|---|---|---|---|
| 23/05/2017 | 17/131 | Submission of the Annual Report and Accounts to NHSI and Parliament | PB/DK | Jul-17 | |
| 23/05/2017 | 17/131 | Submission of the Quality Account 2016/17 to the DoH | SP | - | Completed |
| 23/05/2017 | 17/132 | Approval of the Annual Report and Accounts of the Charitable Funds and authorisation to sign the required statement and balance sheet | Chairman & CM | - | Approved |
| 23/05/2017 | 17/132 | Submission of the Annual Report and Accounts of the Charitable Funds to the Charities Commission | DK | - | Approved |
| 23/05/2017 | 17/133 | Subject to no issues being raised by the Council of Governors, the Annual Statements required by NHSI to be signed off | Chairman & CM | - | Completed (No issues were raised by the CoG) |
| 23/05/2017 | 17/135 | To note that additional narrative is to be provided in future Performance Dashboard Reports on the top three reasons for cancelled appointments | SP | - | To note |
| 23/05/2017 | 17/135 | Proposals for the tolerances for the money indicators in the Performance Dashboard to be presented to the Board following discussions with the finance department | SP | - | See agenda item 12 |
| 23/05/2017 | 17/135 | Approval of the targets for the length of stay and out of area admissions indicators in the 2017/18 Performance Dashboard | SP | - | Approved |
| 23/05/2017 | 17/136 | To note that additional narrative is to be provided in the Strategic Direction Performance Reports where there are variations in performance between that shown and the Performance Dashboard due to different reporting periods | SP | - | To note |
| 23/05/2017 | 17/136 | Approval of changes to the Business Plan | SP | - | Approved |
| 23/05/2017 | 17/136 | Approval of target for KPI 24 in the Strategic Direction Performance Report | SP | - | Approved |
| 23/05/2017 | 17/137 | Time to be set aside at a Board meeting or Seminar for a full discussion on the equality data | DL/PB | Oct-17 | |

| Date | Minute No. | Action | Owner(s) | Timescale | Status |
|---|---|---|---|---|---|
| 23/05/2017 | 17/137 | Approval of the equality data documents for publication on the Trust's website | DL | - | Approved |
| 23/05/2017 | 17/137 | Approval of changes to the Locality equality objectives | DL | - | Approved |
| 23/05/2017 | 17/137 | The final version of the revised workforce race equality standards and action plan to be presented to the Board for sign-off | DL | 20/07/2017 | |

**Item 7**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **Tuesday, 04 July 2017** |
| **TITLE:** | **To receive the assurance report of the Quality Assurance Committee** |
| **REPORT OF:** | **Dr Hugh Griffiths, Chairman, Quality Assurance Committee** |
| **REPORT FOR:** | **Assurance** |

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

## Executive Summary:

The purpose of this report is to update the Board of Directors on any current areas of concern in relation to quality and to provide assurance on the systems and processes in place.

Assurance statement pertaining to QuAC meeting held on 01 June 2017:

The Quality Assurance Committee has consistently reviewed all relevant Trust quality related processes, in line with the Committee's Terms of Reference. Issues to be addressed have been documented, are being progressed via appropriate leads and monitored via the appropriate sub-groups of QuAC.

Key matters considered by the Committee are summarised as follows:

- The Locality areas of Forensics and York & Selby where key concerns were around estate, transforming care, recruitment and staffing and capacity and demand.
- Updates from the Patient Safety Group, Patient Experience Group, Research Governance Group and Drug & Therapeutics Committee, together with the Workforce Staffing Report.
- CQC compliance and Safeguarding & Public Protection assurance updates.
- Health, Safety, Security and Fire Report and the QuAC Annual performance Assessment Results.

## Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 01 June 2017.
- Note the confirmed minutes of the meeting held on 04 May 2017 (appendix 1).
- Note the matter of escalation to the Board around the capacity and demand pressures in CAMHS service in York and Selby.

| | |
|---|---|
| **MEETING OF:** | **Board of Directors** |
| **DATE:** | **Tuesday, 04 July 2017** |
| **TITLE:** | **To receive the assurance report of the Quality Assurance Committee** |

## 1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 01 June 2017.

## 2. BACKGROUND INFORMATION AND CONTEXT

This report makes reference to the regular assurance reports from the clinical governance infrastructure, which includes the Locality Management and Governance Boards, together with the corporate assurance working groups of the Quality Assurance Committee, including progress reports. Monthly compliance with the Care Quality Commission regulatory standards, with copies of assurance reports to support the regulatory standards were also considered.

## 3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from Forensics and York & Selby localities.

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

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

### 4.1 FORENSIC SERVICES LMGB

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

1. Estates and security issues, following a security incident in February 2017 an independent review of security has been undertaken and an action plan will be submitted to the June LMGB meeting.
2. Transforming care - further requirements from NHS England to reduce Adult and Forensic LD beds still lacked transparency due to no final agreement around the amount of bed numbers to be deceased and the decision making process.
3. Staffing - recruiting suitably qualified and experienced staff remained a challenge as well as pressure recruiting psychologists and AHPs. Some joint recruitment events were planned, as well as a project around rostering and some work on the retention of staff with exit interviews.

In terms of the current nursing workforce 18% are within their preceptorship period with a slightly higher % in FLD than in FMH. They are not spread evenly across the wards for clinical and logistical reasons however movement between wards is considered and facilitated when necessary. Whilst this means 72% of band 5 / 6 staff are not in their preceptorship period it is noted within the service that many of the band 5 staff were until recently preceptees and so the ability to support current preceptees with suitably experienced staff remains an ongoing challenge.

4.2 **YORK & SELBY LMGB**

The Committee received the LMGB report for York & Selby noting the top concerns around:

1. The level of Management of Change and the impact on staff.
2. Capacity and demand issues with ongoing issues around CAMHS services. Significant waiting list issues continued and the service was working with the Business Planning team to complete a capacity and demand review. The review has highlighted significant staffing level gaps in all of the clinical pathways and a model of staffing level requirements to clear the waiting lists has been worked through.

   The locality cannot release funding to address the staffing gaps at present and discussions with Commissioners around the next steps would need to take place.

***It was agreed that the matter of capacity and demand issues in CAMHS services in York & Selby should be escalated to the Board of Directors.***

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

4.3 **Annual Patient Safety Group Report 2016/17 & Learning from Serious Incidents Report**

1. A total of 21,196 incidents had been reported via Datix, which was an increase of 5,438 from 2015/16. Some (but not all) of this increase related to the first full financial year of York & Selby reporting.
2. Teesside had reported the highest number of incidents at 6,179, followed by North Yorkshire with 4,239 incidents. This was probably due to the Teesside locality having the most inpatient beds (263) but was worthy of future monitoring.
3. The report included a new category of 'expected death' in line with national mortality reporting guidance.
4. North Yorkshire reported the highest number of serious incidents at 34, followed by Durham and Darlington.

Assurance was provided to the committee that there were robust processes and monitoring in place around learning from incidents where the root cause or contributory factors would be examined and actions taken to address matters.

This report is due for consideration at the Board of Directors under confidential agenda item number 6.

4.4 **Patient Safety Report and Patient Safety Data Quality Report**

1. The Patient Safety Group had met on 15 May 2017 and reviewed all Trust Patient Safety activities in line with the Group's terms of reference.
2. The Group were presented with two completed structured case reviews, one of which raised some concerns regarding access to psychology services which have been raised with the service concerned.
3. As a result of the new Learning from Deaths guidance the Trust would be required to publish data in relation to deaths of service users quarterly in the form of a report to the public Board of Directors.

### 4.5 Patient Experience Group Report (PEG)

1. The Patient Experience Group had met on 11 April and 9 May 2017.
2. Concern has been raised over representation from the localities at the Patient Experience Group meetings, with difficulties for all to be present at each monthly meeting. The Committee considered whether the PEG should meet bi-monthly and this would be taken back to the next meeting for discussion, together with a general review of the Group.

### 4.6 Safeguarding and Public Protection Report

1. There had been three CQC Safeguarding Children reviews for looked after children in Durham, York and North Yorkshire, which has led to the development of a Trust wide action plan.
2. There was now a hub base for the Safeguarding team in York at Cherry Trees Hospital, which has enabled an influential safeguarding presence in York.
3. Concerns had been raised by Commissioners around the safeguarding children level three compliance. The uptake around this training has been variable and will be monitored closely.
4. There has been an increase in the number of MAPPA's that the Trust has been invited to and work was underway with the MAPPA coordinators to ensure appropriate TEWV representation.

### 4.7 Research Governance Group Report

1. The Committee received assurance that Audit One had conducted an internal audit of the effectiveness of controls over research activity undertaken by the Trust, which provided a good level of assurance and that risks were being managed effectively.
2. The first Research Awareness Course at the ARCH Recovery College has been co-delivered by the research team and service users with research experience which has been well received. A further course would take place in June 2017.

### 4.8 Drug & Therapeutics Report

1. The Drug & Therapeutics Committee had met on 25 May 2017 and assurance was provided on the medicine management documents approved.
2. Regarding medicines safety urine drug testing kits - "Home Health One Step Drug of Abuse" tests had been supported, which would detect the use of various drugs in urine and this would be the only available test available to procure on Cardea.

### 4.9 Workforce and Staffing Report

1. The report contained the latest available workforce Race Equality Standard information and an update on progress against the action plan.

2. With regard to indicator Five – 'the percentage of staff experiencing bullying and harassment or abuse from patients, relatives or the public in the last 12 months' had increased for both BAME and white staff from 27% and 20% to 37% and 28%.

   Mr Levy advised that there was some further work to do around indicator Five before the report was presented to the July 2017 Board of Directors to ensure that this was being looked at in a targeted way.

***Recommended to the Board of Directors that, subject to the caveat around indicator 5, the action plan around workforce Race Equality Standards be approved.***

## 5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

### 5.1 Compliance with CQC Registration Requirements

The key issues raised in the report were:

1. The new Quality Compliance Group had met twice so far to monitor the CQC action plan and to try and share information across localities to prevent the repeat actions raised following MHA inspections.
2. Mock inspections would be led by operational services, supported by corporate services and re-framed as a quality/peer review visit. A new monitoring tool would be used which would be more interactive and responsive for services to use.

## 6 GOVERNANCE

### 6.1 Health, Safety, Security and Fire Report

1. There had been a significant increase in physical assaults against Trust staff and the data would be reviewed to ensure that the incidents met the NHS Protect criteria and would be taken to the 6 July 2017 Health, Safety, Security and Fire Group for consideration.
2. Fire incidents reported during 2016/17 had increased to 255 from 73 in 2015/16 and 55 of these incidents have occurred inside premises. For future reports these incidents would be broken down by Hospital site.

### 6.2 QuAC Annual Performance Assessment Results 2016/17

1. Overall the Committee had improved on all areas from 2015/16, except communication between QuAC and LMGBs and its assurance groups. Mr Tucker suggested that the Committee review the relationship between QuAC and LMGBs, following on from the work that was undertaken 18 months ago.
2. A representative group of QuAC members and LMGB leads would meet to look at further improvements around providing assurance to the Committee.

## 7. IMPLICATIONS

### 7.1 Quality

One of the key objectives within the QuAC terms of reference is to provide assurance to the Board of Directors that the organisation is discharging its duty of quality in compliance with section 18 of the Health Act 1999. This is evidenced by the quality

assurance and exception reports provided, with key priorities for development and actions around any risks clearly defined.

7.2 **Financial/value for money**

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

7.3 **Legal and Constitutional (including the NHS Constitution)**

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

7.4 **Equality and Diversity**

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

## 8. CONCLUSIONS

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

## 9. RECOMMENDATIONS

That the Board of Directors:

(1) Note the issues raised at the Quality Assurance Committee meeting on 01 June 2017 and to note the confirmed minutes of the meeting held on 04 May 2017 (appendix 1).
(2) Subject to the caveat around indicator 5, approve the action plan around workforce Race Equality Standards. (This matter is due to be presented to the Board of Directors at its meeting on 20 July 2017.
(3) Note the escalation of the matter of capacity and demand issues in CAMHS.

**Jennifer Illingworth**
**Director of Quality Governance**
**July 2017**

**APPENDIX 1**

# MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 4 MAY 2017, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

**Present:**
Mr Jim Tucker, Acting Chairman of the Committee, (Deputy Chairman of the Trust)
Mr Brent Kilmurray, Chief Operating Officer
Dr Nick Land, Medical Director
Mr Colin Martin, Chief Executive
Mr David Jennings, Non-Executive Director
Mr Richard Simpson, Non-Executive Director
Mrs Shirley Richardson, Non-Executive Director

**In attendance:**
Mrs Karen Atkinson, Head of Nursing for Teesside
Mrs Karen Agar, Associate Director of Nursing & Governance
Mr David Brown, Director of Operations for Teesside
Mrs Adele Coulthard, Director of Operations for North Yorkshire
Dr Lenny Cornwall, Deputy Medical Director for Teesside
S Hopper, Consultant Lead Psychologist, MHSOP, Teesside
Dr Neil Mayfield, Deputy Medical Director for North Yorkshire
Ms Donna Oliver, Deputy Trust Secretary
Dr Stephen Wright, Deputy Medical Director for York & Selby

## 17/53 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Lesley Bessant, Chairman of the Trust, Mrs Elizabeth Moody, Director of Nursing & Governance, Mrs Ruth Hill, Director of Operations for York & Selby, Dr Hugh Griffiths, Chairman of the Committee and Dr Ingrid Whitton, Deputy Medical Director for Durham & Darlington.

## 17/54 MINUTES OF PREVIOUS MEETING

**Agreed** – that the minutes of the meeting held on 6 April 2017 be signed as a correct record by the Acting Chairman of the Committee.

## 17/55 ACTION LOG

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

16/169iii) A review of systems used to support the reporting of seclusion would be undertaken by QuAC.
This matter was covered under agenda item number 9 (see minute 17/62)
**Completed**

17/23 Position paper to come to QuAC around the Trust response to self-harm.
This matter was covered under agenda item number 10 (see minute 17/63)
**Completed**

17/42 Log with Complaints Department the issue of PALS and complaints being received by MPs around York & Selby that need to be recorded.

This action was deferred to the June 2017 QuAC meeting.

17/46 Feedback from the team on Bilsdale Ward following issues raised by the CQC on 1 March 2017, where patients had been disappointed with staff engagement.

Mrs Illingworth advised that the Compliance Team had followed up this matter and all actions had been resolved.

**Completed**

**17/56 NORTH YORKSHIRE LMGB REPORT**

The Committee received and noted the North Yorkshire LMGB Report.

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

3. Recruitment and hard to fill Consultant posts.
4. Adult mental health access to PICU.
5. The remodelling of the community new model of care linked to Harrogate being a Vanguard site, across acute, primary and social care.

On this matter it was noted that a short term leadership role was in post to drive efficiencies in the system.

Mr Martin acknowledged the work undertaken by the staff in the MHSOP team who had demonstrated their commitment and going that extra mile to support the Vanguard work.

6. LD transforming care where NHS England was closely monitoring delayed discharges and developments of community service infrastructure. Lack of engagement from Specialist Commissioners in Yorkshire and Humber resulting in delayed discharges.

Arising from discussion it was noted that Recruitment premiums would be used for the first time by the Trust in order to attract applicants to vacant Consultant posts.

On this matter it was noted that Scarborough was a very difficult area to recruit to, due to location, travelling via a difficult commute and a feeling of “professional isolation” and other incentives were being considered to attract applicants to vacancies.

The Committee was assured that job plans were being re-visited for new and existing Consultants to allow some protected time each week in the busy clinical schedules.

Mr Tucker observed repetition of some of the risks outlined on the risk register and Mrs Coulthard undertook to correct these for the next LMGB report.

**Action: Mrs Coulthard**

**17/57 TEES LMGB REPORT**

The Committee received and noted the Tees LMGB Report.

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

(1) Nursing home provision for older people and few if any accommodation alternatives for those with learning difficulties. This was an ongoing issue for the Trust.
(2) Recruitment to vacancies, particularly Consultant medical staff.

Dr Cornwall commented that the biggest pressure for vacancies was in Tier 3 services, where jobs were being viewed as not so attractive in comparison to other areas and there was a lack of regionally trained Consultant staff available to apply for posts.

Dr Land advised that the recruitment position would be much improved in a years' time and that the Trust did not currently have the worst vacancy position compared to surrounding Trusts.

(3) Increased referrals to the CYPS teams, impacting on the ability to deliver treatment and interventions.

The Non-Executive Directors:
(1) Highlighted the work of the Trust around children refugees and the interest of the Home Office in the proactive approach the Trust had taken.
(2) Sought assurance that the clinical expertise at Hope House was not being compromised in light of the fact that staff had been working hard to support placements of patients with complex learning difficulties.

Mr Brown advised that:
(1) There were currently 20 families from Syrian refugees, 10 families housed in Redcar and a similar number in Hartlepool.
(2) As a result of very little market development and as part of Transforming Care a number of patients with complex problems had been placed at Hope House. After the addition of a patient from Cumbria, management changes and staff turner the situation had been alerted to the Police, CCG and Local Authority. MDT meetings ensured no clinical standards were being compromised in dealing with this challenging situation.

A CQC visit had been requested by the Local Authority and Cumbria CCG had been asked to find suitable accommodation for the complex individual.

**17/58 PATIENT SAFETY GROUP REPORT**

The Committee received and noted the Patient Safety Group report, including:
(1) The Patient Safety Group Quality Report for the reporting period 1 – 28 February 2017.
(2) The Quality Strategy Scorecard Metrics.
(3) The Patient Safety Team KPI's.

Mrs Illingworth reported that:
(1) A structured case note review had been used as a mortality tool to look at February 2017 cases of deaths of patients whilst subject to CPA.
On this matter it was felt that the structured case note review tool would be the most appropriate mortality tool to be used in the review of deaths of patients whilst on CPA until further guidance was released, however if the scope of the service users to be reviewed was expanded additional capacity would be required in the future for this work to be undertaken.

(2) A Trust policy would be devised on responding to deaths, which included the mortality review and would include working with service users and carers.
(3) There would be a more focussed reporting style, including analysis of the service and care delivery problems to identify causal factors in the serious incident template and NPSA Guidance. One suggestion had been to change the language of "root cause" to "strongly causal".

A pilot of the amended review method would be undertaken and fed back to the July/August 2017 Patient Safety Group meeting.

The Non-Executive Directors sought clarification on:
(1) Point E of the executive summary, Quality Strategy scorecard (Appendix 1), "Data for April 2017, number of level 3 incidents including self-harm had exceeded the annual target".
(2) The resources that would be required to investigate future deaths.

In response Mrs Illingworth advised that:
- The number of level 3 incidents reported up to the end of February 2017 had exceeded the *annual* target.
- Only those patients on CPAs at the times of death would be looked at equalling around 15-20 per month, however the cause of death was not always known. The national guidance was broad enough to give the Trust some scope as to how they wanted to undertake the reviews.

Committee members were assured that the mortality review would take a proportionate view of those people dying prematurely, whilst on CPAs.

**17/59 SAFEGUARDING & PUBLIC PROTECTION EXCEPTION REPORT**

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

Arising from the report it was noted that:
(1) The three serious case reviews in Hartlepool, due for publication on 9 May 2017 had been postponed due to Purdah.
(2) The report on North Yorkshire remained outstanding on 'Review of Health Services for Children and Looked After and Safeguarding' by the CQC. York and Durham reports had been received and an action plan would be implemented once North Yorkshire's report was received.

The Acting Chairman asked whether the compliance with safeguarding training was a matter for concern.

Mrs Agar confirmed that there was adequate safeguarding training in place; however the difficulty arose trying to maintain the uptake of the training places.

The Committee noted that the safeguarding children and adult team were at full capacity and as new serious case reviews or safeguarding adult's reviews arise, capacity within the team would be reviewed to ensure compliance with the safeguarding legislation.

**17/60 INFECTION, PREVENTION & CONTROL QUARTERLY REPORT**

The Committee received and noted the Infection, Prevention & Control Report for Quarter 4 including:

(1) The Infection Prevention and Control Annual Report 2017/18.
(2) The Infection Prevention and Control Annual Programme 2017/18.

The Committee:

(1) Received assurance on the matters pertaining to the information contained in the report for Quarter 4.
(2) Discussed the deep clean at Cherry Tree House, which had been extended to Meadowfields and Acomb Garth, noting in particular the challenges around older people's services.
(3) Discussed levels of cleanliness in facilities across the York & Selby area.

Mr Kilmurray advised that the internal domestics and housekeepers were provided by TEWV and this matter would warrant further consideration at EMT.

**Action: Mr Kilmurray**

Mr Martin commented on the high standard of cleanliness he had noticed at a recent visit to Meadowfields.

**17/61 EQUALITY, DIVERSITY & HUMAN RIGHTS STEERING REPORT**

The Committee received and noted the Equality, Diversity & Human Rights Steering Report.

Mrs Jay highlighted the following matters:

(1) The report provided an assurance statement following the Equality, Diversity and Human Rights (EDHR) Steering Group meetings, held on 11 January and 12 April 2017.
(2) Actions against the EDHR strategy and scorecard had been completed for 2016/17 with the exception of 3 actions around autism, ensuring the Equality Act in relation to age discrimination was met and to undertake better research on staff who share similar characteristics, however report lower levels of satisfaction in surveys. The proposed actions for 2017/18 had been agreed by the Group.
(3) A briefing on Disability Access audits had been noted following a review by the Health and Safety team on all inpatient premises in Durham and Darlington. The Group noted however that the audits did not cover all clinical rooms, wards and other inpatient areas across the Trust.
(4) A briefing on the accessible information standard had been received , introduced by NHS England in 2016.
(5) PARIS updates would enable staff to record accessible information needs in the central index, it was however unclear whether clinical services were aware of this facility or the requirements of the standard to provide appropriate communication support and information in the preferred format.

Mr Kilmurray advised that a large piece of work would need to be undertaken to ensure accessible information standard was being achieved and a paper to EMT would enable further consideration.

**Agreed:**
That a paper be written for EMT on the proposals to ensure accessible information standards are being met.

**Action: Mrs S Jay**

**17/62 REVIEW OF THE SYSTEMS USED TO SUPPORT THE REPORTING OF SECLUSION**

The Committee received and noted the Review of the Systems used to Support the Reporting of seclusion.

Arising from the report it was noted that:

(1) Arrangements were in place to record and review the use of seclusion, in order to ensure compliance with the requirements of the Code of Practice MHA 2015. Monitoring had also been agreed, in addition to the requirements of the Code of Practice MHA to provide additional safeguards for longer term seclusion episodes.

(2) Paris upgrades in June 2017 would include changes to the seclusion/segregation case note facility which would have a positive impact on recording seclusion and reporting.
On this matter it was noted that some work would be undertaken to cross check the information reported on Datix with that on Paris to ensure the numbers of reported episodes of seclusion were the same.

Mrs Illingworth advised that this would be fed back to the Mental Health Legislation Committee at its meeting to be held on 13 July 2017.

(3) The Code of Practice did not include arrangements for prolonged periods of seclusion, which were becoming more prevalent in the Trust and other providers and the measures being implemented by the Trust would give further assurance around the monitoring of seclusion.

(4) That future reporting of seclusion through the Mental Health Legislation Committee would provide assurance on the appropriateness of individual episodes of seclusion.

**17/63 SELF-HARM REPORT**

The Committee received and noted a report on Self-Harm.

Mrs Illingworth drew attention to the following matters:

(1) This report had been provided following a request from the Quality Assurance Committee at its meeting held on 2 March 2017 (action17/23).

(2) There was currently no baseline best practice to support staff across the Trust, however a review of the evidence base has concluded that a recovery orientated approach to harm minimisation, which supports co-production and collaboration with service users and carers should be taken.

Mrs Richardson acknowledged the importance of families and carers to establish a recovery orientated approach and a shared understanding about individual cases of self-harm.

(3) Given the changes to Paris and a move towards a narrative based risk assessment and harm minimisation approach there would be a re-audit planned against NICE guidance.

(4) Further work would be undertaken to map out current service provision and approaches to treatment/management across the Trust.

(5) Consideration would also be given to developing guidance for staff setting out the Trust's approach to harm reduction.

Following discussion it was noted that the levels and patterns of self-harm would require significant work to establish a firm position.

Mr Kilmurray advised that this would be included in next year's Business Plan, to be considered against other Trust priorities.

Mr Simpson asked if the statistics shown on page 2, 2.1, "Between 4% and 70% of people self-harm during an inpatient admission" was correct.

Mrs Illingworth undertook to find out if these statistics were accurate.

**Action: Mrs Illingworth**

**17/64 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS REPORT**

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

Arising from the report it was noted that:

(1) Draft reports following the CQC visit to the Trust in January 2017 were being checked for factual accuracy.
On this matter it was noted that:
(i) A Quality Compliance Group had been set up to monitor the CQC action plan.

(ii) There had been common themes identified following MHA inspections often linked to CQC inspections and in order to prevent recurring non-compliance issues, staff would be informed of these matters with regular communication.

The Committee was assured that actions were being taken to mitigate against future recurring issues of non-compliance.

(2) Ofsted Registration for Holly and Baysdale had progressed positively with pre-registration visits to both areas.

**17/65 QUALITY ACCOUNT 2016/17**

The Committee received and noted the Quality Account 2016/17.

Mrs Pickering highlighted from the report:

(1) The draft Quality Account had been sent to stakeholders for comments by the 14 May 2017, following a number of presentations to a number of Overview and Scrutiny Committees.
On this matter it was noted that there had been some minor feedback from Hartlepool Overview & Scrutiny Committee around the Trust not reaching the training compliance rates around harm minimisation.
(2) The Final version of the Quality Account would then be considered by the Audit Committee and the Board of Directors.

***Recommended to the Board of Directors –*** *that following presentation at the Audit Committee, the Draft Quality Account 2016/17 be approved.*

**17/66 PROPOSED QUALITY ACCOUNT PERFORMANCE METRICS**

The Committee received and noted the Proposed Quality Account Performance Metrics Report.

Mrs Pickering highlighted from the report:

(1) The purpose of the paper was to present the proposed metrics for part 3 of the quality report to align to those included in the Trust's Quality Strategy and to seek agreement to report on these metrics from 1 April 2017.
(2) Following review of the Quality metrics it was proposed that six of the metrics be replaced within the Patient Safety and Patient Experience domains and to also include Clinical Effectiveness measures.

**Agreed:** *That the proposed metrics for part 3 of the Quality Report would include the six new measures around Patient Safety and Patient Experience and also include the Clinical Effectiveness measures (4-6.*

:

**17/67 ACCESS TO HEALTHCARE ASSESSMENT**

The Committee received and noted the Access to Healthcare Assessment Report.

Mrs Pickering highlighted the following:

(1) That this report provided assurance to the Committee of the Trust's compliance in relation to the indicator Certification against compliance with requirements regarding access to health care for people with a learning disability, as at 31 March 2017.
(2) Each of the localities after completing a self-assessment in March 2017 against the criteria demonstrated compliance with the criteria.
(3) The assessments had been approved by the LMGBs and discussed at the Learning Disability Speciality Development Group.

**17/67 QuAC ANNUAL PERFORMANCE ASSESSMENT RESULTS 2016/17**

Due to the Chairman of the Committee not being present this item was deferred to the Quality Assurance Committee at its meeting, to be held on 1 June 2017.

**Action: Ms Oliver**

**17/68 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)**

There were no exceptions to report.

**17/69 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS OR PROPOSED FOR ADDITION TO THE TRUST RISK REGISTER, AUDIT COMMITTEE, RESOURCES COMMITTEE OR CLINICAL LEADERSHIP BOARD.**

There were no matters to escalate.

**17/70 ANY OTHER BUSINESS**

There was no other business to note.

**17/71 COMMITTEE MEETING EVALUATION**

There was nothing to note.

**17/72 DATE AND TIME OF NEXT MEETING:**

The next meeting of the Quality Assurance Committee will be held on Thursday 1 June 2017,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email papers/reports to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 4.15pm

**ITEM 8**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **4th July 2017** |
| **TITLE:** | **To consider the "Hard Truths" monthly Nurse Staffing Exception Report** |
| **REPORT OF:** | **Elizabeth Moody, Director of Nursing and Governance** |
| **REPORT FOR:** | **Assurance/Information** |

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

**Executive Summary:**

The purpose of this report is to present to the Board by 'exception' the monthly safe staffing information as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to May 2017 data.

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

- The number of rosters equates to 71 inpatient wards.
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 26 wards.
- The Forensic directorate have the highest level of 'red' fill rates (12 in May)
- The lowest fill rate indicators in May related to Oak Rise (closure of bungalow to allow works to be undertaken), Cedar (NY) (vacancies) and Ward 15 (vacancies)
- The Highest fill rates in May were observed by Merlin (seclusion and enhanced observations), Bedale (change in establishment) and Holly (support Talbot Direct Care).
- In relation to bank usage there were no wards identified that were utilising in excess of 50% bank during May. The highest bank user was in relation to Merlin with 43% bank usage (reasons for bank included: enhanced Observations, vacancies and sickness)
- Agency usage equated to 1.49% in May. The highest user of agency within the reporting period related to Acomb Garth. This equated to 38% of the total hours worked.
- In terms of triangulation with incidents and complaints:

- There were 0 Serious Incidents (SI) that occurred within inpatient areas during the month of May.
- There were 2 level 4 incidents that occurred in May citing Cedar (NY). This ward has also being cited in this report in relation to a low fill rate and agency usage.
- There were 6 level 3 incidents (self-harm) that occurred in May with the following featuring in this report as follows:
  - Elm (1 incident) – cited in this report for bank usage in excess of 25%
  - Clover / Ivy (2 incidents) - cited in this report for bank usage in excess of 25%
  - Fulmar (1 incident) - cited in this report for bank usage in excess of 25%
- There were 5 complaints raised in May with the following featuring in this report as follows:
  - Bedale (1 complaint) – cited in this report for having a high staffing fill rate and bank usage in excess of 25%
  - Bransdale (1 complaint) - cited in this report for having bank usage in excess of 25%
- There were 33 PALS related issues raised with the following featuring within this report as follows:
  - Bransdale (2 PALS) – cited in this report for bank usage and a complaint
  - Cedar (NY) (3 PALS) - cited in this report for having a low staffing fill rate, agency usage and 2 level 4 incidents
  - Elm (1 PALS) – cited in this report for having bank usage and a level 3 incident.
  - Harrier / Hawk (2 PALS) – cited in this report for having agency usage.
  - Northdale (3 PALS) – cited in this report for having bank and agency usage.
  - Merlin (3 PALS) – cited in this report for having a high staffing fill rate and bank usage
- A number of incidents requiring control and restraint occurred during May. The highest user was The Evergreen Centre with a total of 147 incidents. The Evergreen Centre has not been cited during this report.

There were 526 shifts allocated in May where an unpaid break had not been taken. From those shifts where breaks were not taken the majority were in relation to day shifts (327 shifts).

There were 13 incidents raised in May citing concern's in relation to staffing levels. There was an incident on Willow Ward on the 30th May whereby there was no RN on duty for the night shift. This was recorded on Datix and the escalation process is being reinforced.

A severity calculation has been applied within this report to highlight any areas of concern from a safe staffing point of view. In May Meadowfields and Oak Rise had the highest score with 9 points awarded to each ward. In terms of the cumulative score Sandpiper remains the highest with 51 points awarded (November to May). The top 10 for May can be found on page 8 of this report along with an explanation of severity scores and appendix 3 shows all scores for all wards. Appendix 4 shows the severity scores by speciality.

A work stream approach to Safe Staffing is underway; this includes a review of roster planning efficiencies which is taking place during quarter 4.

**Recommendations:**

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

| | |
|---|---|
| **MEETING OF:** | **Board of Directors** |
| **DATE:** | **4th July 2017** |
| **TITLE:** | **To consider the "Hard Truths" monthly Nurse Staffing Exception Report** |

## 1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the exceptions arising from the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to May 2017 data.

## 2. BACKGROUND INFORMATION AND CONTEXT:

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

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

## 3. EXCEPTIONS:

### 3.1 Safe Staffing Fill Rates – May 2017

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

The highest numbers of red fill rate indicators relate to Registered Nurses on day shifts which equates to 26 in May. This is a decrease of 1 when compared to April.

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

| Ward | Fill Rate Indicator | Comments |
|---|---|---|
| May 2017 | | |
| Oak Rise | 41.9% HCA on Nights<br>64.3% HCA on Days<br>83.9% RN on Nights | The shortfall is due to one of the bungalow's being closed on the 9th May for building works. This reduced the number of patients and staffing |

| | | |
|---|---|---|
| | | required. |
| Cedar (NY) | 49.5% RN on Nights<br>86.1% HCA on Nights | The shortfall on nights is as a result of vacancies. Shifts have been covered where possible utilising bank, agency or overtime. |
| Ward 15 | 62.5% RN on Days | The shortfall was filled by flexing the HCA shifts. This is evident within the fill rate (138.4%) |

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In May there were 43 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues. This is a reduction of 3 when compared to April.

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

| Ward | Fill Rate Indicator | Comments |
|---|---|---|
| May 2017 | | |
| Merlin | 271.4% HCA on Nights<br>197.2% HCA on Days | Over establishment is due to 1 long term seclusion, numerous other seclusion episodes and 1 patient on 2:1 observations 24 hours per day. |
| Bedale Ward | 236.6% HCA on Days<br>68.5% RN on Days | 1 RN on Long Term Sick and 1 RN left service. This has been recruited to but the RN has not yet started. HCA increase due to Change in ward establishment. |
| Holly | 202.0% RN on Days<br>161.0% HCA on Days<br>164.3% RN on Nights<br>184.1% HCA on Nights | Additional staffing is to support Talbot Direct Care unit. |

## 3.2 Bank Usage

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

There were no wards reporting 50% or above for bank usage in May. The highest user of bank in May related to Merlin reporting at 43%. The reasons Merlin gave for requesting bank are as follows:

- Enhanced Observations (185 shifts)
- Establishment Vacancies (19 shifts)
- Sickness (12 shifts)
- Training (12 shifts)
- Overbooked (3 shifts)
- Unknown (3 shifts)

- Special leave cover (2 shifts)
- Staff being utilised on other wards (2 shifts)

Wards reporting over 25% and above for bank usage in April are detailed below:

| | |
|---|---|
| Merlin | 43% |
| Westerdale South | 37% |
| Clover/Ivy | 35% |
| Northdale Centre | 34% |
| Fulmar Ward. | 34% |
| Bedale Ward | 33% |
| Ward 15 Friarage | 31% |
| Cedar Ward | 28% |
| Bankfields Court Unit 2 | 27% |
| Bransdale Ward | 25% |
| Elm Ward | 25% |

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

## 3.3 Agency Usage

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

In May the agency usage equated to 1.49% a decrease of 0.36% when compared to April.

The highest user of agency within the reporting period related to Acomb Garth equating to approximately 38% of the total hours worked. This ward continues to have problems with recruitment of registered nursing staff and is running at reduced bed occupancy to mitigate some of the risks identified with this.

Wards reporting agency usage in May are detailed below:

| | |
|---|---|
| Acomb Garth | 38% |
| Springwood Community Unit | 14% |
| Cedar Ward (NY) | 11% |
| Ebor Ward | 10% |
| Rowan Ward | 5% |
| Meadowfields | 4% |
| Northdale Centre | 3% |
| Minster Ward | 2% |
| Oak Rise | 2% |
| Harrier/Hawk | 1% |

| | |
|---|---|
| Kestrel/Kite. | 1% |

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

## 3.4 Quality Data Triangulation

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

- There were 0 Serious Incidents (SI) that occurred within inpatient areas during the month of May.
- There were 2 level 4 incidents that occurred in May citing Cedar (NY). This ward has also being cited in this report in relation to a low fill rate and agency usage.
- There were 6 level 3 incidents (self-harm) that occurred in May with the following featuring in this report as follows:
  - Elm (1 incident) – cited in this report for bank usage in excess of 25%
  - Clover / Ivy (2 incidents) - cited in this report for bank usage in excess of 25%
  - Fulmar (1 incident) - cited in this report for bank usage in excess of 25%
- There were 5 complaints raised in May with the following featuring in this report as follows:
  - Bedale (1 complaint) – cited in this report for having a high staffing fill rate and bank usage in excess of 25%
  - Bransdale (1 complaint) - cited in this report for having bank usage in excess of 25%
- There were 33 PALS related issues raised with the following featuring within this report as follows:
  - Bransdale (2 PALS) – cited in this report for bank usage and a complaint
  - Cedar (NY) (3 PALS) - cited in this report for having a low staffing fill rate, agency usage and 2 level 4 incidents
  - Elm (1 PALS) – cited in this report for having bank usage and a level 3 incident.

Harrier / Hawk (2 PALS) – cited in this report for having agency usage.
Northdale (3 PALS) – cited in this report for having bank and agency usage.
Merlin (3 PALS) – cited in this report for having a high staffing fill rate and bank usage
A number of incidents requiring control and restraint occurred during May. The highest user was The Evergreen Centre with a total of 147 incidents. The Evergreen Centre has not been cited during this report.

## 3.5 Missed Breaks

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

A thorough analysis of the HealthRoster system has identified that there were 526 shifts in May where unpaid breaks had not been taken. This is an increase of 13 when compared to April (513 shifts).

The majority of the shifts where breaks were not taken occurred on day shifts (327 shifts). The number of night shifts where breaks were not taken equated to 199 shifts in May.

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

### 3.6 Incidents raised citing Staffing Levels

It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. There were 13 incidents reported in May 2017 on Datix citing issues with staffing. 12 related to Inpatients and 1 in relation to Crisis Team.

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

Elm raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report in relation to bank, having a level 3 incident and PALS related issue.
Westerdale South raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report in relation to bank.
Acomb Garth raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report in relation to agency usage.
Clover raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report in relation to bank usage and a level 3 incident.

The staffing concerns escalation process is currently undergoing a review, details will be provided in this report once completed. There has been an internal audit of the escalation process which demonstrated a reasonable level of assurance that risks were being managed effectively and that compliance with the control framework was not found to be taking place in a consistent manner. This related to the roster not always being updated with appropriate notes when gaps are covered from elsewhere and three shifts where the genuine shortages had not been escalated in line with the escalation protocol. The relevant recommendations are being picked up with Directors of Operations by the safe staffing lead.

Work is currently underway through the safe staffing programme to look at locking ward rosters down on a weekly rather than monthly basis in order to provide validated ‘real time’ information on rosters and reduce batching of notes and amendments to the roster which is currently managed on a monthly basis at ward level. It is important to note however that all shifts where no RN is documented as

being on duty are currently reviewed and validated prior to the safe staffing report being published. This information is also provided in the safe staffing dashboard to OMT on a monthly basis as part of the performance VCB. If a decision is made to lock down rosters on a weekly basis, this information can be reviewed in a more timely manner.

### 3.7 Severity

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

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

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

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

| WARD | Red Fill Rate | Blue Fill Rate | Missed Breaks | Agency Usage | Bank Usage | SUI | Level 4 Incidents | Level 3 Incidents | Complaints | Control & Restraint | TOTAL SCORE (May) | YTD Total Score (Nov-May) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Meadowfields | 6 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **9** | **46** |
| Oak Rise | 6 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | **9** | **30** |
| Cedar Ward (NY) | 4 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 1 | **8** | **45** |
| Overdale Ward | 2 | 2 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | **7** | **31** |
| Clover/Ivy | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 2 | 0 | 1 | **7** | **32** |
| Fulmar Ward. | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 2 | **7** | **32** |
| Merlin | 0 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 2 | **7** | **38** |
| The Evergreen Centre | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | **6** | **28** |
| Cherry Tree House | 4 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **6** | **26** |
| Rowan Ward | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | **6** | **38** |
| Newberry Centre | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | **6** | **39** |

3.8 **Other**

It has been reported that on the 30th May 2017 Willow Ward (night duty) were left without a registered nurse due to sickness reported earlier that afternoon. A Datix incident was submitted on the 31st May and the use of the escalation process has been reinforced.

The Forensic directorate have the highest number (12 wards' in May) of 'red' fill rates for registered nurses on day shifts. In line with Transforming Care, there are plans to reconfigure a further ward which should ease staffing pressures going forward.

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

Establishment reviews have now been undertaken across all in-patient areas using the Hurst tool and professional judgement interviews have been booked in to take place in May and June. An update and recommendations will be provided to EMT and the Board on conclusion of this work.

## 4. IMPLICATIONS:

### 4.1 Compliance with the CQC Fundamental Standards:

No direct risks or implications to patient safety from the staffing data have been identified within this report, although there are a number of areas that are not able to meet their planned staffing levels on a regular basis particularly with regard to registered nursing staff fill rates on days. This issue has been highlighted as a concern by the CQC in recent inspection reports for other Mental Health Trusts and may pose a risk as to our ratings.

### 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 Safe Staffing work stream referred to above

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

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

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

4.4 **Equality and Diversity:**

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

4.5 **Other implications:**

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

## 5. RISKS:

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

## 6. CONCLUSIONS:

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

6.2 The comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has not shown any significant impact to date although ‘hot-spots’ are now being tracked through severity scores. Work is underway in localities to address shortfalls where planned establishments are not being met or high levels of registered nurse agency/bank are being used and to provide assurance on how this is being addressed.

## 7. RECOMMENDATIONS:

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

**Emma Haimes, Head of Quality Data**
**June 2017**

**APPENDIX 1**

| TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN May | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | DAY | | NIGHT | |
| WARD | Locality | Speciality | Bed Numbers | FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED) | FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED) | FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED) | FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED) |
| Ayckbourn Unit Danby Ward | North Yorkshire | Adults | 11 | 64.8% | 132.0% | 103.2% | 96.8% |
| Ayckbourn Unit Esk Ward | North Yorkshire | Adults | 11 | 83.1% | 125.0% | 100.0% | 100.0% |
| Bedale Ward | Teesside | Adults | 10 | 68.5% | 236.6% | 103.5% | 111.9% |
| Bilsdale Ward | Teesside | Adults | 14 | 93.1% | 116.9% | 104.7% | 100.0% |
| Birch Ward | Durham & Darlington | Adults | 15 | 92.1% | 113.4% | 100.0% | 101.6% |
| Bransdale Ward | Teesside | Adults | 14 | 94.5% | 148.4% | 103.2% | 159.7% |
| Cedar Ward | Durham & Darlington | Adults | 10 | 99.6% | 157.3% | 100.3% | 141.9% |
| Cedar Ward (NY) | North Yorkshire | Adults | 18 | 93.1% | 93.8% | 49.5% | 86.1% |
| Ebor Ward | York and Selby | Adults | 12 | 103.2% | 91.9% | 117.5% | 104.8% |
| Elm Ward | Durham & Darlington | Adults | 20 | 98.5% | 116.0% | 100.0% | 100.0% |
| Farnham Ward | Durham & Darlington | Adults | 20 | 143.4% | 110.7% | 103.2% | 104.8% |
| Kirkdale Ward | Teesside | Adults | 16 | 88.9% | 97.7% | 100.6% | 98.0% |
| Lincoln Ward | Teesside | Adults | 20 | 91.7% | 114.6% | 102.0% | 112.9% |
| Lustrum Vale | Teesside | Adults | 20 | 63.8% | 152.1% | 100.6% | 110.6% |
| Maple Ward | Durham & Darlington | Adults | 20 | 90.9% | 108.9% | 96.8% | 116.1% |
| Minster Ward | York and Selby | Adults | 12 | 104.6% | 89.4% | 100.6% | 98.7% |
| Overdale Ward | Teesside | Adults | 18 | 88.7% | 125.6% | 100.0% | 121.0% |
| Primrose Lodge | Durham & Darlington | Adults | 15 | 66.6% | 123.6% | 100.0% | 100.0% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Stockdale Ward | Teesside | Adults | 18 | 102.0% | 115.6% | 94.1% | 111.7% |
| The Orchards (NY) | North Yorkshire | Adults | 10 | 97.4% | 71.0% | 91.9% | 103.2% |
| Tunstall Ward | Durham & Darlington | Adults | 20 | 121.7% | 102.9% | 135.5% | 100.0% |
| Ward 15 Friarage | North Yorkshire | Adults | 12 | 62.5% | 138.4% | 90.5% | 105.1% |
| Willow Ward | Durham & Darlington | Adults | 15 | 106.8% | 121.6% | 100.0% | 110.7% |
| Baysdale | Teesside | CYPS | 6 | 109.3% | 112.6% | 100.0% | 103.2% |
| Holly Unit | Durham & Darlington | CYPS | 4 | 202.0% | 161.0% | 164.3% | 184.1% |
| Newberry Centre | Teesside | CYPS | 14 | 88.1% | 140.8% | 97.5% | 110.0% |
| Talbot Direct Care | Durham & Darlington | CYPS | 1 | 104.8% | 117.1% | 100.0% | 116.3% |
| The Evergreen Centre | Teesside | CYPS | 16 | 92.0% | 162.5% | 112.7% | 142.8% |
| Westwood Centre | Teesside | CYPS | 12 | 99.6% | 149.6% | 105.0% | 170.6% |
| Clover/Ivy | Forensics | Forensics LD | 12 | 99.1% | 132.8% | 119.4% | 201.8% |
| Eagle/Osprey | Forensics | Forensics LD | 10 | 89.8% | 97.2% | 100.0% | 96.8% |
| Harrier/Hawk | Forensics | Forensics LD | 10 | 83.0% | 111.6% | 100.0% | 111.3% |
| Kestrel/Kite. | Forensics | Forensics LD | 16 | 97.2% | 118.0% | 103.2% | 132.3% |
| Langley Ward | Forensics | Forensics LD | 10 | 88.6% | 103.2% | 100.0% | 100.0% |
| Northdale Centre | Forensics | Forensics LD | 12 | 88.7% | 116.5% | 96.8% | 97.7% |
| Oakwood | Forensics | Forensics LD | 8 | 94.1% | 176.7% | 100.0% | 100.0% |
| Thistle | Forensics | Forensics LD | 5 | 74.5% | 112.8% | 96.8% | 99.2% |
| Brambling Ward | Forensics | Forensics MH | 13 | 89.9% | 101.1% | 103.2% | 100.0% |
| Fulmar Ward. | Forensics | Forensics MH | 12 | 91.2% | 142.7% | 104.8% | 211.4% |
| Jay Ward | Forensics | Forensics MH | 5 | 90.2% | 85.5% | 100.0% | 93.6% |
| Lark | Forensics | Forensics MH | 15 | 94.7% | 110.1% | 103.2% | 100.0% |
| Linnet Ward | Forensics | Forensics MH | 17 | 89.7% | 100.8% | 100.0% | 100.0% |
| Mallard Ward | Forensics | Forensics MH | 16 | 85.3% | 99.3% | 99.5% | 104.8% |
| Mandarin | Forensics | Forensics MH | 16 | 85.3% | 92.0% | 100.9% | 97.2% |
| Merlin | Forensics | Forensics MH | 10 | 116.1% | 197.2% | 97.1% | 271.4% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Newtondale Ward | Forensics | Forensics MH | 20 | 87.1% | 94.3% | 85.5% | 98.0% |
| Nightingale Ward | Forensics | Forensics MH | 16 | 85.8% | 95.8% | 106.7% | 95.2% |
| Sandpiper Ward | Forensics | Forensics MH | 8 | 95.7% | 119.6% | 91.9% | 159.7% |
| Swift Ward | Forensics | Forensics MH | 10 | 79.0% | 105.7% | 96.8% | 119.6% |
| Aysgarth | Teesside | LD | 6 | 104.1% | 97.2% | 101.4% | 103.4% |
| Bankfields Court Flats | Teesside | LD | 0 | 102.7% | 83.4% | 114.3% | 97.9% |
| Bankfields Court Unit 2 | Teesside | LD | 5 | 113.0% | 102.3% | 116.1% | 119.7% |
| Bankfields Court Unit 3 | Teesside | LD | 0 | 77.1% | 108.7% | 100.0% | 91.9% |
| Bankfields Court Unit 4 | Teesside | LD | 0 | 98.1% | 95.2% | 109.1% | 92.2% |
| Bek-Ramsey Ward | Durham & Darlington | LD | 11 | 137.6% | 128.8% | 100.0% | 103.2% |
| Oak Rise | York and Selby | LD | 8 | 99.0% | 64.3% | 83.9% | 41.9% |
| The Lodge | Teesside | LD | 0 | 96.9% | 88.8% | 82.3% | 107.8% |
| Acomb Garth | York and Selby | MHSOP | 14 | 108.5% | 109.8% | 100.0% | 232.8% |
| Ceddesfeld Ward | Durham & Darlington | MHSOP | 15 | 95.9% | 111.4% | 100.0% | 95.2% |
| Cherry Tree House | York and Selby | MHSOP | 18 | 98.1% | 88.1% | 80.9% | 105.0% |
| Hamsterley Ward | Durham & Darlington | MHSOP | 15 | 95.6% | 110.1% | 100.0% | 130.6% |
| Meadowfields | York and Selby | MHSOP | 14 | 80.1% | 80.1% | 71.0% | 92.6% |
| Oak Ward | Durham & Darlington | MHSOP | 12 | 104.9% | 94.6% | 102.5% | 100.0% |
| Roseberry Wards | Durham & Darlington | MHSOP | 15 | 95.4% | 102.0% | 100.0% | 99.9% |
| Rowan Lea | North Yorkshire | MHSOP | 20 | 101.6% | 113.1% | 105.9% | 99.1% |
| Rowan Ward | North Yorkshire | MHSOP | 16 | 87.3% | 158.0% | 99.0% | 98.5% |
| Springwood Community Unit | North Yorkshire | MHSOP | 14 | 69.5% | 113.6% | 103.2% | 176.1% |
| Ward 14 | North Yorkshire | MHSOP | 10 | 76.6% | 115.5% | 99.9% | 100.3% |
| Westerdale North | Teesside | MHSOP | 18 | 97.2% | 128.3% | 100.0% | 108.5% |
| Westerdale South | Teesside | MHSOP | 14 | 97.9% | 120.1% | 100.0% | 126.5% |
| Wingfield Ward | Teesside | MHSOP | 10 | 94.1% | 110.4% | 100.3% | 100.3% |

**APPENDIX 2**

| Scored Fill Rate compared to Quality Indicators - May 2017 | | | | Agency Usage Vs Actual Hours | | | Bank Usage Vs Actual Hours | | | Totals for Quality Indicators | | | | | Incidents of Restraint | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Known As | Locality | Speciality | Bed Numbers | Total Actual Hours | Total Agency Hours | % Against actual Hours | Total Actual Hours | Total Bank Hours | % Against actual Hours | SUI | Level 4 Incidents | Level 3 Incidents | Complaints | PALS | Incidents | PRO used | Other | Restraint Total |
| Ayckbourn Unit Danby Ward | North Yorkshire | Adults | 11 | 2531.8 | | 0% | 2531.8 | 319.5 | 13% | | | | 1 | | 8 | | 8 | 8 |
| Ayckbourn Unit Esk Ward | North Yorkshire | Adults | 11 | 2825.3 | | 0% | 2825.3 | 372 | 13% | | | | | 1 | 9 | | 11 | 11 |
| Bedale Ward | Teesside | Adults | 10 | 3838.5 | | 0% | 3838.5 | 1268.5 | 33% | | | | 1 | | 4 | | 6 | 6 |
| Bilsdale Ward | Teesside | Adults | 14 | 2646.3 | | 0% | 2646.3 | 161 | 6% | | | | | | | | | |
| Birch Ward | Durham & Darlington | Adults | 15 | 3344.3 | | 0% | 3344.3 | 504 | 15% | | | | | 1 | | | | |
| Bransdale Ward | Teesside | Adults | 14 | 3394.0 | | 0% | 3394.0 | 839.5 | 25% | | | | 1 | 2 | 5 | | 14 | 14 |
| Cedar Ward | Durham & Darlington | Adults | 10 | 3971.9 | | 0% | 3971.9 | 1127.66 | 28% | | | | | | 17 | 2 | 28 | 30 |
| Cedar Ward (NY) | North Yorkshire | Adults | 18 | 2980.6 | 342.00 | 11% | 2980.6 | 206.05 | 7% | | 2 | | | 3 | 7 | | 11 | 11 |
| Ebor Ward | York and Selby | Adults | 12 | 2920.5 | 287.50 | 10% | 2920.5 | 164.5 | 6% | | | | | | 8 | | 9 | 9 |
| Elm Ward | Durham & Darlington | Adults | 20 | 2836.7 | | 0% | 2836.7 | 695.83 | 25% | | | 1 | | 1 | 16 | | 25 | 25 |
| Farnham Ward | Durham & Darlington | Adults | 20 | 3183.5 | | 0% | 3183.5 | 168 | 5% | | | | | 1 | 2 | | 2 | 2 |
| Kirkdale Ward | Teesside | Adults | 16 | 3036.6 | | 0% | 3036.6 | 123.75 | 4% | | | | | | | | | |
| Lincoln Ward | Teesside | Adults | 20 | 3031.3 | | 0% | 3031.3 | 396 | 13% | | | 1 | | | 4 | | 8 | 8 |
| Lustrum Vale | Teesside | Adults | 20 | 2894.3 | | 0% | 2894.3 | 445.5 | 15% | | | | | | 2 | | 3 | 3 |
| Maple Ward | Durham & Darlington | Adults | 20 | 2852.0 | | 0% | 2852.0 | 341.83 | 12% | | | | | 1 | | | | |
| Minster Ward | York and Selby | Adults | 12 | 2742.7 | 46.00 | 2% | 2742.7 | 150.5 | 5% | | | | | | 2 | | 6 | 6 |
| Overdale Ward | Teesside | Adults | 18 | 2675.0 | | 0% | 2675.0 | 507 | 19% | | | 1 | | | 2 | | 3 | 3 |
| Primrose Lodge | Durham & Darlington | Adults | 15 | 2629.5 | | 0% | 2629.5 | 360 | 14% | | | | | | 1 | | 1 | 1 |
| Stockdale Ward | Teesside | Adults | 18 | 2806.5 | | 0% | 2806.5 | 457.5 | 16% | | | | | 1 | 4 | 1 | 9 | 10 |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| The Orchards (NY) | North Yorkshire | Adults | 10 | 2224.5 | | 0% | 2224.5 | 12 | 1% | | | | | | | | | | | |
| Tunstall Ward | Durham & Darlington | Adults | 20 | 3101.3 | | 0% | 3101.3 | 48 | 2% | | | | | 2 | 2 | 2 | 1 | 3 |
| Ward 15 Friarage | North Yorkshire | Adults | 12 | 2498.5 | | 0% | 2498.5 | 780.5 | 31% | | | | | | | | | |
| Willow Ward | Durham & Darlington | Adults | 15 | 2702.2 | | 0% | 2702.2 | 252 | 9% | | | | | | | | | |
| Baysdale | Teesside | CYPS | 6 | 2636.2 | | 0% | 2636.2 | 205.78 | 8% | | | | | | | | | |
| Holly Unit | Durham & Darlington | CYPS | 4 | 1639.4 | | 0% | 1639.4 | 217.18 | 13% | | | | | | 1 | | 1 | 1 |
| Newberry Centre | Teesside | CYPS | 14 | 4036.8 | | 0% | 4036.8 | 421.64 | 10% | | | | 1 | | 33 | 1 | 53 | 54 |
| Talbot Direct Care | Durham & Darlington | CYPS | 1 | 3005.4 | | 0% | 3005.4 | 0 | 0% | | | | | | 4 | | 10 | 10 |
| The Evergreen Centre | Teesside | CYPS | 16 | 5784.0 | | 0% | 5784.0 | 696.25 | 12% | | | | | | 147 | | 222 | 222 |
| Westwood Centre | Teesside | CYPS | 12 | 5257.2 | | 0% | 5257.2 | 576.25 | 11% | | | | | 1 | 18 | | 31 | 31 |
| Clover/Ivy | Forensics | Forensics LD | 12 | 5165.1 | | 0% | 5165.1 | 1830.08 | 35% | | | 2 | | | 16 | | 32 | 32 |
| Eagle/Osprey | Forensics | Forensics LD | 10 | 3249.1 | | 0% | 3249.1 | 339.75 | 10% | | | | | | 1 | | 1 | 1 |
| Harrier/Hawk | Forensics | Forensics LD | 10 | 3998.6 | 45.00 | 1% | 3998.6 | 422.58 | 11% | | | | | 2 | 3 | | 5 | 5 |
| Kestrel/Kite. | Forensics | Forensics LD | 16 | 4589.7 | 31.00 | 1% | 4589.7 | 752 | 16% | | | | | | 2 | | 2 | 2 |
| Langley Ward | Forensics | Forensics LD | 10 | 2195.1 | | 0% | 2195.1 | 123.75 | 6% | | | | | | | | | |
| Northdale Centre | Forensics | Forensics LD | 12 | 4881.9 | 146.25 | 3% | 4881.9 | 1682.25 | 34% | | | | | 3 | | | | |
| Oakwood | Forensics | Forensics LD | 8 | 2199.6 | | 0% | 2199.6 | 7.5 | 0% | | | | | | | | | |
| Thistle | Forensics | Forensics LD | 5 | 3013.8 | | 0% | 3013.8 | 219.75 | 7% | | | | | 2 | 1 | | 1 | 1 |
| Brambling Ward | Forensics | Forensics MH | 13 | 2831.5 | | 0% | 2831.5 | 222.25 | 8% | | | | | 1 | 13 | | 18 | 18 |
| Fulmar Ward. | Forensics | Forensics MH | 12 | 4460.0 | | 0% | 4460.0 | 1503 | 34% | | | 1 | | | 31 | | 46 | 46 |
| Jay Ward | Forensics | Forensics MH | 5 | 2622.6 | | 0% | 2622.6 | 248.25 | 9% | | | | | | | | | |
| Lark | Forensics | Forensics MH | 15 | 2745.3 | | 0% | 2745.3 | 258.75 | 9% | | | | | 1 | | | | |
| Linnet Ward | Forensics | Forensics MH | 17 | 2844.5 | | 0% | 2844.5 | 521.75 | 18% | | | | | | 2 | | 5 | 5 |
| Mallard Ward | Forensics | Forensics MH | 16 | 3106.3 | | 0% | 3106.3 | 658 | 21% | | | | | | 2 | | 2 | 2 |
| Mandarin | Forensics | Forensics MH | 16 | 2693.9 | | 0% | 2693.9 | 266.75 | 10% | | | | | 4 | 1 | | 1 | 1 |
| Merlin | Forensics | Forensics MH | 10 | 6087.2 | | 0% | 6087.2 | 2604.42 | 43% | | | | | 3 | 41 | 2 | 58 | 60 |
| Newtondale Ward | Forensics | Forensics MH | 20 | 3484.3 | | 0% | 3484.3 | 480.75 | 14% | | | | | | | | | |
| Nightingale Ward | Forensics | Forensics MH | 16 | 2742.2 | | 0% | 2742.2 | 277.5 | 10% | | | | | 1 | 1 | | 1 | 1 |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sandpiper Ward | Forensics | Forensics MH | 8 | 4524.2 | | 0% | 4524.2 | 1012.5 | 22% | | | | | 2 | 106 | 12 | 268 | 280 |
| Swift Ward | Forensics | Forensics MH | 10 | 3206.8 | | 0% | 3206.8 | 626.5 | 20% | | | | | | 14 | | 29 | 29 |
| Aysgarth | Teesside | LD | 6 | 2287.6 | | 0% | 2287.6 | 444.83 | 19% | | | | | | | | | |
| Bankfields Court Flats | Teesside | LD | 0 | 1913.4 | | 0% | 1913.4 | 195.09 | 10% | | | | | | 4 | | 4 | 4 |
| Bankfields Court Unit 2 | Teesside | LD | 5 | 2514.8 | | 0% | 2514.8 | 683.73 | 27% | | | | | | | | | |
| Bankfields Court Unit 3 | Teesside | LD | 0 | 2322.3 | | 0% | 2322.3 | 109.99 | 5% | | | | | | 5 | | 6 | 6 |
| Bankfields Court Unit 4 | Teesside | LD | 0 | 2057.9 | | 0% | 2057.9 | 128.25 | 6% | | | | | | 9 | | 14 | 14 |
| Bek-Ramsey Ward | Durham & Darlington | LD | 11 | 4512.2 | | 0% | 4512.2 | 156 | 3% | | | | | | 39 | | 48 | 48 |
| Oak Rise | York and Selby | LD | 8 | 2956.0 | 66.00 | 2% | 2956.0 | 56.5 | 2% | | | | | | | | | |
| The Lodge | Teesside | LD | 0 | 1713.3 | | 0% | 1713.3 | 134 | 8% | | | | | | | | | |
| Acomb Garth | York and Selby | MHSOP | 14 | 4435.5 | 1680.50 | 38% | 4435.5 | 63 | 1% | | | | | | | | | |
| Ceddesfeld Ward | Durham & Darlington | MHSOP | 15 | 3178.0 | | 0% | 3178.0 | 191.5 | 6% | | | | | | 1 | | 2 | 2 |
| Cherry Tree House | York and Selby | MHSOP | 18 | 3271.9 | | 0% | 3271.9 | 100 | 3% | | | | 1 | | 3 | | 3 | 3 |
| Hamsterley Ward | Durham & Darlington | MHSOP | 15 | 3248.8 | | 0% | 3248.8 | 437.17 | 13% | | | | | | 2 | | 2 | 2 |
| Meadowfields | York and Selby | MHSOP | 14 | 2761.8 | 115.00 | 4% | 2761.8 | 664 | 24% | | | | | | 9 | | 12 | 12 |
| Oak Ward | Durham & Darlington | MHSOP | 12 | 2748.8 | | 0% | 2748.8 | 62 | 2% | | | | | | | | | |
| Roseberry Wards | Durham & Darlington | MHSOP | 15 | 2902.5 | | 0% | 2902.5 | 396.17 | 14% | | | | | | | | | |
| Rowan Lea | North Yorkshire | MHSOP | 20 | 3705.8 | | 0% | 3705.8 | 137.02 | 4% | | | | | | 13 | | 19 | 19 |
| Rowan Ward | North Yorkshire | MHSOP | 16 | 2913.5 | 148.50 | 5% | 2913.5 | 313.5 | 11% | | | | | | | | | |
| Springwood Community Unit | North Yorkshire | MHSOP | 14 | 3351.3 | 455.00 | 14% | 3351.3 | 411 | 12% | | | | | | 15 | | 17 | 17 |
| Ward 14 | North Yorkshire | MHSOP | 10 | 2594.5 | | 0% | 2594.5 | 93.5 | 4% | | | | | | 6 | | 11 | 11 |
| Westerdale North | Teesside | MHSOP | 18 | 2841.8 | | 0% | 2841.8 | 184 | 6% | | | | | | 1 | | 1 | 1 |
| Westerdale South | Teesside | MHSOP | 14 | 4544.8 | | 0% | 4544.8 | 1685.67 | 37% | | | | | | 7 | | 11 | 11 |
| Wingfield Ward | Teesside | MHSOP | 10 | 2549.5 | | 0% | 2549.5 | 115 | 5% | | | | | | | | | |

## Severity Scoring by Total Score

**APPENDIX 3**

| WARD | Locality | Speciality | Bed Numbers | Red Fill Rate | Blue Fill Rate | Missed Breaks | Agency Usage | Bank Usage | SUI | Level 4 Incidents | Level 3 Incidents | Complaints | Control & Restraint | TOTAL SCORE (May) | YTD Total Score (Nov-May) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Meadowfields | York and Selby | MHSOP | 14 | 6 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **9** | **46** |
| Oak Rise | York and Selby | LD | 8 | 6 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | **9** | **30** |
| Cedar Ward (NY) | North Yorkshire | Adults | 18 | 4 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 1 | **8** | **45** |
| Overdale Ward | Teesside | Adults | 18 | 2 | 2 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | **7** | **31** |
| Clover/Ivy | Forensics | Forensics LD | 12 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 2 | 0 | 1 | **7** | **32** |
| Fulmar Ward. | Forensics | Forensics MH | 12 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 2 | **7** | **32** |
| Merlin | Forensics | Forensics MH | 10 | 0 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 2 | **7** | **38** |
| The Evergreen Centre | Teesside | CYPS | 16 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | **6** | **28** |
| Cherry Tree House | York and Selby | MHSOP | 18 | 4 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **6** | **26** |
| Rowan Ward | North Yorkshire | MHSOP | 16 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | **6** | **38** |
| Newberry Centre | Teesside | CYPS | 14 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | **6** | **39** |
| Lustrum Vale | Teesside | Adults | 20 | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **21** |
| Northdale Centre | Forensics | Forensics LD | 12 | 2 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **38** |
| Ayckbourn Unit Danby Ward | North Yorkshire | Adults | 11 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | **5** | **31** |
| Ayckbourn Unit Esk Ward | North Yorkshire | Adults | 11 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | **5** | **38** |
| Bedale Ward | Teesside | Adults | 10 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | **5** | **35** |
| Bransdale Ward | Teesside | Adults | 14 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | **5** | **35** |
| Holly Unit | Durham & Darlington | CYPS | 4 | 0 | 4 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **23** |
| Newtondale Ward | Forensics | Forensics MH | 20 | 4 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **36** |
| Springwood Community Unit | North Yorkshire | MHSOP | 14 | 2 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **46** |
| Minster Ward | York and Selby | Adults | 12 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **4** | **25** |
| Mallard Ward | Forensics | Forensics MH | 16 | 2 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **4** | **30** |
| Westerdale South | Teesside | MHSOP | 14 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **4** | **21** |
| Cedar Ward | Durham & Darlington | Adults | 10 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | **4** | **34** |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Primrose Lodge | Durham & Darlington | Adults | 15 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **4** | **26** |
| Ward 15 Friarage | North Yorkshire | Adults | 12 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **4** | **31** |
| Sandpiper Ward | Forensics | Forensics MH | 8 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | **4** | **51** |
| Swift Ward | Forensics | Forensics MH | 10 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | **4** | **34** |
| The Lodge | Teesside | LD | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **4** | **4** |
| Kirkdale Ward | Forensics | Adults | 16 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **13** |
| The Orchards (NY) | North Yorkshire | Adults | 10 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **33** |
| Langley Ward | Forensics | Forensics LD | 10 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **23** |
| Mandarin | Forensics | Forensics MH | 16 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **26** |
| Westerdale North | Teesside | MHSOP | 18 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **10** |
| Elm Ward | Durham & Darlington | Adults | 20 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | **3** | **23** |
| Westwood Centre | Teesside | CYPS | 12 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **36** |
| Harrier/Hawk | Forensics | Forensics LD | 10 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **33** |
| Kestrel/Kite. | Forensics | Forensics LD | 16 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **3** | **33** |
| Brambling Ward | Forensics | Forensics MH | 13 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **19** |
| Linnet Ward | Forensics | Forensics MH | 17 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **3** | **28** |
| Bek-Ramsey Ward | Durham & Darlington | LD | 11 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **13** |
| Ward 14 | North Yorkshire | MHSOP | 10 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **24** |
| Ebor Ward | York and Selby | Adults | 12 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **26** |
| Stockdale Ward | Teesside | Adults | 18 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **2** | **11** |
| Bankfields Court Unit 2 | Teesside | LD | 5 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **2** | **13** |
| Wingfield Ward | Teesside | MHSOP | 10 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **2** | **18** |
| Lincoln Ward | Teesside | Adults | 20 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | **2** | **5** |
| Tunstall Ward | Durham & Darlington | Adults | 20 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **7** |
| Eagle/Osprey | Forensics | Forensics LD | 10 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **19** |
| Thistle | Forensics | Forensics LD | 5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **17** |
| Jay Ward | Forensics | Forensics MH | 5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **25** |
| Nightingale Ward | Forensics | Forensics MH | 16 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **18** |
| Bankfields Court Flats | Teesside | LD | 5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **2** |
| Bankfields Court Unit 3 | Teesside | LD | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **2** |
| Acomb Garth | York and Selby | MHSOP | 14 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **21** |
| Hamsterley Ward | Durham & Darlington | MHSOP | 15 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **2** | **28** |
| Birch Ward | Durham & Darlington | Adults | 15 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** | **15** |
| Farnham Ward | Durham & Darlington | Adults | 20 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | **13** |
| Maple Ward | Durham & Darlington | Adults | 20 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** | **18** |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Willow Ward | Durham & Darlington | Adults | 15 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | **18** |
| Oakwood | Forensics | Forensics LD | 8 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | **22** |
| Aysgarth | Teesside | LD | 6 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** | **14** |
| Oak Ward | Durham & Darlington | MHSOP | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** | **8** |
| Roseberry Wards | Durham & Darlington | MHSOP | 15 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** | **8** |
| Bilsdale Ward | Teesside | Adults | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **14** |
| Baysdale | Teesside | CYPS | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **4** |
| Talbot Direct Care | Durham & Darlington | CYPS | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **16** |
| Lark | Forensics | Forensics MH | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **12** |
| Bankfields Court Unit 4 | Teesside | LD | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** |
| Ceddesfeld Ward | Durham & Darlington | MHSOP | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **8** |
| Rowan Lea | North Yorkshire | MHSOP | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **7** |

## Severity Scoring by Speciality

**APPENDIX 4**

| WARD | Locality | Speciality | Bed Numbers | Red Fill Rate | Blue Fill Rate | Missed Breaks | Agency Usage | Bank Usage | SUI | Level 4 Incidents | Level 3 (Self-Harm) Incidents | Complaints | Control & Restraint | TOTAL SCORE | YTD Total Score (Nov-May) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ayckbourn Unit Danby Ward | North Yorkshire | Adults | 11 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | **5** | **31** |
| Ayckbourn Unit Esk Ward | North Yorkshire | Adults | 11 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | **5** | **38** |
| Bedale Ward | Teesside | Adults | 10 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | **5** | **35** |
| Bilsdale Ward | Teesside | Adults | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **14** |
| Birch Ward | Durham & Darlington | Adults | 15 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** | **15** |
| Bransdale Ward | Teesside | Adults | 14 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | **5** | **35** |
| Cedar Ward | Durham & Darlington | Adults | 10 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | **4** | **34** |
| Cedar Ward (NY) | North Yorkshire | Adults | 18 | 4 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 1 | **8** | **45** |
| Ebor Ward | York and Selby | Adults | 12 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **26** |
| Elm Ward | Durham & Darlington | Adults | 20 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | **3** | **23** |
| Farnham Ward | Durham & Darlington | Adults | 20 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | **13** |
| Kirkdale Ward | Forensics | Adults | 16 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **13** |
| Lincoln Ward | Teesside | Adults | 20 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | **2** | **5** |
| Lustrum Vale | Teesside | Adults | 20 | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **21** |
| Maple Ward | Durham & Darlington | Adults | 20 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** | **18** |
| Minster Ward | York and Selby | Adults | 12 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **4** | **25** |
| Overdale Ward | Teesside | Adults | 18 | 2 | 2 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | **7** | **31** |
| Primrose Lodge | Durham & Darlington | Adults | 15 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **4** | **26** |
| Stockdale Ward | Teesside | Adults | 18 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **2** | **11** |
| The Orchards (NY) | North Yorkshire | Adults | 10 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **33** |
| Tunstall Ward | Durham & Darlington | Adults | 20 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **7** |
| Ward 15 Friarage | North Yorkshire | Adults | 12 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **4** | **31** |
| Willow Ward | Durham & Darlington | Adults | 15 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | **18** |
| Baysdale | Teesside | CYPS | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **4** |
| Holly Unit | Durham & Darlington | CYPS | 4 | 0 | 4 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **23** |
| Newberry Centre | Teesside | CYPS | 14 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | **6** | **39** |
| Talbot Direct Care | Durham & Darlington | CYPS | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **16** |
| The Evergreen Centre | Teesside | CYPS | 16 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | **6** | **28** |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Westwood Centre | Teesside | CYPS | 12 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **36** |
| Clover/Ivy | Forensics | Forensics LD | 12 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 2 | 0 | 1 | **7** | **32** |
| Eagle/Osprey | Forensics | Forensics LD | 10 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **19** |
| Harrier/Hawk | Forensics | Forensics LD | 10 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **33** |
| Kestrel/Kite. | Forensics | Forensics LD | 16 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **3** | **33** |
| Langley Ward | Forensics | Forensics LD | 10 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **23** |
| Northdale Centre | Forensics | Forensics LD | 12 | 2 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **38** |
| Oakwood | Forensics | Forensics LD | 8 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | **22** |
| Thistle | Forensics | Forensics LD | 5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **17** |
| Brambling Ward | Forensics | Forensics MH | 13 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **19** |
| Fulmar Ward. | Forensics | Forensics MH | 12 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 2 | **7** | **32** |
| Jay Ward | Forensics | Forensics MH | 5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **25** |
| Lark | Forensics | Forensics MH | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **12** |
| Linnet Ward | Forensics | Forensics MH | 17 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **3** | **28** |
| Mallard Ward | Forensics | Forensics MH | 16 | 2 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **4** | **30** |
| Mandarin | Forensics | Forensics MH | 16 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **26** |
| Merlin | Forensics | Forensics MH | 10 | 0 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 2 | **7** | **38** |
| Newtondale Ward | Forensics | Forensics MH | 20 | 4 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **36** |
| Nightingale Ward | Forensics | Forensics MH | 16 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **18** |
| Sandpiper Ward | Forensics | Forensics MH | 8 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | **4** | **51** |
| Swift Ward | Forensics | Forensics MH | 10 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | **4** | **34** |
| Aysgarth | Teesside | LD | 6 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** | **14** |
| Bankfields Court Flats | Teesside | LD | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **2** |
| Bankfields Court Unit 2 | Teesside | LD | 5 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **2** | **13** |
| Bankfields Court Unit 3 | Teesside | LD | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **2** |
| Bankfields Court Unit 4 | Teesside | LD | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** |
| Bek-Ramsey Ward | Durham & Darlington | LD | 11 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **13** |
| Oak Rise | York and Selby | LD | 8 | 6 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | **9** | **30** |
| The Lodge | Teesside | LD | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **4** | **4** |
| Acomb Garth | York and Selby | MHSOP | 14 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **21** |
| Ceddesfeld Ward | Durham & Darlington | MHSOP | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **8** |
| Cherry Tree House | York and Selby | MHSOP | 18 | 4 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **6** | **26** |
| Hamsterley Ward | Durham & Darlington | MHSOP | 15 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **2** | **28** |
| Meadowfields | York and Selby | MHSOP | 14 | 6 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **9** | **46** |
| Oak Ward | Durham & Darlington | MHSOP | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** | **8** |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Roseberry Wards | Durham & Darlington | MHSOP | 15 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** | **8** |
| Rowan Lea | North Yorkshire | MHSOP | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **7** |
| Rowan Ward | North Yorkshire | MHSOP | 16 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | **6** | **38** |
| Springwood Community Unit | North Yorkshire | MHSOP | 14 | 2 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **5** | **46** |
| Ward 14 | North Yorkshire | MHSOP | 10 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **24** |
| Westerdale North | Teesside | MHSOP | 18 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **3** | **10** |
| Westerdale South | Teesside | MHSOP | 14 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **4** | **21** |
| Wingfield Ward | Teesside | MHSOP | 10 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **2** | **18** |

**Appendix 1 Table of Issues and Actions**

| Key Issues | Contributory factors | Impacts/Consequences | Actions taken | Actions Planned |
|---|---|---|---|---|
| Recruitment and retention difficulties.<br><br>Consistent and long term Inability to access nurse bank.<br><br>Expansion of community services has led to relatively newly qualified staff obtaining band 6 roles in the community rather than developing their skills in in-patient services (turnover in inpatient services)<br><br>Many band 6 staff are happy remaining in a clinical role in the community and inpatients (not attracted to the role of ward or CMHT manager) | Historical and well identified low external to the area interest in vacancies - constant recruitment issues<br><br>Lessening numbers of registered nurses through completion of nurse training<br><br>Lower numbers of applications for RMN and LD nurse training<br><br>Shift patterns (12 hour shifts – more and more frequently verbalised as un attractive)<br><br>Isolation of units in some areas, low levels of support / response. | High use of agency, extra shift working.<br><br>Crisis and community team staff covering wards in times of shortage, impacting on their work.<br><br>Ability of staff to respond to incidents and to take staff breaks.<br><br>Delivery of planned activities.<br><br>Inability to achieve expected standards (appraisal / supervision) meet policy requirements and deliver planned activities<br><br>Feeling of ward being unsafe expressed by staff triggering 'stop the line' processes<br><br>Lowering confidence and competence (skills) | Multiple national and trust wide recruitment drives and ongoing continual adverts and interviews<br><br>2 strategically planned recruitment drives for Harrogate, in Leeds; and Scarborough in Hull have been much more successful for Harrogate and Scarborough than the other trust wide and national recruitment events<br><br>Use of regular agency registered staff (Harrogate)<br><br>North Yorkshire Nurse Development programme<br><br>Escalation protocol circulated but anecdotally unclear if always followed<br><br>Roster Reviews have taken place<br><br>Development of a 'local nurse bank' explored<br><br>Scarborough Recruitment Workshop on improving the way we advertise the area as well as | Roll out of establishment review tool underway<br><br>Trust wide approach to alternative recruitment and nurse training opportunities – (benefits unfortunately will not be realise for at least 3 to 4 years – there is predicted to be a significant registered staffing shortfall in that time)<br><br>Continued recruitment drives strategically targeted for North Yorkshire.<br><br>Access to trust systems for Agency staff. |

| | | | | |
|---|---|---|---|---|
| | | | posts available.<br><br>'Stop the Line' action plans have been implemented however, there is an increasing reluctance of current staff and community staff to provide additional input onto the ward as this has been required over several months | |
| Personal development opportunities including non-statutory training and access to clinical supervision | Difficulty in release of staff from the wards / cancellation of staff attending training due to short term staffing pressures.<br><br>Training is sometimes planned after roster is produced making release harder.<br><br>As additional requirements have been and are added to training, and other non-direct clinical activity, no additional buffer - headroom from current establishment has been factored in to facilitate | Lack of sense of value if not invested in through development<br><br>Feeling of being unsafe<br><br>'Targets' not being achieved – increasing pressure on Ward managers – Particular difficulties in meeting appraisal and Safeguarding targets<br><br>Not achieving development activities with nursing staff | | |
| Instability in the multidisciplinary team staffing across other professions | | Multidisciplinary team confidence in making decisions and robust planning | | |

| | | | | |
|---|---|---|---|---|
| Medics/Consultants<br>OT<br>Physio<br>Dietitians | | Access to specialist professional advice; training; MDT | | |
| Use of high levels of enhanced observations | Environmental and geographical isolation<br><br>Small inpatient units 1; and 2 wards - geographically separated from each other and other areas of inpatient services by travel times between 1 and 2 hours. Increasing clinical complexity of the patient population (Increased acuity)<br><br>No seclusion facility in Harrogate and PICU facilities only available in other operational localities.<br><br>PICU difficult to access in times of need with geographical and staffing cover transfer of patient challenges | Limited options for cross cover in times of short notice loss of staff, or increased need due to clinical demands. Compromised Safety of both staff and patients in isolated units due to limited response/support, difficulties in accessing and moving patients in need to specialist units such as PICU. | | |
| Varied levels of proficiency in the use of e-roster system | Spreading leave evenly across the year; but also needing to ensure all staff have equal opportunities for leave | | | E roster reviews and help ‘clinics’ |

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**ITEM 9**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **Tuesday 4th July 2017** |
| **TITLE:** | **Staffing pressures and mitigations within North Yorkshire inpatient services** |
| **REPORT OF:** | **Elizabeth Moody, Director of Nursing and Governance** |
| **REPORT FOR:** | **Information** |

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

**Executive Summary:**

There have been a number of occasions in North Yorkshire where staffing pressures across inpatient services have presented issues that have required escalation. Some of these have related to specific operational issues but have also occurred as a consequence of more structural challenges in the area. Where staffing pressures have occurred these have been linked to:

- Recruitment and retention difficulties
- Environmental and geographical isolation factors
- Increasing clinical complexity of the patient population (increased acuity)
- Instability in the multidisciplinary team staffing across other professions
- Varied levels of proficiency in the use of e-roster system
- Changes in the clinical and managerial leadership of the service

Staffing pressures within inpatient areas have been regularly escalated and reported through the Locality Management and Governance Board to the Executive Management Team, Quality Assurance Committee and the Nursing and Governance Directorate.

In response to these pressures a number of steps have been undertaken and further actions planned. Action plans have been put in place for short and medium term resolutions.

These short to medium term resolutions are being supported through the trust with further training on the proficient use of e-roster, clinical leadership team development

through the Purposeful Inpatient Admission process (PIPA), access to coaching support and specific events to support local recruitment.

There are trust wide longer term projects for training, recruitment and retention of nurses, but also localised projects such as the Scarborough recruitment and advertising table top event; and two strategically planned recruitment events specific to Harrogate and Scarborough respectively.

The North Yorkshire locality, in partnership with others, is also developing its longer term clinical model of care to ensure the sustainability of an efficient, effective and high quality service. The potential re-modelling of the local services will see an emphasis on enhancing the level and skill base of community teams which, in turn, will support a reduction in the reliance on hospital admission and address the associated staffing issues.

**Recommendations:**

To note the contents of this report, and to provide comment and any recommendations as to progress to date.

| | |
|---|---|
| **MEETING OF:** | **Board of Directors** |
| **DATE:** | **4th of July 2017** |
| **TITLE:** | **Staffing pressures and mitigations within North Yorkshire inpatient services** |

## 1. INTRODUCTION & PURPOSE:

1.1 This report is provided to the Trust Board to detail the nature and degree of staffing pressures within North Yorkshire in-patient wards, and provide assurance as to both the mitigations in place to manage the pressure and the steps undertaken to reduce the long-term impact.

## 2. BACKGROUND INFORMATION AND CONTEXT:

The North Yorkshire inpatient services have, over the years, gone through periods when there have been particular staffing pressures, the causes of which are multifaceted. This has been an ongoing issue for North Yorkshire across services and locations. The report will cover issues relating to recruitment and retention, sickness, environmental issues and aspects of multi-disciplinary working. There have been a number of key processes used to ameliorate the position.

- Recruitment fares
- Improvement in bank provision
- The use of Health Roster
- Staffing establishment reviews
- Working to ensuring access to the full multidisciplinary team across the inpatient service, particularly psychology input
- Use of QIS tools
- Clinical training, skills development and clinical pathway work
- Environmental improvement works.
- Increase in numbers of modern matrons.

These have improved clinical confidence and team working, but sustainability may be impacted by continuous recruitment and retention difficulties, environmental challenges in some inpatient facilities, and other key issues listed under section 3.

## 3. KEY ISSUES:

### 3.1 **Recruitment and retention difficulties**.

The table below outlines the current position in terms of vacancies over the last 12 months.

3.2 Recruitment retention and vacancies over the previous 12 months

| Ward | Number of Qualified Nurse vacancies that went to advert between April 2016 and march 2017 | Number of occasions posts had to be advertised | Current Qualified staff vacancies | Commentary on current status. |
|---|---|---|---|---|
| Ward 15 | 5 | 2 | 2.44 | Ward Manager has recently secured offer of another post and will be leaving |
| Ward 14 | 1<br><br>(+ 0.5 Physiotherapy Band 6) | 1<br><br>2 | 0 | Low numbers of applicants Majority of applicants for RMN post students or newly qualified.<br>Several shortlisted candidates didn't turn up for interview leaving only one newly qualified nurse who was appointable.<br><br>Physiotherapist appointed but still waiting for CRB check, can take up to three months |
| Cedar | 3<br><br>1 Clinical lead band 6 went out to advert October 2016 once<br><br>1 Clinical lead band 6 post went out to advert March 2017 once | First advert October 2016 no applicants. Advert went back out and has been a rolling advert since.<br>Band 6 post filled first time advertised<br><br>Band 6 post filled first time advertised | 1 + 1 appointed into waiting to start following recruitment checks. | Waiting for 1 band 5 to start.<br>Rolling band 5 advert still current on NHS jobs.<br>Pressure remains as 1 band 5 currently on maternity leave due to start back? June 2017 (to confirm) currently works 0.6 WTE.<br><br>1 Band 5 0.4 WTE (16 hours) on long term sick.<br><br>5 current HCA posts. 3 filled last November 2016 waiting on recruitment checks.<br>1 recruited April 2017 waiting on recruitment checks.<br>1 advertised and shortlisted due to interview 27th April 2017. |
| Rowan | 3 (2 covering maternity leave) | Rolling advert for mat' leave posts since end of 2016. | 2 Band 5 posts (covering mat' leave however staff due back next May and June so not | Never recruited into the maternity leave posts so have been seeking cover from Bank.<br>Staff return from maternity in May and June and one nurse will be returning on reduced hours leaving a |

| | | | | |
|---|---|---|---|---|
| | | | re-advertised) | shortfall |
| Orchards | 4 | 1 | 0 | Sickness (long-term) |
| Springwood | 3 | 4 times | 3 | Also struggling to appoint B5 dietician – currently relying on locums. Post advertised twice. Now looking at ways of making the post more interesting – Rachel is discussing suggestions with Naomi. |
| Rowan Lea | 2 | Now out for the 3rd time | 2 will be a 3 in the next Month | OT Vacancy, Psychology Vacancy, Dietician Vacancy, Physio only 14 hours |
| Danby (Aykbourne Unit) | 5 (2 vacant for this entire period).<br><br>A four month period of no Clinical Lead. | Every month rolling advert | 2 | Most months there have not been any applicants or none that meet the criteria.<br><br>Had a four month period of no band 6 Clinical Lead.<br><br>Ward (Unit) Manager on Maternity leave through most of the period - acting ward manager in place. |
| Esk (Aykbourne Unit) | 2.6 (1.6 vacant for this entire period). | Every month rolling advert | 1.6 | Most months there have not been any applicants or none that meet the criteria.<br><br>Ward (Unit) Manager on Maternity leave through most of the period - acting ward manager in place. |
| **TOTAL** | **30.6 WTE** | **Detail per ward** | 16.04 with offsets = **13 WTE** | 16.04 figure offset by pending additional vacancy – Rowan Lea; pending appointment – Cedar; pending maternity retuning staff (I with reduced in hours) |

### 3.3 Recruitment Fares

The trust in the last 12 months has run recruitment fares in various cities and locations in an attempt to bolster recruitment trust wide. For North Yorkshire there has been 2 specific targeted events. A recruitment event took place on Friday 3rd March 2017 in Leeds. This event was specifically focused on the need to fill vacancies in the Harrogate area. 14 appointments were made with 11 of those offered to students from various universities in the Yorkshire area.

A recruitment event took place on the 30th March 2017 at the Freedom Centre in Hull. The fair focused on recruiting to vacancies in the Scarborough area. 8 people were interviewed and appointed from this event.

Out of the 14 appointments made in Harrogate;

- 1 RNLD took up a post within FLD Tees
- 1 RMN took a CAMHS post at York
- 8 students are still in the recruitment process
- 1 student withdrawn
- 3 of these have secured places on the nursing development programme within North Yorkshire and the other 8 will be taking up posts within Harrogate, specific post details to be given at our reconnection event next month (7 MH, 1 LD)

From the 8 appointments made at the Hull event for Scarborough:

- 1 student withdrawn
- 3 have secured places within the nursing development programme within North Yorkshire
- The other 4 students will be given specific post details at our reconnection event next month (2 LD, 2 MH)

The recruitment fares can be seen to have had a positive impact in recruiting to the locality, although the majority will not be in post until September. A further event is being planned for Scarborough in August. Improvement in bank provision has been instigated but this has met with limited success to date. Further work will be undertaken to try and improve bank capacity. Recruitment and retention however remains the dominant issue. Appendix 1 collates the key issues relating to recruitment and retention and in terms of sustainable staffing, the impacts/consequences, mitigating actions taken so far and those planned.

## 3.4 Sickness

The target for sickness/absence is 4.5%. The North Yorkshire locality overall position is 4.28% (AMH 2.9%, MHSOP 6.07%, LD 4.24%, CYPS 5.62%). Whilst the overall position is relatively good long term sickness is having an impact in particularly MHSOP in Harrogate, although it is reducing. The long term sickness specifically relating to the Orchards is greatly improved and with staff returning from maternity leave the unit is more stable. Any sickness/absence in inpatient areas will currently have an impact and is being covered mainly by agency staff.

## 3.5 E-roster

Services have reported varied levels of proficiency in the use of the e-roster system for example spreading leave evenly across the year; but also needing to ensure all staff have equal opportunities for leave. E roster reviews and help ‘clinics’ have been set up to offer further training and support.

3.6 **Environmental issues.**

The majority of inpatient units in North Yorkshire are relatively small and geographically separated from each other. This makes it extremely difficult for units and wards to support each other in terms of staffing. This results in limited options for cross cover in times of short notice loss of staff, or increased need due to clinical demands.

As for all services there is an increasing clinical complexity of the patient population (increased acuity) and the ward environments. Added to this there is no seclusion facility in Harrogate and PICU facilities are only available in other operational localities. This sometimes means that PICU can be difficult to access in times of need with geographical and staffing cover transfer of patient challenges. For staff results in additional challenges on a day to day basis.

3.7 **Multi-disciplinary working**

In the wider context of safe staffing there have been reported clinical and staffing pressures in other health disciplines, particularly medical staff cover.

MHSOP Medical staffing

Key issues have been high patient case load particularly in Scarborough coupled with nursing staffing pressures meaning that patient throughput has been negatively impacted. Fitting in admission or discharge meetings can be very hard due to Consultants diary and other commitments and has meant 72 hour meetings are done much later. Pressure on junior Doctors and consultant time often leads to a lot of meetings being held without the consultant being present (admission and discharge meetings).

Consultant leave puts greater pressure on the system due to already limited consultant availability, particularly in Scarborough. Rowan lea has been without an F1 for some time leaving only 1 junior doctor which has led to late discharge summaries, falls clips not being completed, and diary jobs late in being attended to.

In Hambleton and Richmondshire (Ward 14) one Consultant covers the ward plus Liaison Hambleton Community this has an impact on overall capacity. However the main concern is around the junior doctor's on-call rota and the impact of that on routine work, if they are called out the previous night.

There is also a difficulty with the post falls protocol, junior doctors are required to be within 30 mins travel time and the North Yorkshire geography can make this difficult to achieve, there is also concern that if the Harrogate and Northallerton rotas merge this will be even more of an issue.

AMH Medical staffing

There have been difficulties of medical staff recruitment and retention in AMH across all areas. Key medical posts have been occupied by locum staff on a

number of occasions which leads to a number of difficulties. Scarborough, Whitby and Ryedale has struggled to recruit junior medics, and there has been increased sickness at Consultant level which has led to needing to source a Locum Consultant for Danby ward. In the past 12 months there have been 4 different Locums leading to a lack of stability/consistency. This has led to additional challenges especially with PIPA, as many of the Locums have not been familiar with this way of working and have had to re train each time a new locum has been appointed.

As a consequence there has been re work and less efficiency has arguably contributed to increased bed occupancy due to poorer discharges. Danby ward has a vacant SHO post and the current Locum has been on annual leave for 1 month, however additional leadership meetings to promote bed management and effective discharges from wards have built in. The appointment of a in-patient clinical psychologist in Danby has had a very positive impact on the multi-disciplinary team and quality of care for patients.

In terms of inpatient flow the medical cover position for Scarborough community mental health team (CMHT), early intervention for psychosis, (EIP) and the assertive outreach team (AOT) also plays a significant role in terms of the inpatient medical pressures. Scarborough CMHT has been managing with 1 Consultant Psychiatrist for generic CMHT and then the locum (which is part time for Danby and then part time for AOT, EIP) is the repeat position as described in the narrative for the inpatients.

12 months ago there was a reported positive change in the medical model for inpatients services in SWR, creating 1 Consultant Psychiatrist for each ward as well as a Staff grade (speciality doctor) covering across the 2 wards; the challenge is to maintain this.

Modern Matrons

The modern matron role was re-established to

- Provide Leadership to professional and direct care staff within their group of wards in order to secure and assure the highest standards of clinical care
- Provide visibility, be accessible and have a sense of presence on the inpatient wards so that patients and carers can feel assured by
- Take a lead in IPC and maintaining safe and clean wards

In North Yorkshire when modern matrons were established there was only one modern matron that covered Scarborough (Cross Lane Hospital), Northallerton (ward 15), Harrogate (Cedar ward) and The Orchards (Ripon) which had a direct impact on the role of the matron and what they could deliver due to the geographical challenges. Now that North Yorkshire has a modern matron post in each locality it has enhanced the ability to carry out focused work on

- Health Roster and Safe Staffing including daily management

- Oversight on Standards of Care (Essence of care, NICE, IPC, CQUIN's)
- It will strengthen the Leadership team
- Modern Matrons are needing to work outside the normal 9-5, to support staff out of hours and weekends when we have a reduction in the multi-disciplinary leadership presence

Other discipline pressures have been when there are a higher number of continuous and enhanced observations AHPs (OT) often get asked to cover these which takes them away from their core therapeutic roles on the wards.

Speech and Language Therapy, Physiotherapy and Dietetics provision in particular in AMH is lacking.

## 4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
Safe staffing is a fundamental standard, and must be assured.

4.2 **Financial/Value for Money:**
Staffing pressures have led to an increase in use of bank staff and the introduction of agency staff for the first time, whose costs have had to be absorbed by the service. There are number of processes and actions which are in place to reduce and eventually ameliorate the position.

4.3 **Legal and Constitutional (including the NHS Constitution):**
None identified.

4.4 **Equality and Diversity:**
None identified.

4.4 **Other implications:**
None.

## 5. RISKS:

Safe staffing levels are on the risk registers of the

## 6. CONCLUSIONS:

The service has responded to a sustained and prolonged staffing pressure through a series of short and medium term actions to ensure safe staffing and good patient outcomes and experience.

## 7. RECOMMENDATIONS:

For Trust Board to review and comment on the progress to date within North Yorkshire in response to staffing pressures.

**Author** **Tim Cate and Craig Hill**

**Title** **Acting Director of Operations and Head Of Nursing.**

**Background and supporting Papers:**

APPENDIX 1 - Table of Issues and Actions

**Item 10**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **04 July 2017** |
| **TITLE:** | **Finance Strategy April 2017 to March 2019** |
| **REPORT OF:** | **Drew Kendall, Interim Director of Finance and Information** |
| **REPORT FOR:** | **Information and approval** |

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

## Executive Summary:

The Finance Strategy for the period April 2017 to March 2019 was presented to 13th June 2017 Resources Committee and subject to a number of minor changes, which are included in the attached, it was recommended for Board of Directors approval.

The Finance Strategy supports a number of strategic goals but specifically focusses on 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.

The strategy scorecard proposes the key metrics to support delivery of the financial strategy.

## Recommendations:

The Board of Directors are asked to note the content of the Finance Strategy and to comment accordingly.

The Board of Directors are asked to approve the Finance Strategy.

# Finance Strategy

## 2017-2019



| | | |
|---|---|---|
| **Strategy Sponsor:**<br>Drew Kendall (Director of Finance and Information) | | |
| **Strategy Lead:**<br>Drew Kendall (Director of Finance and Information) | | |
| **Version:**<br>1 | **Date approved** | **Date of Next Review:**<br>April 2019 |

# Preface

This document is Tees, Esk and Wear Valleys NHS FT (TEWV) Finance Strategy for the period April 2017 to March 2019.

The Trust needs to have in place a Finance Strategy that underpins the strategic goals of the organisation and is reflective of the environment that it operates in; and whilst it supports a number of strategic goals this strategy focusses on 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.***

TEWV is in a stable financial position and has consistently delivered its financial plan since its formation in 2006; despite continued pressures and rising demand across all areas of the NHS. This has been achieved through a combination of good financial control and delivery of annual recurrent cash releasing efficiency savings (CRES); which have been sufficient to fund inflationary pressures and meet the business plan priorities.

The Trust strategy could be summarised as a **"surplus for a purpose"**. Specifically the Trust surplus has been used to generate cash to invest in the estate and technology with over £100m being invested since 2008 in the capital infrastructure; excluding the PFI schemes.

This strategy will build on this strong position and make sure that the Trust can continue to invest in quality and sustain financial stability in the medium to long term.

Should you require any further information on the detail of the Finance Strategy then you should contact Drew Kendall, Director of Finance and Information (drew.kendall@nhs.net).

## Director of Finance and Information

## Contents

# 1. Where are we now

Since being authorised as a Foundation Trust in July 2008 the Trust has continued to build on its strong underlying financial position. This is demonstrated through:

### Financial Stability

- TEWV has achieved or exceeded its financial plan year on year;
- Has grown its turnover by £112m despite the challenging efficiency requirements by;
    - Successful tenders to provide MH & LD services to Craven, Harrogate, Hambleton and Richmondshire and York & Selby;
    - Awarded regional contract for Adult and Children Inpatient Eating Disorder Service;
    - Increased Forensic Service Capacity at Roseberry Park Hospital;
    - Awarded Offender Health contract to provide health services into prisons.

### Capital Investment

- Provided £113m capital investment to improve the quality of patient care;
- PFI Investment in two hospitals Roseberry Park £75m and Lanchester Road £18m.

### Cash Releasing Efficiency Savings (CRES)

- Delivered £73m required recurrent savings including:
    - Voluntary termination of the West Park Hospital PFI contract – **The first in the NHS** Saving £14million;
    - Inpatient bed reductions Saving over £20m.

### Clinical Engagement

- To support mental health Currency and Tariff development the finance department has appointed a range of clinical staff to support its implementation and to enhance clinical engagement. This team have developed an information dashboard as part of the Integrated Information Centre for clinicians to view live key performance data to improve patient care and help support the reduction of variation across clinical services.

### Currency and Tariff Development

- The Trust has had key representation on national work stream groups to contribute to the currency and tariff development agenda;
- The latest Reference Cost at 95, demonstrates the Trust is more efficient than the national average.

In addition this position has allowed new investments in services, Trust business priorities and improvements in quality to take place against a background of low levels of financial risk.

This strategy plans to build on the strong underlying financial position from previous years with our most recent financial year (2016/17) objectives, both planned and achieved, are shown in the following table:

| Objectives | Outcomes |
|---|---|
| Delivering a £8.1m financial surplus | Financial surplus of £19.2m realised |
| Delivering an EBITDA of £22.6m | EBITDA of £34.8m delivered |
| Achieving an NHSI use of resources rating of 1 | Calculated rating of 1 achieved |
| Delivery of £6.6m cash releasing efficiency savings | Delivery of £6.7m cash releasing efficiency savings |
| EBITDA margin of 6.9% | EBITDA margin of 10.1% achieved |

The Trust planned an operating surplus of £8.1m for the financial year and realised a surplus of £19.2m. The surplus was higher than planned mainly due to additional Sustainability and Transformation incentivised Funding (STF) received centrally from NHS Improvement, contract variations with commissioners and lower than anticipated pay expenditure.

The Trust's performance against NHS Improvement's compliance regime is shown in the table below:

| | Performance | Rating |
|---|---|---|
| Capital Service Cover | 2.47x | 2 |
| Liquidity | 49.9 days | 1 |
| I&E Margin | 6.48% | 1 |
| I&E Margin variance from plan | 3.41% | 1 |
| Agency | -6.32% | 1 |
| Overall rating | | 1 |

However, to sustain this will be more challenging. The local health economy in Durham, Darlington, Teesside, North Yorkshire and York continues to be challenging with most CCG's experiencing some financial pressures linked to Acute Trust activity and overall delivery on QIPP (Quality Innovation Productivity and Prevention) efficiency savings. NHS England Specialised Services budgets continue to be under financial pressure primarily due to rises in acute sector activity and cost but overall the sector is expected to set a balanced budget.

At a national level the allocations to the NHS have been increased in the form of a Sustainability and Transformation Fund, which continues to support providers moving to a stable financial footing over the current planning round to 2019.

The current planning round of 2017-19 Mental Health contracts are being developed to support the move away from block contracts to a payments system, as part of the implementation of national Mental Health currencies; which looks to incentivise a greater focus on clinical outcomes. In doing so the Trust will identify the associated impact and risk in order that this can be factored in to the financial planning process to ensure ongoing future financial stability.

## 2. Environmental Analysis and the drivers for change

In developing this strategy the Trust has considered and assessed the relevant government and regulatory policies in order to determine the likely level of change in the following fields during the lifetime of the strategy:

- Political
- Economic
- Social and Demographic
- Technological
- Legal and Regulatory
- Environmental

This has built on the work done by the Trust when compiling the Trust Business Plan.

Key areas of the PESTLE that the strategy will focus on include:

- Delivery of the Trust's Financial Plan;
- Achievement of NHS I set control total to support provider return to a balance;
- Implementation of Five Year Forward View;
- Championing mental health and LD services within our regions through our ongoing engagement within Sustainability and Transformation Partnerships and Accountable Care Partnerships
- Achieve parity of esteem through Mental Health Investment Standard;
- Continue to monitor future economic position and understanding of impact of Brexit.

A full analysis of the key implications of the PESTLE is included at Appendix 1.

### National position

Early indications of 2016/17 performance suggests that most trusts and Clinical Commissioning Groups (CCGs) performed as well or better in 2016/17 than they expected at the beginning of the financial year. For trusts the main contributor of the positive variance was higher than planned sustainability and transformation fund payments. For CCGs this was due to the release of a 1% risk reserve held by NHS England.

The aim at a national level is to return the provider sector to a balanced position by March 2019. However, 2016/17 outturn suggest a provider aggregate deficit of c. £800m, meaning the sector is already behind the trajectory needed. Having already invested a large amount of the £8bn sustainability and transformation fund set aside in 2015/16 the expectation is for providers to make significant savings.

To support the recovery of NHS finances nationally for the first time in 2016/17 providers operated under control totals; and the Trust has again agreed to sign up to the NHS Improvement 'ask' for 2017/18 and 2018/19. In doing so the Trust will have access to £1.9m funding available through the sustainability and transformation fund. This is only accessible by the Trust upon meeting its control total and containing agency expenditure.

The Next Steps on the Five Year Forward View outlines a 10 point plan for the next two years to increase efficiency in the NHS. Whilst the Trust will be impacted by all of the points raised the following are a number of key areas to take into account:

- Further reductions in hospital beds expected;
- Further efforts to reduce temporary staffing costs;
- Requirement to participate in the Carter Nationally Contracted Products programme;
- Reduction of unwarranted variation in clinical quality and efficiency;
- Reduce the cost of corporate services and admin.

In recent years there has been a sustained focus at a national level to address the lack of parity between mental health and physical health services. The Five Year Forward View for Mental Health sets out an ambitious and challenging agenda to deliver a range of improvements in a set of 58 recommendations. Whilst commissioners have been required to increase spending funding has not always made its way to frontline services. The Trust continues to push the agenda to achieve Mental Health Investment Standard but this will be challenging against a backdrop of growing financial pressure within CCGs and their prioritisation of the acute sector.

The impact of Brexit on the NHS is currently unclear and will be kept under review as part of the Trust PESTLE analysis. The current factors being considered include ability to recruit and retain workforce from the EU and contract prices and inflation influenced by the strength of the pound.

## Overview of TEWV Foundation Trust

TEWV provides a range of inpatient and community mental health and learning disability services for approximately 2 million people of all ages living in County Durham, Darlington, the four Teesside boroughs of Hartlepool, Stockton, Middlesbrough and Redcar and Cleveland, the Scarborough, Whitby, Ryedale, Hambleton, Richmondshire, Selby and Harrogate areas of North Yorkshire, the City of York and the Wetherby area of West Yorkshire. Our specialist services also serve other local health economies.

Whilst TEWV is in a stable financial position and has consistently delivered its financial plan since its formation in 2006 pressures and rising demand across all areas of the NHS are increasing. The delivery of annual recurrent cash releasing efficiency savings (CRES) is becoming more difficult and challenging. It is crucial that this financial strategy provides the basis to quality improvement and sustainability.

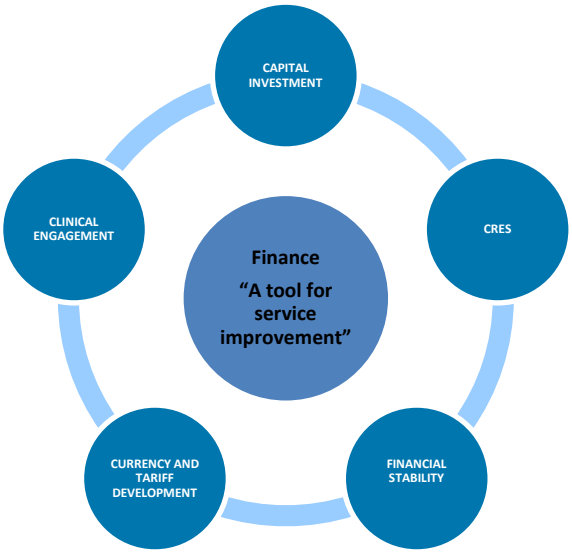
## 3. Our Vision – where do we need to be

The Trust's vision is:

***To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations.***

In support of this vision the finance strategy is:

***Finance - a tool for service improvement in enabling TEWV to be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations.***




In the face of significant financial challenge in order to remain sustainable we will continue to control costs whilst enabling change. We will do this through achieving efficiency gains and developing new ways of delivering services.

We will make better use of the estate, data and technology in delivering safe, effective and sustainable Trust services.

# 4. Objectives

***Finance – 'a tool for service improvement'.***

The finance strategy will support the delivery of the Trust's vision and strategic goals and vision through a number of objectives as follows:

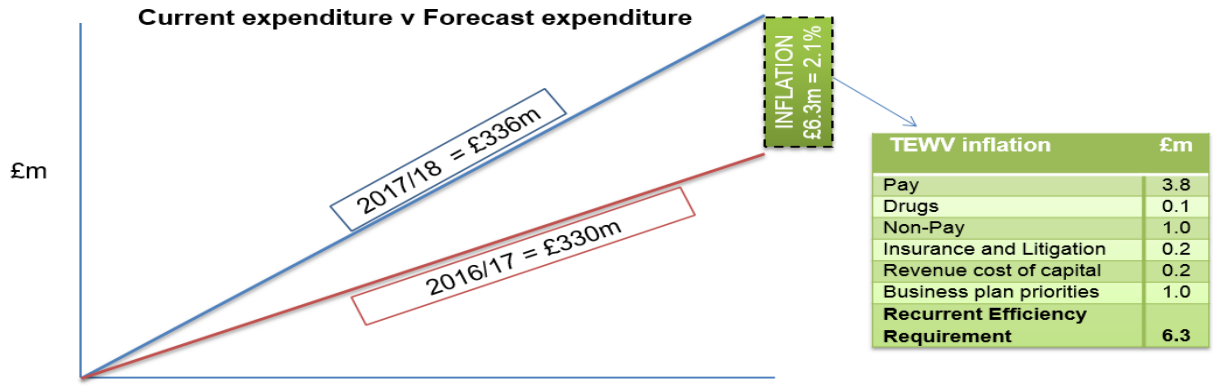
- To continue to plan and build on and maintain financial stability;
- To maintain a discipline of good financial management and budgetary control;
- To challenge ourselves to improve quality whilst meeting the NHS annual cash releasing efficiency savings targets year on year;
- To generate cash to invest in the estate and technology;
- To build on clinical engagement into finance matters to support improved clinical outcomes
- To use finance as an enabler on the purposeful and productive services agenda which supports the reduction of unwarranted clinical variation; and helps us to redesign systems and eliminate waste
- To engage with the established STPs and influence their plans;
- To support the development of the Accountable Care Partnership across Durham and Teesside currently and other models of care as they develop.

The finance strategy specific objectives within the NHS Improvement annual plan over the period April 2017 to March 2019 are set out below:

| 2017/18 | 2018/19 |
|---|---|
| Delivering a £10.1m financial surplus | Delivering a £10.1m financial surplus |
| Delivering an EBITDA of £23.0m | Delivering an EBITDA of £24.2m |
| Achieving an NHSI use of resources rating of 1 | Achieving an NHSI use of resources rating of 1 |
| Delivery of £8.3m cash releasing efficiency savings | Delivery of £6.3m cash releasing efficiency savings |
| EBITDA margin of 7% | EBITDA margin of 7.3% |
| Investment in capital of £13.5m | Investment in capital of £37.3m |

The biggest and most important objective to achieve financial stability for the Trust will be to deliver the required annual recurrent CRES savings; which will need to be sufficient to fund inflationary pressures and meet the business plan priorities.

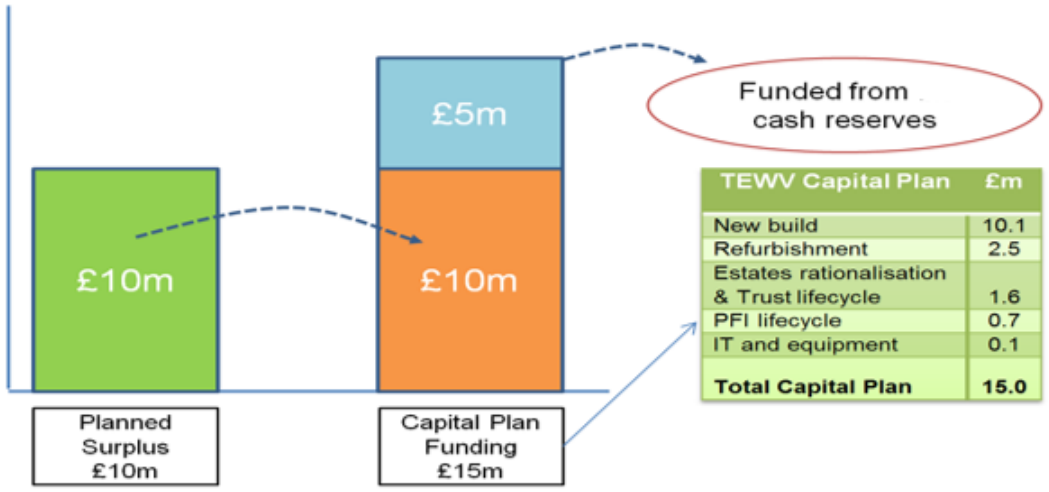
An illustration of the efficiency requirement for a typical financial year; which is how CRES targets are set is shown below:




| TEWV inflation | £m |
|---|---|
| Pay | 3.8 |
| Drugs | 0.1 |
| Non-Pay | 1.0 |
| Insurance and Litigation | 0.2 |
| Revenue cost of capital | 0.2 |
| Business plan priorities | 1.0 |
| **Recurrent Efficiency Requirement** | **6.3** |

During the next 5 years the Trust plan is to continue to invest in the estate and the quality of its services (£75.2m) and as such the need to maintain headroom in the financial position will be an important factor in achieving this plan. With sources of finance outside of the Trust's own resources being limited it is vital that the retained earnings are sufficient to meet the funding requirements.

The "surplus for a purpose" concept is illustrated below for a typical financial year to fund a £15m Capital Expenditure programme. This would include costs relating to new buildings, refurbishment of existing estate and equipment.




| TEWV Capital Plan | £m |
|---|---|
| New build | 10.1 |
| Refurbishment | 2.5 |
| Estates rationalisation & Trust lifecycle | 1.6 |
| PFI lifecycle | 0.7 |
| IT and equipment | 0.1 |
| **Total Capital Plan** | **15.0** |

The Finance Strategy will ensure that the Trust is able to undertake robust analysis of proposals put forward in order to make the appropriate investment decisions in the interest of delivering safe, effective and sustainable Trust services. It will make those decisions in line with its statutory obligations under the NHS Improvement's (NHSI) Single Oversight Framework; as well as being compatible with their best practice advice and guidance.

The Trust's Quality Improvement System methodology will be essential to help improve the quality and value of services we provide by looking at existing ways of operating, removing waste from processes and maximising activities that add value. It has already helped to deliver the underlying finance objectives and will be a key mechanism for addressing the financial challenges of reducing unwarranted clinical variation, further rationalisation and

reconfiguration of hospital beds, reducing temporary staffing costs and reducing the cost of corporate services and admin, to name a few.

We will continue to champion mental health and LD services within our regions through our ongoing engagement within Sustainability and Transformation Partnerships and Accountable Care Partnerships. This alongside the move away from block contracts to a system that looks to incentivise a greater focus on clinical outcomes to ensure that clinical quality and patient experience is at the heart of what we do.

## 5. Outcomes Scorecard

| Financial Strategy Scorecard | | | | | | | |
|---|---|---|---|---|---|---|---|
| Metric | | Lead Responsible | Baseline 16/17 | Targets | | | |
| | | | | 17/18 | 18/19 | 19/20 | Source of data |
| **1.Deliver financial targets in line with NHS Improvement control total and financial plan** | | | | | | | |
| 1 | Delivery of control total in full as per NHS Improvement financial plan | Director of Finance and Information | £19.2m surplus | £10.1m surplus | £10.1m surplus | £10.1m surplus | Trust finance ledger (Oracle Financials) and IIC. Reported routinely through EMT/Board/Resources Committee |
| 2 | Delivery of EBITDA in full as per NHS Improvement financial plan | Director of Finance and Information | £34.8m | £23.0m | £24.2m | £24.2m | Trust finance ledger (Oracle Financials) and IIC. Reported routinely through EMT/Board/Resources Committee |
| 3 | Maintain an EBITDA margin OF 7% | Director of Finance and Information | 10.1% | 7% | 7% | 7% | Trust finance ledger (Oracle Financials) and IIC. Reported routinely through EMT/Board/Resources Committee |
| 4 | Contain agency expenditure within agreed limit | Director of Finance and Information | £6.7m | £5.8m | £5.8m | £5.8m | NHS Improvement monitoring returns. Reported routinely through EMT/Board/Resources Committee |
| 5 | Achieving an NHSI use of resources rating of 1 to retain the Trust's earned level of autonomy | Director of Finance and Information | 1 | 1 | 1 | 1 | NHS Improvement monitoring return. Reported routinely through EMT/Board/Resources Committee |

| Financial Strategy Scorecard | | | | | | | |
|---|---|---|---|---|---|---|---|
| Metric | | Lead Responsible | Baseline 16/17 | Targets | | | |
| | | | | 17/18 | 18/19 | 19/20 | Source of data |
| **2. Deliver recurrent CRES savings sufficient to fund inflationary pressures and meet the business plan priorities** | | | | | | | |
| 1 | Delivery of cash releasing efficiency savings as per NHS Improvement Financial Plan | Director of Finance and Information | £6.7m | £8.3m | £6.3m | £6.3m | Trust finance ledger (Oracle Financials) and IIC. Reported routinely through EMT/Board/Resources Committee |
| 2 | To achieve a reference cost index less than or equal to 95 | Director of Finance and Information | 95 | 95 | 95 | 95 | Trust costing system and IIC. Reported routinely through EMT/Board/Resources Committee |
| **3. Generate a cash surplus sufficient to cover investment in the capital programme** | | | | | | | |
| 1 | Achieve planned cash balances held by the Trust | Director of Finance and Information | | | | | Trust finance ledger (Oracle Financials) and IIC. Reported routinely through EMT |
| 2 | Investment of cash surplus in capital programme | Director of Finance and Information | £8.6m | £13.5m | £37.3m | £20.1m | Trust finance ledger (Oracle Financials) and IIC. Reported routinely through EMT |
| **4. To provide education and training to all identified budget holders in order to improve finance knowledge for greater financial management and control** | | | | | | | |
| **1** | To deliver financial management training to all budget holders | Locality Accountants | Not available | 50% | 75% | 100% | Training register held in Finance |

## 6. Glossary

| Term | Description |
|---|---|
| Capital Expenditure | Expenditure in relation to purchase or development of buildings, plant and equipment >£5k |
| Capital Service Cover | Assesses the operating surplus generated to ensure the Trust is able to cover all debt repayments due in the reporting period. |
| CCG | Clinical Commissioning Group |
| CRES | Cash Releasing Efficiency Savings - NHS providers are required to deliver savings sufficient to meet the cost of inflation above funding allocations |
| Deficit | The amount of expenditure greater than income received i.e. loss |
| EBITDA | Earnings before interest, tax, depreciation and amortisation - the surplus from operations |
| Financial Plan | A plan of how the Trust's funding allocation will be spent and used over a set period in order to achieve strategic goals and objectives |
| Forecast | The future expected position e.g. surplus / deficit. All prior months reflect actual performance. |
| I&E Margin | Assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. |
| Liquidity | Assesses "liquid" assets and liabilities (those expected to clear within the year) to determine how many days operating expenses can be funded if the Trust ceased trading today. |
| Recurrent | A transaction or action that is in place on an ongoing basis |
| Reference Cost Index | A measure of the relative efficiency of NHS providers - 100 being average |
| Revenue Expenditure | Expenditure in relation to day to day operations e.g. salaries, drugs, utilities |
| Surplus | The level of income remaining after costs i.e. profit |
| Target | The planned position the Trust is responsible for achieving. |
| Turnover | The level of income the Trust has for a financial year |
| UORR | The risk rating NHS Improvement use to assess a Trusts financial stability. |
| Variance from plan | Assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. |

## 7. Appendix 1 – PESTLE

| | Description of the issue | What could the consequence be? | What are we doing already? |
|---|---|---|---|
| Political 1 | Implementing the 5 Year Forward View for Mental Health | Potential new funding in primary care psychological therapies, employment support for people with MH etc.<br><br>Softening of purchaser-provider split through new models of care (NMOC). | CAMHS T4 New Models of Care (NMOC) pilot; bid for Forensic NMOC pilot and Accountable Care Partnership.<br><br>Intensive Team Support clinical lead identified<br><br>Pilots of TEWV clinicians placed within GP practices in South Durham and Catterick |
| P2 | Prime Minister's priorities – Theresa May known to want to prioritise CAMHS (though with emphasis on schools) and workplace MH.<br><br>Both Conservative and Labour election manifestos promise extra money for health and social care, but not at the historic 4% p.a. uplift that health economists argue is necessary to meet increasing demand | Theresa May known to want to prioritise CAMHS (though with emphasis on schools) and workplace MH. Some protection for MH budgets due to NHSI monitoring of the issue<br><br>Continued pressure on NHS budgets regardless of June 8th election result | Recent investment by CCGs into 24/7 CAMHS Crisis & Intensive Home Treatment services and seeking better VFM from specialist CAMHS spend through NMOC<br><br>Planning to deliver to NHSI set control totals<br>Planning to achieve CRES requirements on a recurring basis |
| P3 | Sustainability and Transformation Plans – TEWV split over 4 STPs, which have lack of any focus on MH.<br><br>The most advanced STPs will aspire to be an Accountable Care System (ACS) and work as a locally integrated health system, taking on clear collective responsibility for resources | Was a danger of STPs looking for one MH provider each – this has been mitigated in north of patch by moves to create one STP for whole of North East and North Cumbria<br><br>ACSs may lead to establishment of Accountable Care Organisations. This is where commissioners have a contract with a single organisation for the majority of health and care services. | Engaging with the established STPs and influencing their plans.<br><br>Support the development of the Accountable Care Partnership across Durham and Teesside currently and other models of care as they develop. |
| P4 | End of nursing bursaries | Pressure on providers to subsidise courses themselves or to offer starting bonuses. | TEWV has considered paying recruitment bonuses on some parts of our patch and now only offers permanent nursing |

| | | | |
|---|---|---|---|
| | | Possible nursing shortages if numbers on courses fall | post contracts even when the post is temporary. |
| P5 | Terrorism / e-crime | Pressure on services / financial loss. Also reputational damage if a TEWV service user were ever to be involved in any such incident. | Emergency planning<br>IT security measures<br>Prevent duties awareness training for relevant clinical staff |

| | Description of the issue | What could the consequence be? | What are we doing already? |
|---|---|---|---|
| Economic 1 | NHS Financial position<br><br>Funding and Efficiency – the 5YFV – Next steps outlines a 10 point plan to increase efficiency in the NHS. This includes:<br>Reduce hospital beds<br>Reduce temporary staffing costs<br>Participate in the Carter programme for procurement clout<br>Reduce unwarranted variation in clinical quality and efficiency<br>Reduce the cost of corporate services and admin | Latest provider deficit figures are c.£800m<br><br>CCGs also under pressure with Vale of York in Special Measures<br><br>The Trust has already delivered recurrent savings year on year in most of these areas and therefore some of the controls and targets set could be a challenge and therefore bring reduced autonomy and increased monitoring by NHSI. | Planning to deliver to NHSI set control totals<br>Planning to achieve CRES requirements on a recurring basis<br><br>Plans in place and trust goals set to deliver purposeful and productive services e.g. PIPA, PPCS<br><br>Providing information at a national level on benchmarking corporate services. Watching brief on others who have already gone down the contracted out services route. |
| Eco 2 | Pensions | The NHS Pension scheme was amended by the Coalition government and contributions made since April 2015 are on a career average, not final salary basis. It is planned that employers' contributions will rise in 2019 from 14.38% to 16.37% and a revaluation of the scheme is due next year. Post 2022 "protection" runs out and the normal retirement age will be tied to the state pension age (which will be 67 or higher).<br><br>To reduce running costs, the Department of Health is proposing to transfer administration of the scheme to health providers. If this takes place there could be a £200k additional cost to TEWV. If | Retire and Return scheme approved by EMT<br><br>Increases in cost constantly reviewed to ensure efficiency requirements are understood |

| | | | |
|---|---|---|---|
| | | employers and employee contribution rates continue to rise there may start to be issues around sustainability. | |
| Eco 3 | Apprentice Levy | An apprenticeship levy for all employers commences in April 2017. Public sector organisations will be expected to have apprentices constituting 2% of workforce. There is a financial pressure of approx. £1m although this pressure applies to all employers and so all providers will be affected. | EMT has been considering options for mitigating this levy and have a digital drawdown account in place to ensure the Trust maximises the amount of levy that can be offset against existing training schemes, as well as future new schemes through the regional Apprentice Levy Group. |
| Eco 4 | Impact of choice – patients can choose where they want to receive treatment | Patients, particularly those close to the boundaries of neighbouring providers could choose to go out of Trust, or internally out of locality creating pressure on both service standards and financially. | Plans in place and trust goals set to deliver purposeful and productive services in a standard way. This should reduce unwarranted variation in clinical quality and efficiency, therefore reducing risk of patient choice impact. |
| Eco 5 | Increased pressure and expectation in social care and independent sector providers | This issue could result in increased pressure in NHS services particularly in the transfer of patients in older peoples services and LD to more appropriate care settings | Engaging in the Transforming care agenda and delivery of enhanced community care in older persons services. |

| | Description of the issue | What could the consequence be? | What are we doing already? |
|---|---|---|---|
| Social 1 | Brexit | The status of EU nationals living in the UK is still unclear (and vice versa). This could impact on TEWV staff from the EU.<br><br>The value of the pound has fallen by approx 12% against the Euro and US Dollar. This is feeding through to inflation, which we see in products such as IT equipment and software<br><br>Economic growth has continued at around 0.6% pa but has slowed in the last quarter. | The Trust has communicated that it values our EU staff,<br><br>We are running a medic recruitment campaign in India<br><br>Inflationary pressures will continue to be reviewed and CRES requirements set accordingly. |
| S2 | Increased referrals (due to reduced stigma around MH; possible increased prevalence due to economic and social issues; and reduced capacity of primary care to cope with "borderline" patients | Increased demand for services but no additional income. | Introducing more sophisticated monitoring of referral trends in summer 2017<br><br>Continue to work with commissioners to develop services fit for the demographics of the population the Trust serves and meet MH minimum investment standards.<br><br>PPCS / QIS work to increase team efficiency to support patient flow and demand management. |
| S3 | Patient expectations e.g.<br>Individual / personalised care<br>Access to services i.e. expecting services closer to home<br>7 day services – work life balance | Increased demand for services but no additional income. | PPCS / QIS work to increase team efficiency to support patient flow and demand management.<br><br>Enhanced monitoring of patient experience<br><br>Improving access to services |

| | Description of the issue | What could the consequence be? | What are we doing already? |
|---|---|---|---|
| Technological 1 | NHS Digital Roadmap | TEWV bid for Digital Exemplar funding was unsuccessful but facilitated the development of a new IT Strategy and Digital Programme. | Clear 18 month development timeline for PARIS in place. Clinicians engaging in PPCS observations will help define future requirements. PPCS recognises that financial savings will rely on staff time spent on data entry to be reduced. |

| | Description of the issue | What could the consequence be? | What are we doing already? |
|---|---|---|---|
| Legal / Regulatory 1 | CQC - new Inspection Strategy says that inspections and intelligent monitoring will remain core to their approach, but that their resources will be directed more towards poor services and away from those where "care quality is good and likely to remain so"[1].<br><br>The CQC's Board have stated that, while it recognises that providers are facing a "tight financial environment", it will not be "flexing" its regulatory approach in response, and will not "inflate" ratings to assist NHS cost-cutting | CQC may continue to make binding recommendations which TEWV would regard as poor value for money | Seeking to increase CQC understanding of TEWV and of QIS.<br><br>Develop estate solutions that allow us to exit sub-standard facilities in Northallerton, York and Harrogate which are not owned by TEWV.<br><br>Mock inspection programme |
| L2 | Safe Staffing | There is a risk that any review of staffing establishments in line with national standards and evidence based guidance (once produced) will be unaffordable and / or impossible to implement due to shortages of qualified nursing staff. | Identified as a TEWV Business Plan Strategic Priority. Programme Manager appointed June 2017. |

[1] Shaping the Future: CQC's Strategy for 2016-2021 p6 (www.cqc.org.uk/ourstrategy)

| | Description of the issue | What could the consequence be? | What are we doing already? |
|---|---|---|---|
| Environment 1 | In December 2015 a new global climate deal was signed in Paris. This committed governments to seeking to limit global temperature rises to 1.5 degrees Celsius. The implication of this is that the global economy will need to be carbon neutral by 2050, and possibly earlier. Although the USA federal government is seeking to withdraw from the agreement, most other developed and developing nations around the globe (and large US states and cities) are maintaining their support for it | During 2016 global temperature records have been broken several times. One of the likely impacts of this for the UK will be increased instances of intense rainfall. There was such a rainfall episode over Christmas 2015 which resulted in widespread flooding – including in York where Bootham Park's basement flooded and transport and telephony in the City were seriously affected for several days.<br><br>This could lead to:<br>Operational service delivery issues<br>Estate rectification costs<br>More expensive design requirements for new builds<br>Increased insurance costs<br>Increased energy costs<br>Public pressure to demonstrate commitment to carbon reduction (not currently a political priority but may increase, particularly if prosperity increases) | Considering flood risk in our York hospital options appraisal<br><br>Some use of ground source heat pumps and solar panels in TEWV estate. |

## 7a. Appendix 2 – useful links

### Single Oversight Framework

### Five Year Forward View

### Five Year Forward View for Mental Health

### Next Steps for Five Year Forward View

## 7b. Appendix 3

### Trust Financial Strategy – Guide for Frontline Staff

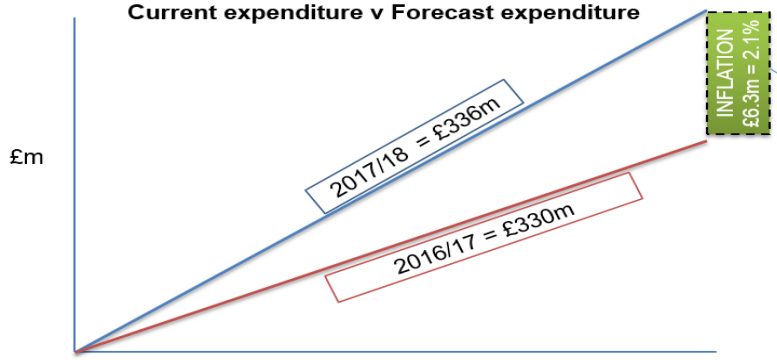
The purpose of this paper is to present a summary overview of the Trust Financial Strategy for use with front line staff.

The Trust needs to have in place a financial strategy that underpins the strategic objectives of the organisation and is reflective of the environment that it operates in.

**If this is not the case it is unlikely that the Trust would remain financially viable in the medium term.**

### TEWV Financial Plan and Strategy

TEWV has consistently delivered its financial plan since its formation in 2006. This has been through a combination of good financial control and delivery of annual recurrent cash releasing efficiency savings (CRES); which have been sufficient to fund inflationary pressures and meet the business plan priorities. An example of the efficiency requirement for a typical financial year which is how CRES targets are set is shown below:




| TEWV inflation | £m |
|---|---|
| Pay | 3.8 |
| Drugs | 0.1 |
| Non-Pay | 1.0 |
| Insurance and Litigation | 0.2 |
| Revenue cost of capital | 0.2 |
| Business plan priorities | 1.0 |
| **Recurrent Efficiency Requirement** | **6.3** |

### TEWV Capital Investment

The Trust strategy could be summarised as a **"surplus for a purpose"**. Specifically the TEWV surplus has been used to generate cash to invest in the estate and technology with over £100m being invested since 2008 in the capital infrastructure; excluding the PFI schemes. The "surplus for a purpose" is illustrated below for a typical financial year to fund a Capital Expenditure programme. This would include costs relating to new buildings, refurbishment of existing estate and equipment.

**Item 11**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **04 July 2017** |
| **TITLE:** | **Finance Report for Period 1 April 2017 to 31 May 2017** |
| **REPORT OF:** | **Drew Kendall, Interim Director of Finance and Information** |
| **REPORT FOR:** | **Assurance and Information** |

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

## Executive Summary:

The comprehensive income outturn for the period ending 31 May 2017 is a surplus of £1,490k, representing 2.7% of the Trust's turnover and is £261k behind plan due to delays in the delivery of CRES schemes.

Identified Cash Releasing Efficiency Savings at 31 May 2017 are £1,114k behind plan however the Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years.

The Use of Resources Rating for the Trust is assessed as 3 for the period ending 31 May 2017 and is in line with plan. The 3 rating arises due to the ITFF loan repayment falling due in April 2017, which impacts on the Capital Service cover score. However, it is planned to return to a rating of 1 by the end of quarter 1.

## Recommendations:

The Board of Directors is requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

| | |
|---|---|
| **MEETING OF:** | **Board of Directors** |
| **DATE:** | **04 July 2017** |
| **TITLE:** | **Finance Report for Period 1 April 2017 to 31 May 2017** |

## 1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2017 to 31 May 2017.

## 2. BACKGROUND INFORMATION

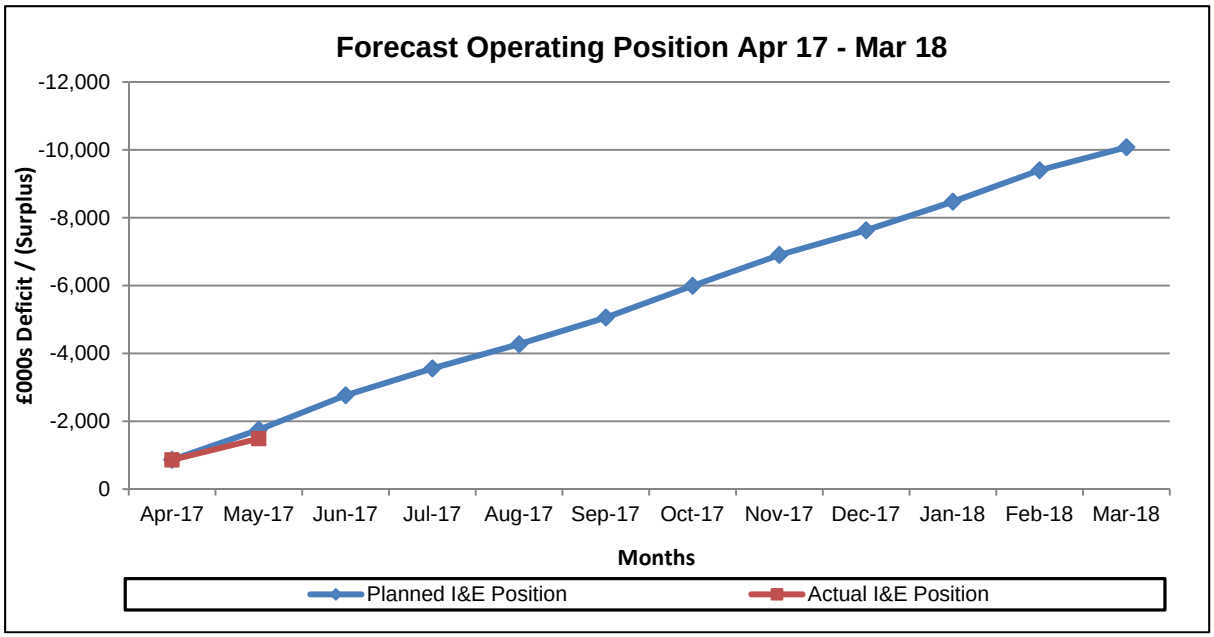
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

## 3. KEY ISSUES:

3.1 Statement of Comprehensive Income

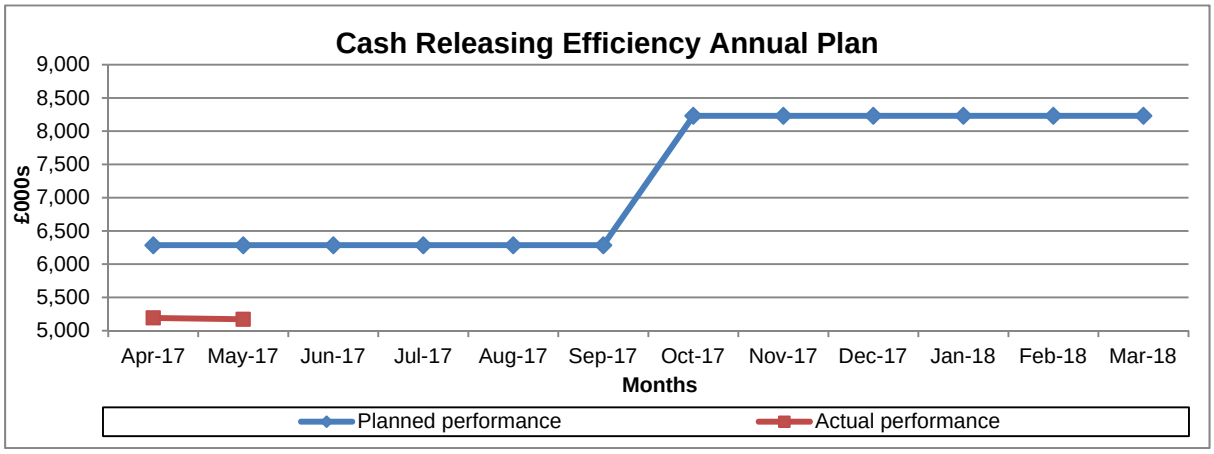
The comprehensive income outturn for the period ending 31 May 2017 is a surplus of £1,490k, representing 2.7% of the Trust's turnover and is £261k behind plan due to delays in the delivery of CRES schemes.

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

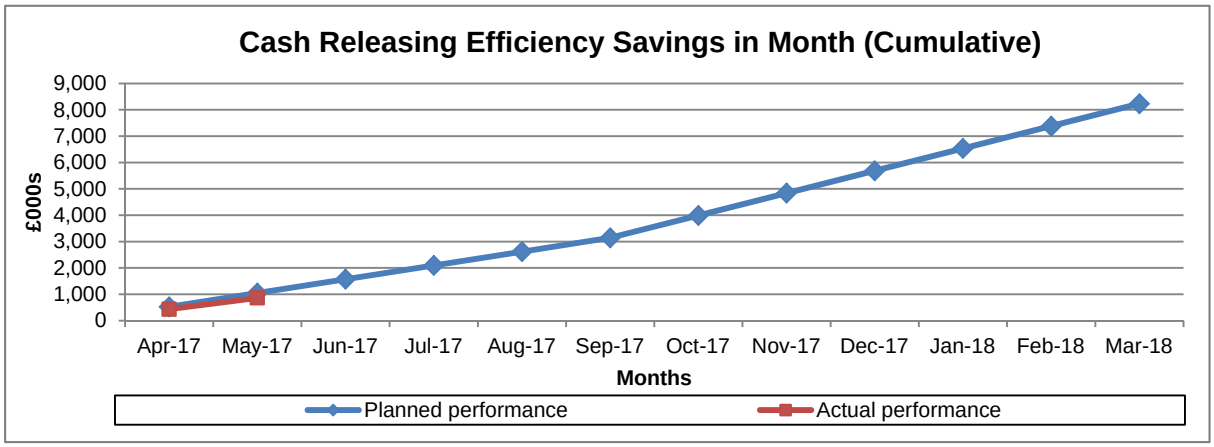


## 3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 May 2017 is £5,170k and is £1,114k behind plan, though the Trust continues to identify and progress schemes to deliver CRES in full for current and future years.

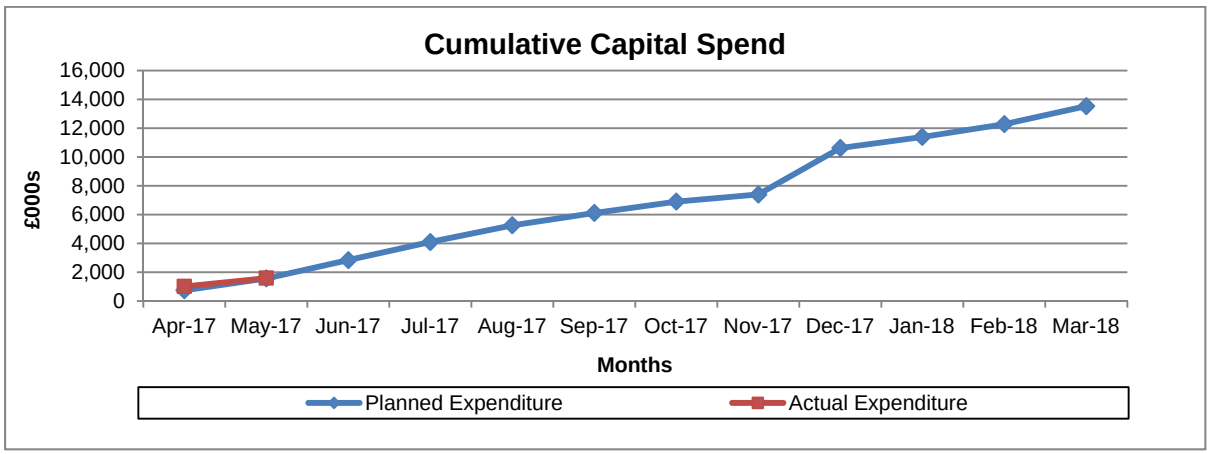



The monthly profile for CRES identified by Localities is shown below.



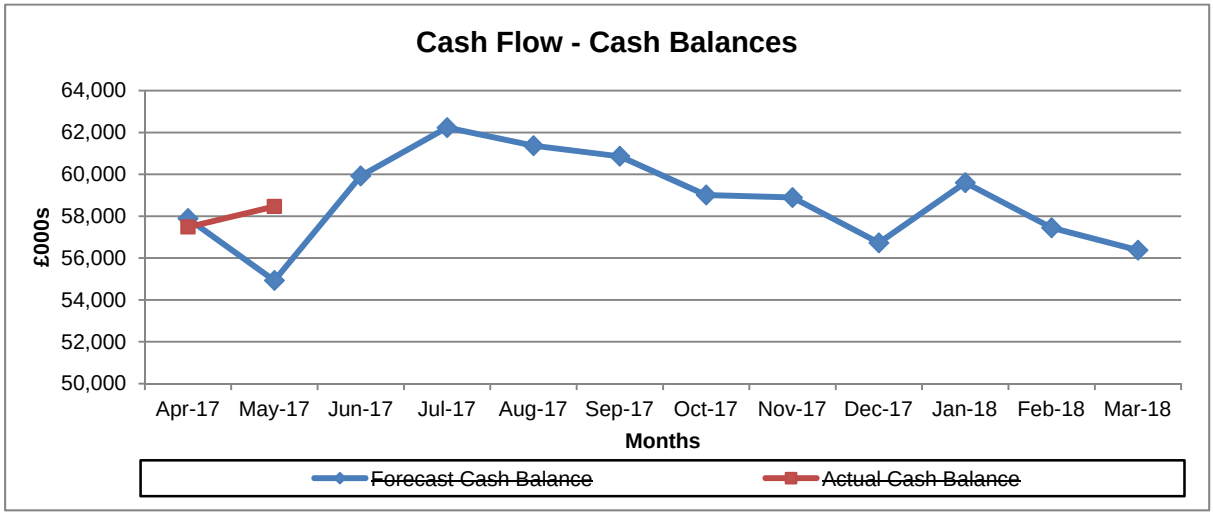

## 3.3 Capital Programme

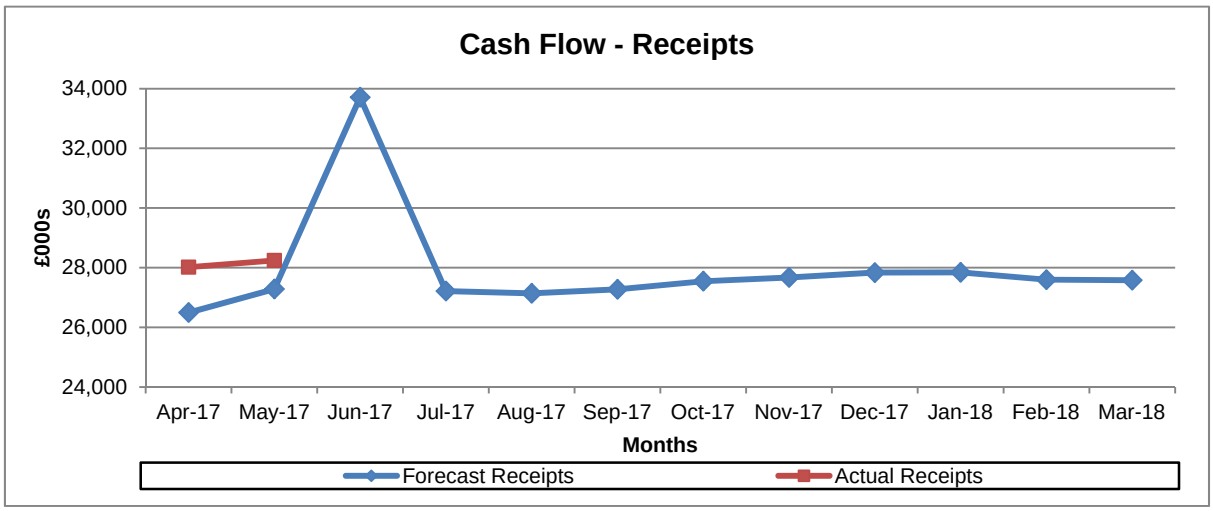
Capital expenditure to 31 May 2017 is £1,593k and is £20k ahead of plan largely due to a number of small schemes which did not complete carrying forward from 2016/17.

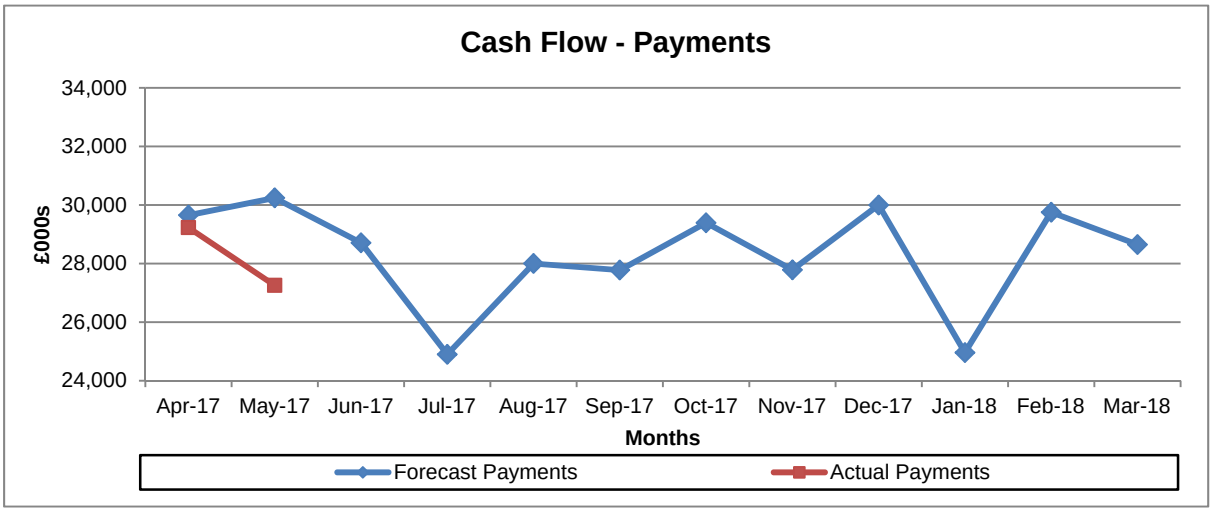


## 3.4 Cash Flow

Total cash at 31 May 2017 is £58,464k and is £3,538k ahead of plan due to working capital variations.



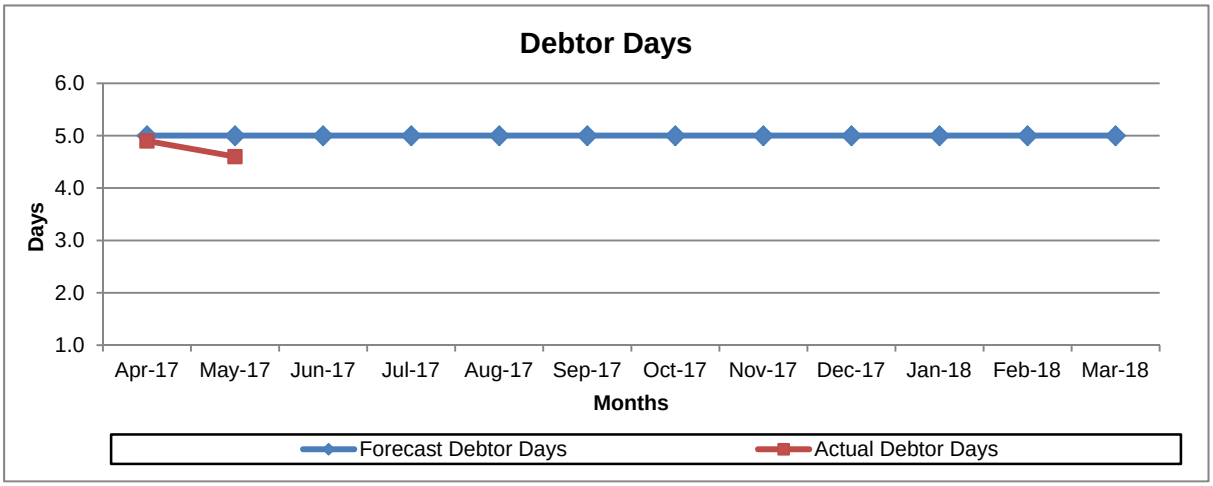



The payments profile fluctuates over the year for 2016/17 Sustainability and Transformation Fund incentive scheme receipt (June), PDC dividend payments, financing repayments and capital expenditure.

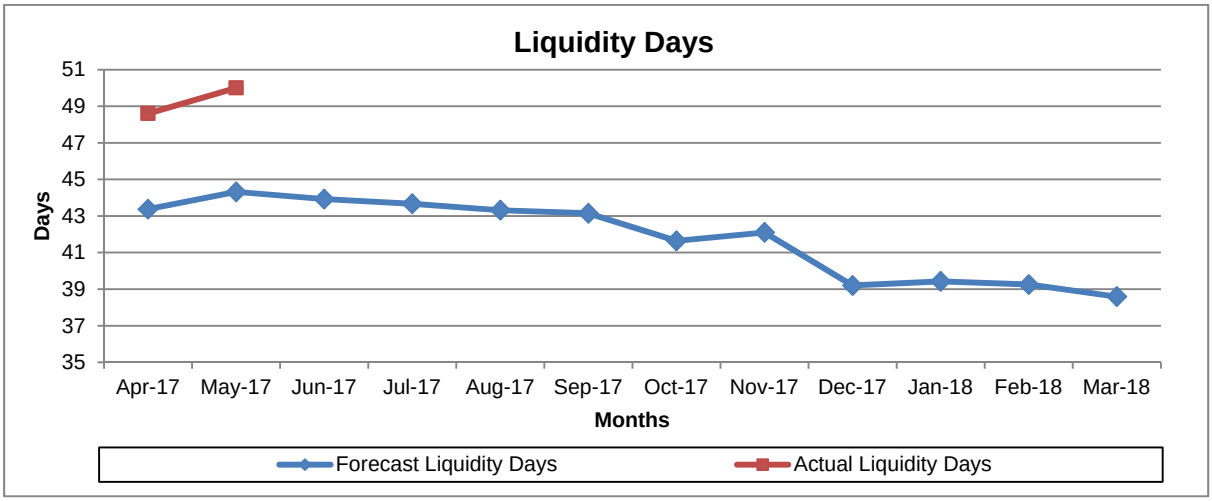
Working Capital ratios for period to 31 May 2017 are:

- Debtor Days of 4.6 days
- Liquidity of 50.0 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 67.57%
  Non NHS 30 Days – 96.74%




The Trust has a debtors' target of 5.0 days, and actual performance of 4.6 days at 31 May 2017, which is ahead of plan.

The liquidity days graph below reflects the metric within NHS Improvement's single oversight framework. The Trust's liquidity day's ratio is ahead of plan due to higher than planned cash balances as described in section 3.4.



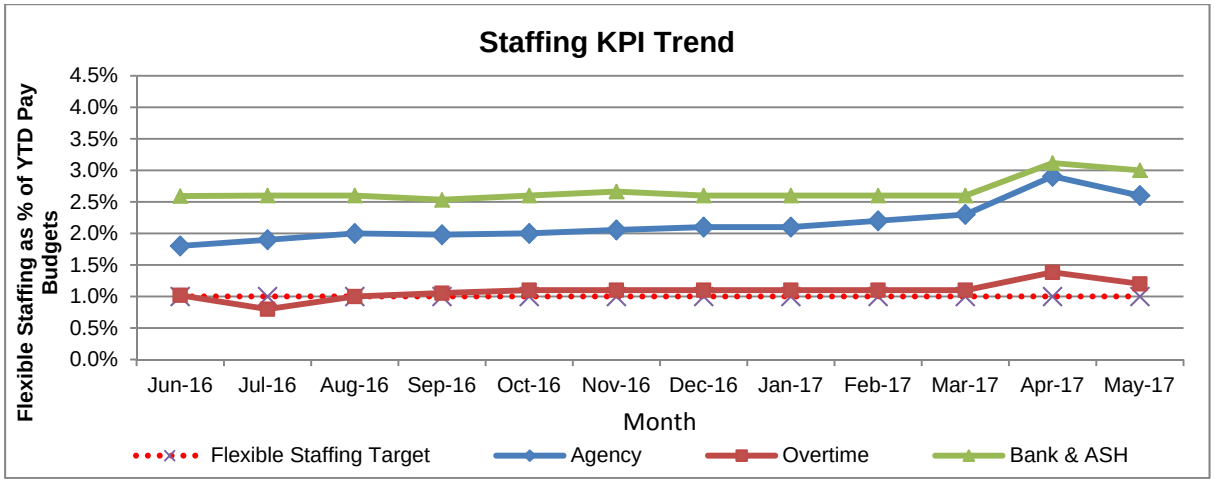

## 3.5 Financial Drivers

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

| Tolerance | Dec | Jan | Feb | Mar | Apr | May |
|---|---|---|---|---|---|---|
| Agency (1%) | 2.1% | 2.1% | 2.2% | 2.3% | 2.9% | 2.6% |
| Overtime (1%) | 1.1% | 1.1% | 1.1% | 1.1% | 1.4% | 1.2% |
| Bank & ASH (flexed against establishment) | 2.6% | 2.6% | 2.6% | 2.6% | 3.1% | 3.0% |
| Establishment (90%-95%) | 93.7% | 93.5% | 93.9% | 93.7% | 94.6% | 94.0% |
| **Total** | **99.5%** | **99.3%** | **99.8%** | **99.8%** | **102.0%** | **100.8%** |

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For May 2017 the tolerance for Bank and ASH is 4.0% of pay budgets.

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




Additional staffing expenditure is 6.8% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (41%), service need (24%), enhanced observations (17%) and sickness (10%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating is assessed as 3 at 31 May 2017, and is in line with plan.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.06x (can cover debt payments due 1.06 times), which is marginally behind and rated as a 4.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 50.0 days, this is ahead of plan and is rated as a 1.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 2.7% and is rated as a 1.

3.6.5 The variance from control total assesses the level of surplus or deficit against plan, excluding STF income. The Trust surplus is 0.5% behind plan and is rated as a 2.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is higher than the cap and is rated as a 2.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to increase to a 3 a surplus increase of £669k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £7,086k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £935k is required.
- Variance from control total from plan – to increase to a 1 an operating surplus increase of £282k is required.
- Agency Cap rating – to increase to a 1 a decrease in agency expenditure of £40k is required.

**Use of Resource Rating at 31 May 2017**

| NHS Improvement's Rating Guide | Weighting % | Rating Categories | | | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 |
| Capital service Cover | 20 | >2.50 | 1.75 | 1.25 | <1.25 |
| Liquidity | 20 | >0 | -7.0 | -14.0 | <-14.0 |
| I&E margin | 20 | >1% | 0% | -1% | <=-1% |
| Variance from control total | 20 | >=0% | -1% | -2% | <=-2% |
| Agency expenditure | 20 | <=0% | -25% | -50% | >50% |

| TEWV Performance | Actual | | YTD Plan | | RAG |
|---|---|---|---|---|---|
| | Achieved | Rating | Planned | Rating | Rating |
| Capital service cover | 1.06x | 4 | 1.13x | 4 | |
| Liquidity | 50.0 days | 1 | 42.7 days | 1 | |
| I&E margin | 2.7% | 1 | 3.2% | 1 | |
| Variance from control total | -0.5% | 2 | 0.0% | 1 | |
| Agency expenditure | £1,067k | 2 | £1,028k | 1 | |
| **Overall Use of Resource Rating** | | **3** | | **3** | |

3.6.7 10.0% of total receivables (£586k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as £354k of debts are supported by a SLA and discussions to resolve debts have been positive.

Excluding debts supported by an SLA the ratio reduces to 4.7%.

3.6.8 1.2% of total payables invoices (£152k) held for payment are over 90 days past their due date. This is below the 5% finance risk tolerance.

3.6.9 The cash balance at 31 May 2017 is £58,464k and represents 67.8 days of annualised operating expenses.

3.6.10 The Trust does not anticipate the Use of Resources rating to be below a 2 beyond quarter 1, as per its annual plan.

## 4. IMPLICATIONS:

4.1 There are no direct CQC, quality, legal or equality and diversity implications associated with this paper.

## 5. RISKS:

5.1 There are no risks arising from the implications identified in section 4.

## 6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 May 2017 is a surplus of £1,490k, representing 2.7% of the Trust's turnover and is £261k behind plan due to delays in the delivery of CRES schemes.

6.2 Identified Cash Releasing Efficiency Savings at 31 May 2017 are £1,114k behind plan however the Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years.

6.3 The Use of Resources Rating for the Trust is a 3 for the period ending 31 May 2017 which is in line with plan. However, it is planned to return to a rating of 1 by the end of quarter 1.

## 7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

**Drew Kendall**
**Interim Director of Finance and Information**

**Item 12**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **4th July 2017** |
| **TITLE:** | **Board Dashboard as at 31st May 2017** |
| **REPORT OF:** | **Sharon Pickering, Director of Planning, Performance & Communication** |
| **REPORT FOR:** | **Assurance** |

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

## Executive Summary:

The purpose of this report is to provide the latest performance for the Board Dashboard as at 31st May 2017 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. The report also contains a recommendation on the 'tolerance' levels for the three finance indicators (as discussed at the Board of Directors meeting in May 2017).

As at the end of May 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red. This is an improvement on the end April position when 5 of the indicators were reporting as red. Of the 5 red indicators 2 are showing an improving trend over the previous 3 months. Two of the indicators rated as red relate to the financial targets and more detail is given in the report.

There were no indicators that were red within the Quality or Staffing dimensions which is particularly positive given the pressures being faced in the services.

## Recommendations:

It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.
- Agree to the recommendation regarding tolerance levels for the three finance indicators as set out in Section 2.1.

| | |
|---|---|
| **MEETING OF:** | **Board of Directors** |
| **DATE:** | **4th July 2017** |
| **TITLE:** | **Board Dashboard as at 31st May 2017** |

## 1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st May 2017 in order to identify any significant risks to the organisation in terms of operational delivery.

## 2. KEY ISSUES:

2.1 Tolerance Levels for Financial Indicators

Following the discussion at the April Trust Board the Finance Department have consider whether 'amber' tolerance levels should be introduced for the Finance Indicators (as is the case with all the other indicators within the Dashboard). The recommendation of the Director of Finance and Information is that an amber rating should NOT be introduced and that performance should be considered as either on or better than target (green) or below target (red). The rationale for this is that the finance indicators are measured and reported consistently with NHSI to monitor delivery of our financial plan. Therefore, should financial performance against these indicators not improve, or deteriorate significantly below plan, a revised plan would be required for both NHSI and the Board.

2.2 Performance Issues

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

- As at the end of May 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red. This is an improvement on the end of April position when 5 of the indicators were reporting as red. Of the 4 red indicators 2 are showing an improving trend over the previous 3 months.

  2 of the indicators rated as red relate to the financial targets and more detail is given below.

  There were no indicators that were red within the Quality or Staffing dimensions which is particularly positive given the pressures being faced in the services.

  There are a further 7 indicators which whilst not completely achieving the target levels are within the amber tolerance levels

- In respect of performance against the key NHSI operational indicators the Trust achieved all the targets set by NHSI in May 2017. However it should be noted that whilst the Trust achieved the IAPT recovery target at 50.3%

there was wide variation at CCG level ranging from 41.4% in Scarborough and Ryedale to 58.8% in Hambleton, Richmondshire and Whitby CCG. In total we did not deliver the 50% target in 4 CCGs (Scarborough and Ryedale, Durham Dales Easington and Sedgefield, Darlington and Harrogate and Rural District). Action plans are in operation in all areas where performance is not achieving target and discussions are ongoing with the National Intensive Support Team in some areas.

- Data Quality Assessment. The planned initial assessment of the new set of indicators within the Dashboard has not yet been completed and therefore the Data Quality Appendix is not included within this report. It is expected that this will be completed during June and therefore will be included in the Trust Dashboard report published in July.

- Appendix B includes the breakdown of the actual number of unexpected deaths.

2.3 The key risks are as follows:

- Referrals (KPI1) – As anticipated in last month's report the number of referrals has increased considerably in the month of May, despite there being two bank holidays within the month. EMT have recently approved an approach to use statistical control charts to better understand the trends in referrals at locality and service level and work will now commence on implementing this. The analysis provided by this approach will be taken to EMT for discussion as appropriate and included in future reports to the Board.
- Bed Occupancy (KPI 3) – The Dashboard shows that bed occupancy at a Trust level has increased in May and is above target with particular pressures in Teesside and North Yorkshire. In North Yorkshire a contributing factor is the number of patients in the wards with a Length of Stay over 90 days linked to the number of delayed discharges within the services. The service has established weekly calls with the Local Authority to ensure we are tackling delays within the discharge process and further work to try to address the issues has been agreed between the two organisations. Access to nursing home placements within Teesside is a contributory factor to the high levels of bed occupancy within Tees.
- External Waiting Times (KPI 7) – There has been a slight reduction in the position across the Trust with the Trust being slightly below the target. The main areas of concerns continues to be Adult and Children and Young Peoples services in York but the Adult position continues to be one of improvement. All areas have action plans in place and a detailed discussion between the services and the Chief Operating Officer and Director of Planning, Performance and Communications on waiting times is planned for the Performance Improvement Group meeting in June.
- Finance Indicators (KPIs 19 and 20). – The Trust continues to be below the targets for Delivery of our Financial Plan and Delivery of our Cash Releasing Efficiency Savings (CRES) as at the end of May 2017. Whilst the underperformance in terms of delivery of CRES (KPI 20) is the same

as in April 2017 this is contributing to the deterioration in the position in terms of meeting the overall Financial Plan (KPI 19).

## 3. RECOMMENDATIONS:

3.1 It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.
- Agree to the recommendation regarding tolerance levels for the three finance indicators as set out in Section 2.1.

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

| **Background Papers:** |
| --- |
| |

# Trust Dashboard Summary for TRUST

# Appendix A

## Activity

| | May 2017 | | | | April 2017 To May 2017 | | | Annual |
|---|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Trend Arrow (3 Months) | Target | YTD | Status | Target |
| 1) Total number of External Referrals into Trust Services | 7,793.00 | 9,103.00 | | | 15,335.00 | 16,620.00 | | 91,759.00 |
| 2) Caseload Turnover | 1.99% | 0.08% | | | 1.99% | 0.08% | | 1.99% |
| 3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards) | 85.00% | 88.44% | | | 85.00% | 87.19% | | 85.00% |
| 4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards) | 75.00 | 72.00 | | | 75.00 | 72.00 | | 75.00 |
| 5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months | 10.00% | 10.25% | | | 10.00% | 9.67% | | 10.00% |
| 6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months | 21.00 | 23.00 | | | 40.00 | 44.33 | | 237.00 |

## Quality

| | May 2017 | | | | April 2017 To May 2017 | | | Annual |
|---|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Trend Arrow (3 Months) | Target | YTD | Status | Target |
| 7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral. | 90.00% | 88.75% | | | 90.00% | 89.00% | | 90.00% |
| 8) Percentage of (Clinic) appointments cancelled by the Trust | 10.00% | 8.33% | | | 10.00% | 9.25% | | 10.00% |
| 9) The percentage of Out of Area Placements (Postvalidated) | 20.00% | 15.53% | | | 20.00% | 14.16% | | 20.00% |
| 10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind) | 92.45% | 93.28% | | | 92.45% | 92.95% | | 92.45% |
| 11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated | 1.00 | 0.49 | | | 2.00 | 1.16 | | 12.00 |

# Trust Dashboard Summary for TRUST

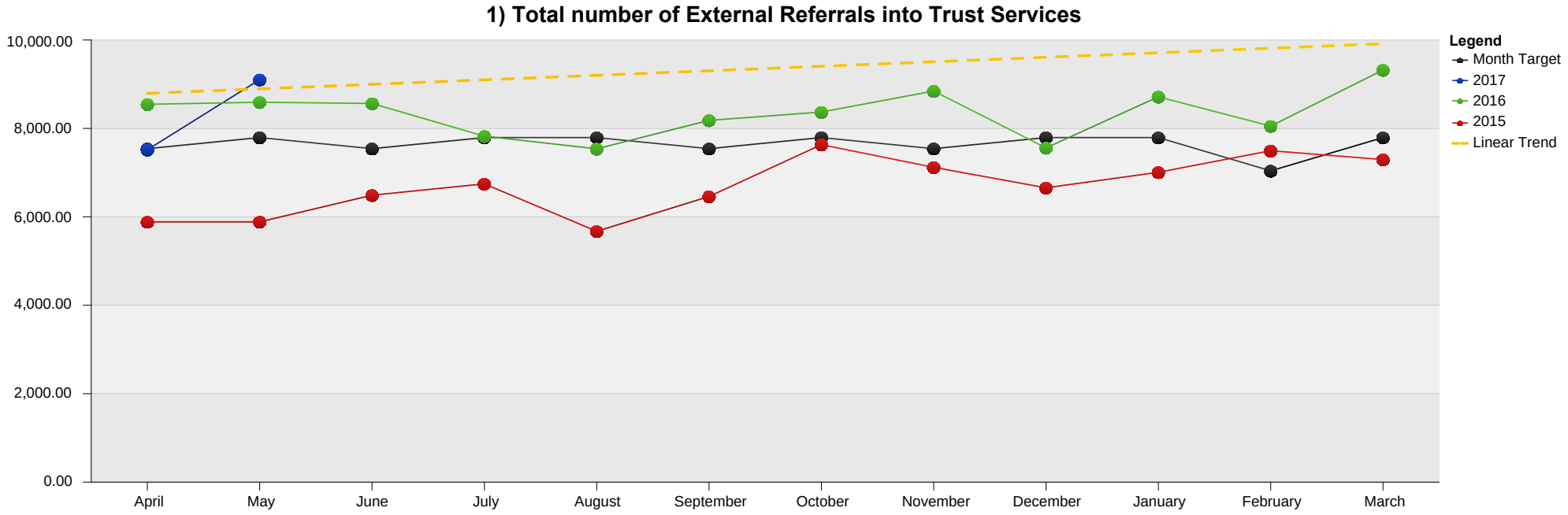
## Workforce

| | May 2017 | | | | April 2017 To May 2017 | | | Annual |
|---|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Trend Arrow (3 Months) | Target | YTD | Status | Target |
| 14) Actual number of workforce in month (Establishment 95%-100%) | 100.00% | 94.04% | | | 100.00% | 94.04% | | 100.00% |
| 15) Percentage of registered healthcare professional jobs that are advertised two or more times | 15.00% | 16.00% | | | 15.00% | 20.86% | | 15.00% |
| 16) Percentage of staff in post more than 12 months with a current appraisal (snapshot) | 95.00% | 91.97% | | | 95.00% | 91.97% | | 95.00% |
| 17) Percentage compliance with ALL mandatory and statutory training (snapshot) | 90.00% | 86.69% | | | 90.00% | 86.69% | | 90.00% |
| 18) Percentage Sickness Absence Rate (month behind) | 4.50% | 4.39% | | | 4.50% | 4.46% | | 4.50% |

## Money

| | May 2017 | | | | April 2017 To May 2017 | | | Annual |
|---|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Trend Arrow (3 Months) | Target | YTD | Status | Target |
| 19) Delivery of our financial plan (I and E) | -886,000.00 | -626,000.00 | | | -1,751,000.00 | -1,490,000.00 | | -10,076,000.00 |
| 20) CRES delivery | 523,680.00 | 430,822.00 | | | 1,047,360.00 | 861,644.00 | | 8,230,080.00 |
| 21) Cash against plan | 54,926,000.00 | 58,464,000.00 | | | 54,926,000.00 | 58,464,000.00 | | 56,376,000.00 |

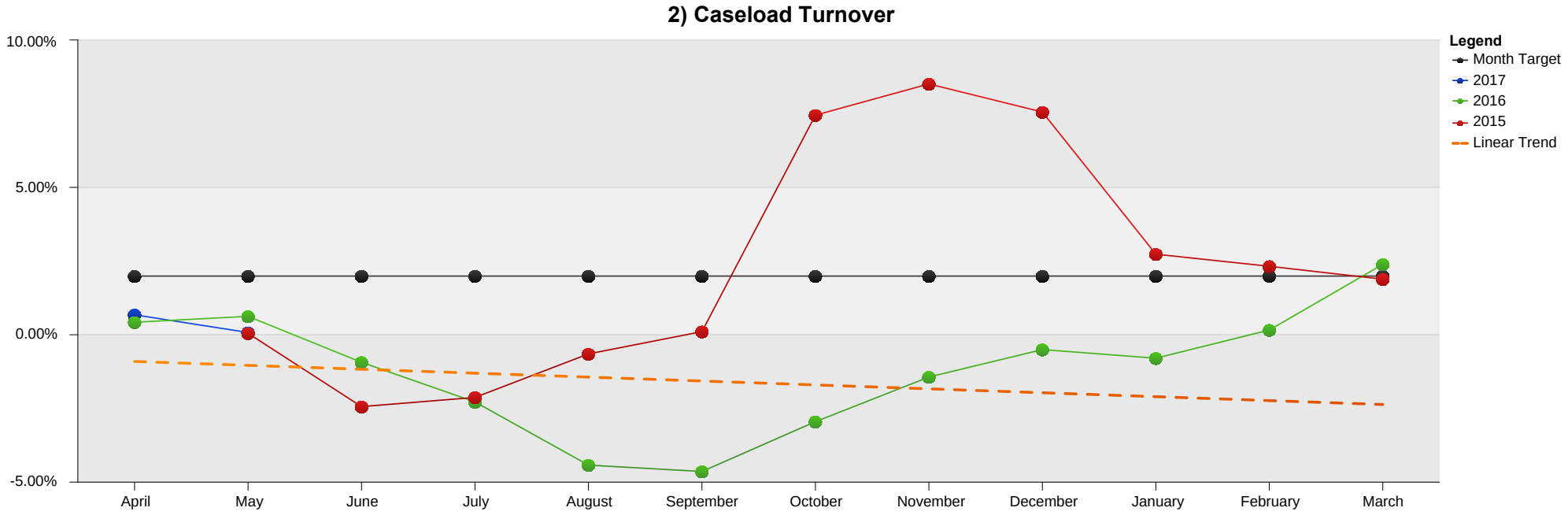
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 1) Total number of External Referrals into Trust Services | 9,103.00 | 16,620.00 | 2,120.00 | 3,696.00 | 2,590.00 | 4,689.00 | 2,233.00 | 4,045.00 | 665.00 | 1,269.00 | 1,430.00 | 2,808.00 | | |

| Narrative |
|---|
| The Trust position for May 2017 is 9,103 which is not meeting the Trust target of 7,793. This is a significant increase on the number of referrals received in April 17, and the increase is not in line with seasonal trends seen in previous years. The figure is also one of the highest numbers of referrals recorded since 15/16. The number of referrals has increased in all localities and across all services with all localities not meeting target. The overall trend is an increasing one, however the level of increases seen does differ with the greatest increases seen in Durham and Darlington and Tees localities and the lowest in York and Selby.In Durham and Darlington the greatest increase in terms of volume of referrals is seen in adult services, however when considered in terms percentages the greatest increase is seen in children's and young people's services. In Teeside the greatest increase is seen in terms of both percentage and numbers in adult services.Based on the increasing trend reported it is anticipated that we will exceed the annual target of 91,759 |

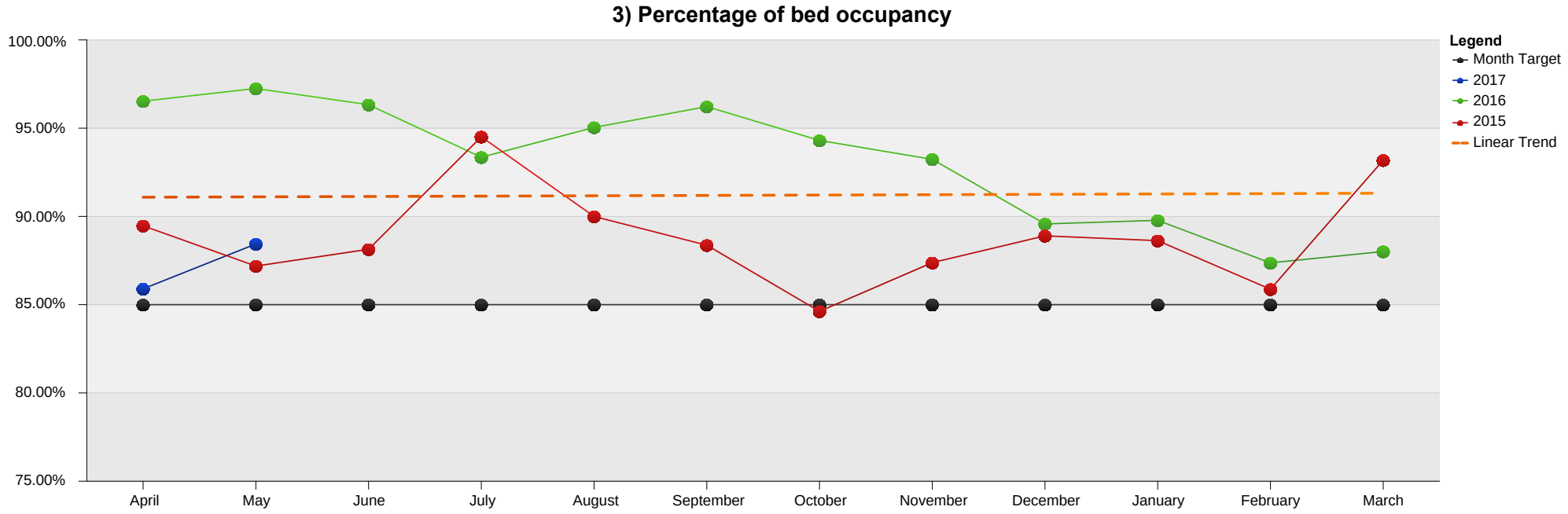
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 2) Caseload Turnover | 0.08% | 0.08% | -0.46% | -0.46% | 1.60% | 1.60% | -1.36% | -1.36% | NA | NA | 0.40% | 0.40% | | |

| Narrative |
|---|
| The Trust position for May 2017 is 0.08% and meeting the Trust target of 1.99%. This is an improvement to that reported in April 2017 and is below that reported for May 2016.All localities are now meeting target for this indicator and this improvement reflects the work of the Purposeful and Productive Community Services Programme (PPCS). |

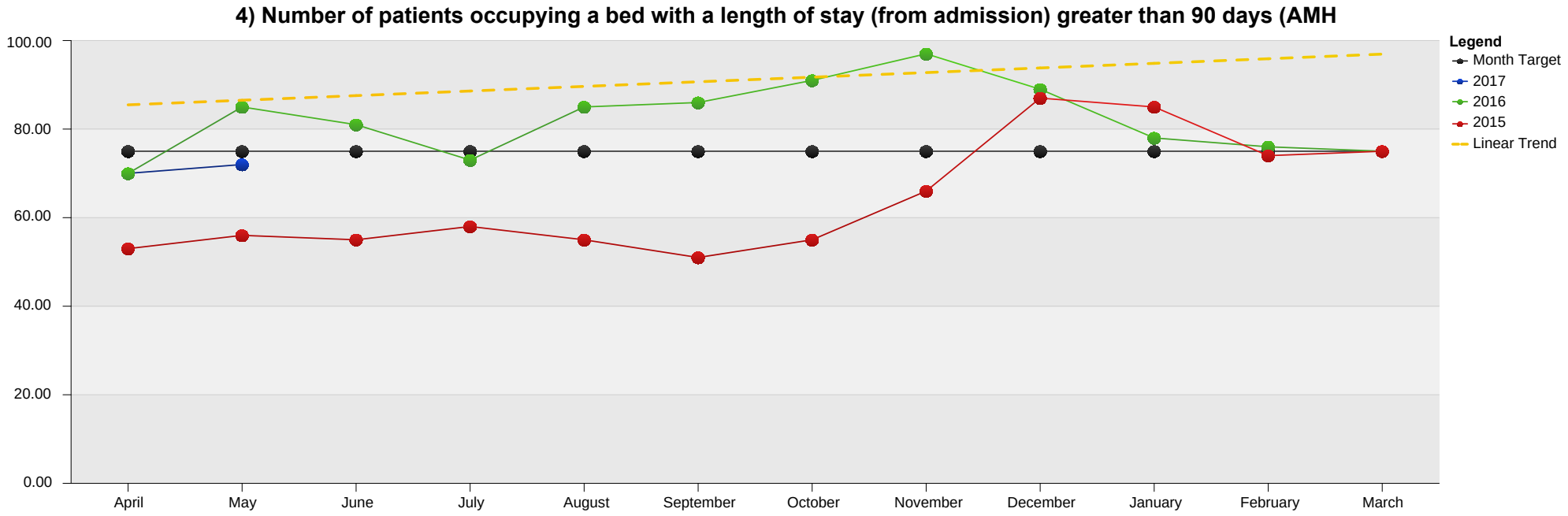
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards) | 88.44% | 87.19% | 88.88% | 89.33% | 93.11% | 90.05% | 90.59% | 90.95% | NA | NA | 76.18% | 72.67% | | |

| Narrative |
|---|
| The Trust position for May 2017 is 88.44% which is 3.44% worse than the Trust target of 85.00% and an increase compared to that reported in April 2017. This position continues to be at similar levels as the improved levels seen in the latter part of 2016/17.All localities are exceeding the 85% target with the exception of York and Selby which have an occupancy level of 76.18%, mainly as a consequence of low occupancy in MHSOP (Meadowfields). |

# Trust Dashboard Graphs for TRUST



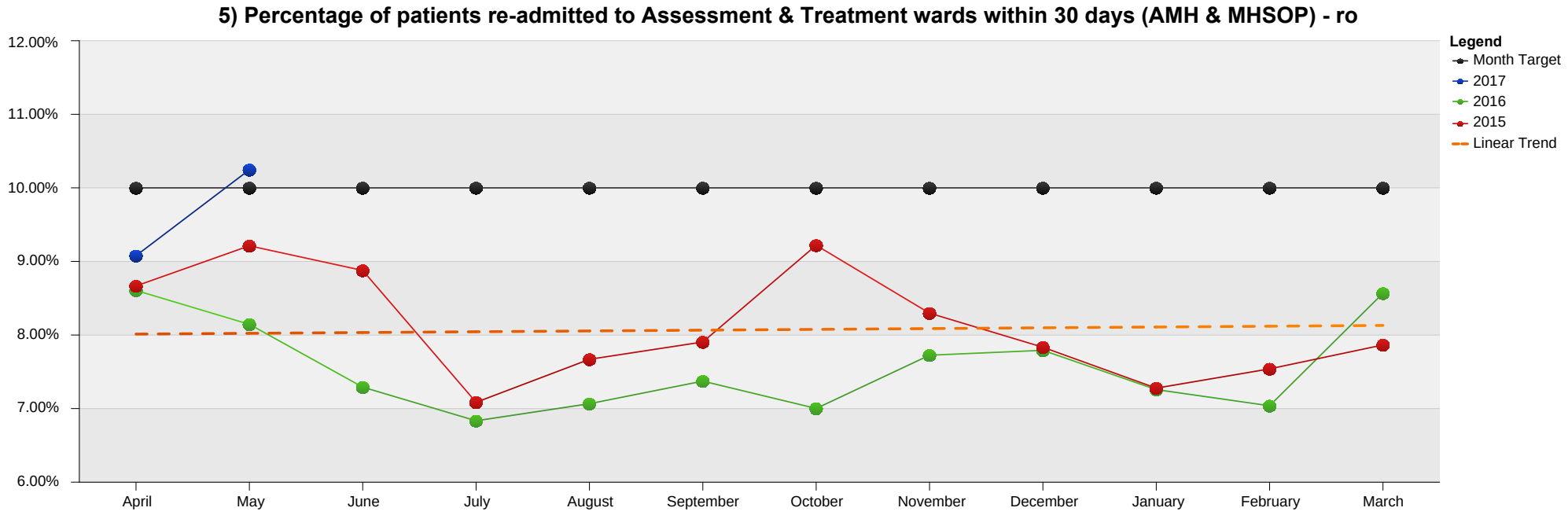

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards) | 72.00 | 72.00 | 19.00 | 19.00 | 12.00 | 12.00 | 24.00 | 24.00 | | | 16.00 | 16.00 | | |

| Narrative |
|---|
| The Trust position for May 2017 is 72 and is meeting the target of 75. This is an improvement compared to that reported in April 2017. This position is also one of lowest recorded since 16/17.<br><br>Only York and Selby are achieving target and this is off setting the other localities who are slightly over target. Of the 72 patients occupying a bed with a LoS greater than 90 days:<br>• 19 (26%) were within Durham and Darlington (7 MHSOP and 12 ADULTS)<br>• 16 (22%) were within York & Selby (8 MHSOP AND 8 ADULTS)<br>• 12 (18%) were within Teesside (6 MHSOP and 6 ADULTS)<br>• 24 (34%) were within North Yorkshire (12 MHSOP and 12 ADULTS)<br><br>In Durham and Darlington MHSOP patients with a LOS greater than 60 days are subject to weekly review to resolve any barriers to discharge. Adult services are to implement a similar process using the 60 day review timescale. This KPI also forms part of the weekly report out process to ensure proactive performance monitoring.<br><br>In North Yorkshire delayed transfers of care in AMH and MSHOP linked to availability of community placements are impacting. Appropriate local authority representatives have been invited to the adult services report out to further support an improvement in discharges. |

# Trust Dashboard Graphs for TRUST

| Narrative |
| --- |
| In Tees all patients are subject to review at 60 days and discussed in weekly report outs. Access to nursing home placements is a cause of concern. |

# Trust Dashboard Graphs for TRUST



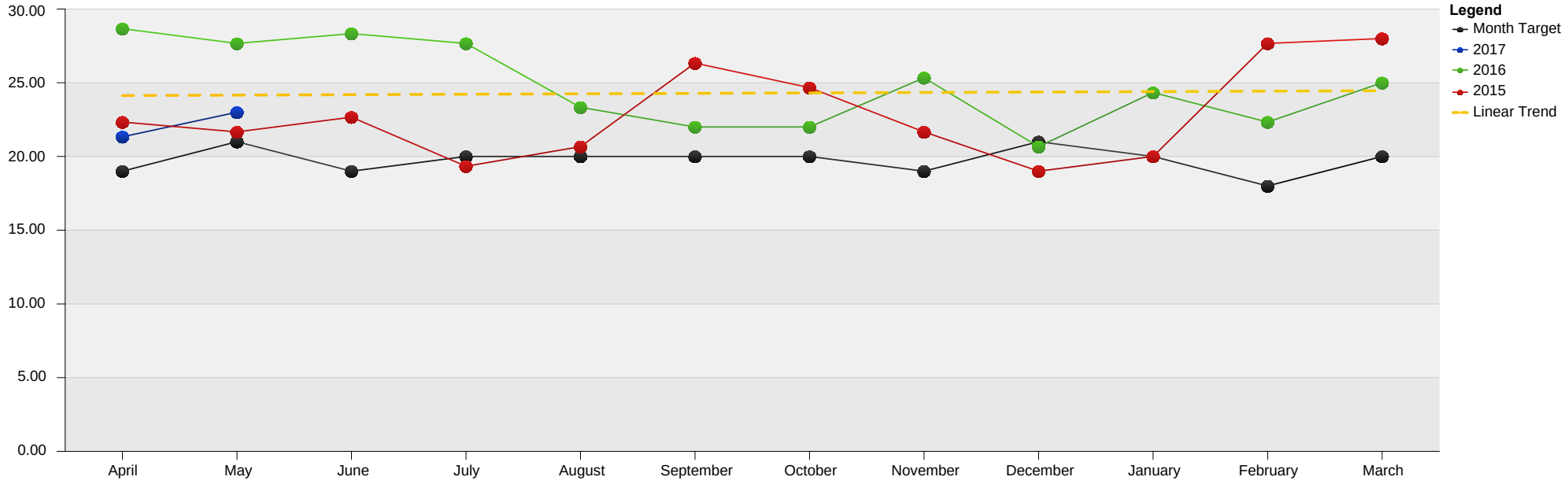

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months | 10.25% | 9.67% | 8.03% | 7.59% | 10.56% | 10.64% | 8.97% | 6.86% | | | 14.49% | 14.34% | | |

**Narrative**

The Trust rolling 3 month position ending May 2017 is 10.25%, which relates to 24.99 patients out of 244 that were readmitted within 30 days. This is slightly worse than the target of 10% and is a continued deterioration on the position reported in April 17, and the worst position recorded since 2015/16.Of the 24.99 patients re-admitted:• 6.66 (27%) were within Durham & Darlington (5.99 AMH and 0.66 MHSOP) • 6.66 (27%) were within York and Selby (6.33 AMH and 0.33 MHSOP).• 4.66 (20%) were within North Yorkshire (3.99 AMH and 0.66 MHSOP) • 6.33 (26%) were within Teesside (5.33 AMH and 0.99 MHSOP)(*Please note data is displayed in decimal points due to the rolling position being calculated.)Only Durham and Darlington and North Yorkshire are meeting target. York and Selby report the poorest performance at 14.49% and the appropriateness of the patient's admission is under investigation.

# Trust Dashboard Graphs for TRUST

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

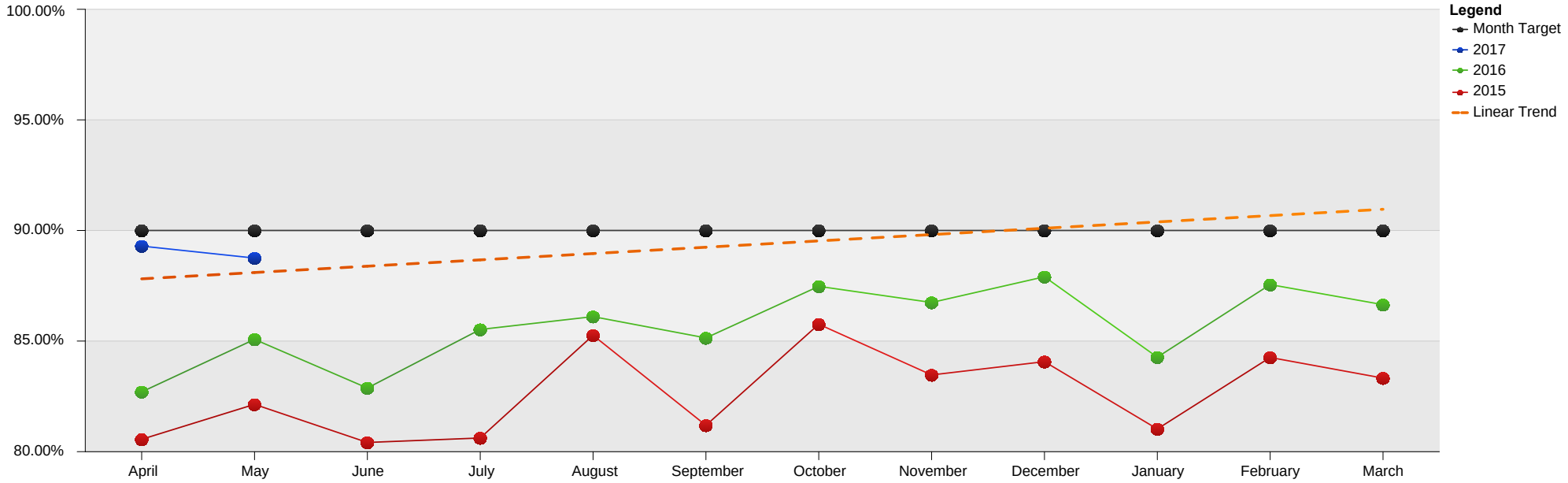



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months | 23.00 | 44.33 | 8.00 | 13.00 | 3.33 | 7.33 | 6.33 | 12.00 | | | 4.67 | 10.67 | | |

| Narrative |
|---|
| The Trust rolling 3 month position ending May 2017 is 23.00, which is 2.00 worse than the target of 21 and a deterioration compared to the position reported in April 2017 but an improvement compared to that in May 2016. Teesside and North Yorkshire are the only localities achieving target. Of the 23 3 or more readmissions:• 7.99 (25%) were within Durham & Darlington (7.66 AMH and 0.33 MHSOP)• 3.66 (23%) were within Teesside (3.66 AMH)• 6.33 (22%) were within North Yorkshire (5.66 AMH and MHSOP 0.66)• 5.99 (30%) were within York and Selby (5.99 AMH)(*Please note data is displayed in decimal points due to the rolling position being calculated.) |

# Trust Dashboard Graphs for TRUST

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

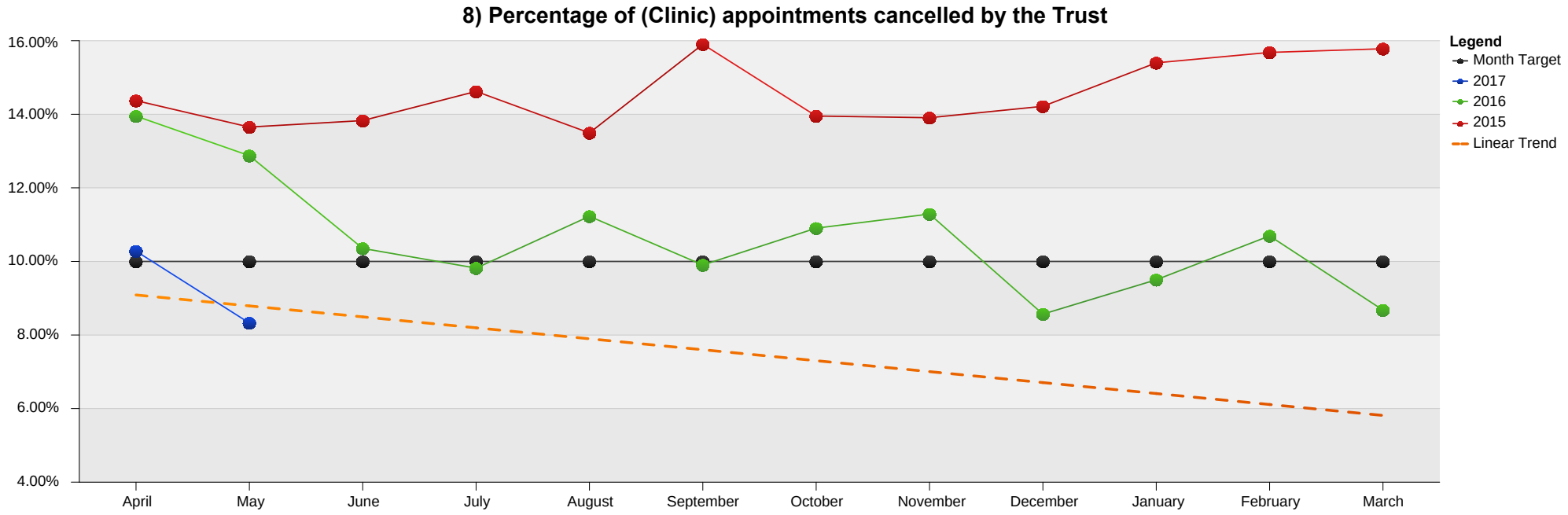



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral. | 88.75% | 89.00% | 86.41% | 86.55% | 98.08% | 98.25% | 81.69% | 81.03% | 99.61% | 99.38% | 70.16% | 71.93% | | |

**Narrative**

The position for May 2017 is 88.75%, relating to 551 patients out of 5116 who waited longer than 4 weeks. This is 1.25% worse than target and a slight deterioration on the April 2017 position. However this is also one of the best performance positions seen since the 4 week indicator was introduced.Areas of concern:• York & Selby CYP at 59.09% (74 out of 182 patients) this is 0.25% deterioration on the April position. A capacity and demand exercise has been completed and this is now being progressed by the Head of Service. A lack of clinic rooms is also impacting on the timeliness of appointments and building alterations are ongoing at Lime Trees with a projected completion date of September / October 2017.• York and Selby Adults at 60.78% (80 out of 182 patients). Whilst this is a 3.4% improvement on the April position there are issues within the service and an action plan is in place to address areas of concern.• North Yorkshire Adults at 78.01%. This is due to an increase in referrals and vacancies in the service and an action plan is in place.• Durham and Darlington Adults at 74.35%. This is due to medic availability and an action plan is in place.Waiting times are to be discussed at a dedicated Performance Improvement Group meeting in June to assess key areas of concern and review action plans in place with a view to agreeing trajectories of when the 4 week waiting time target will be met

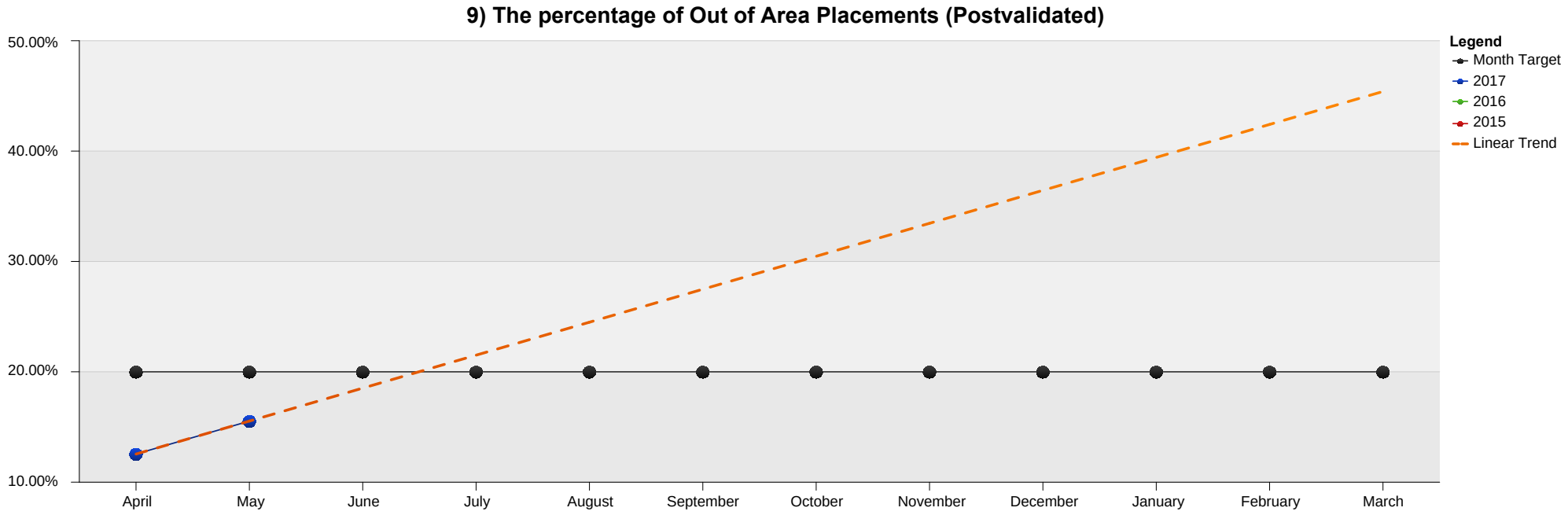
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 8) Percentage of (Clinic) appointments cancelled by the Trust | 8.33% | 9.25% | 11.25% | 11.11% | 5.85% | 7.62% | 9.92% | 11.09% | | | 3.12% | 3.76% | | |

| Narrative |
|---|
| The Trust position for May 2017 is 8.33% which relates to 659 of clinic appointments out of 7125 that have been cancelled. This is meeting the target of 10%, and is an improvement compared to the positions in April 2017 and the figure reported for May 2016. This also the best position recorded since 2015/16.This KPI now relates to clinic appointments only in both the numerator and denominator and is now included within the report process which has improved the proactive monitoring of performance.Only Durham and Darlington are not meeting target at 11.25%. (SP note further detail will be supplied prior to board) |

# Trust Dashboard Graphs for TRUST

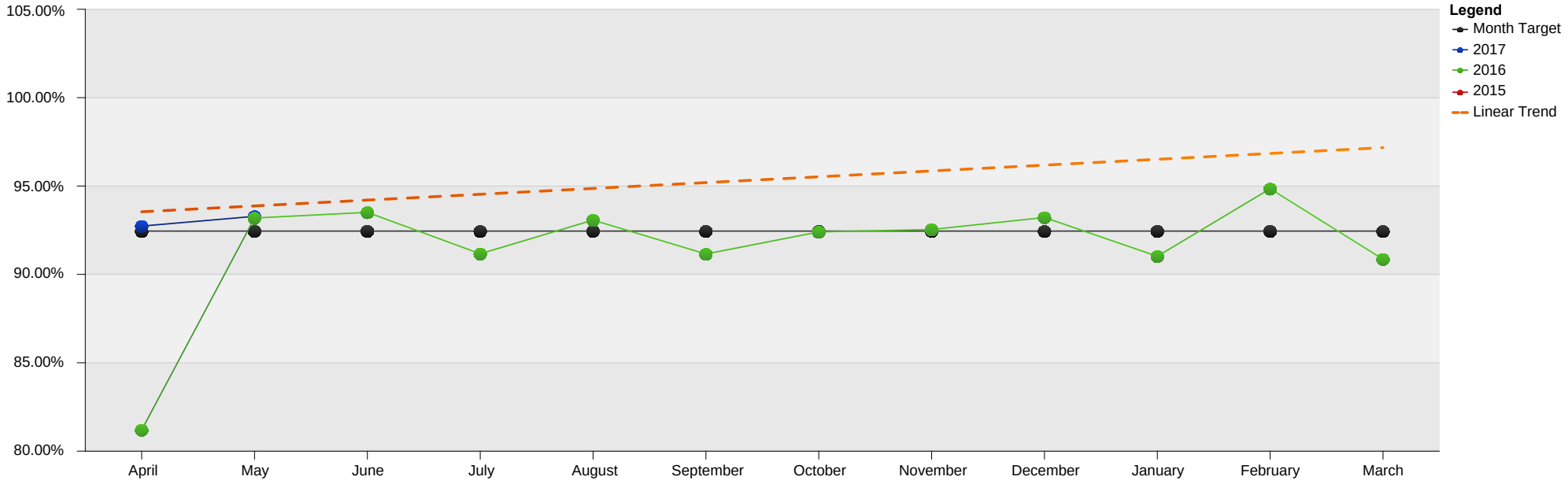



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 9) The percentage of Out of Area Placements (Postvalidated) | 15.53% | 14.16% | 8.11% | 8.78% | 0.00% | 1.10% | 32.08% | 28.28% | | | 44.00% | 39.29% | | |

| Narrative |
|---|
| The Trust position for May 2017 is 15.53%, which relates to 96 admissions out of 618 that were admitted out of area. This is better than the target of 20%.The construction of this indicator has been amended so that it now matches that of the national definition. Therefore there is no historic data available to compare previous performance.All localities are meeting target with the continued exception of North Yorkshire. The high level of bed occupancy in North Yorkshire will be impacting on this position, of which delayed transfers of care continue to be a contributing factor.Of the 96 patients (AMH 74, MHSOP 22) admitted to an 'out of locality' bed, all were due to no beds being available at their local hospital. |

# Trust Dashboard Graphs for TRUST

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



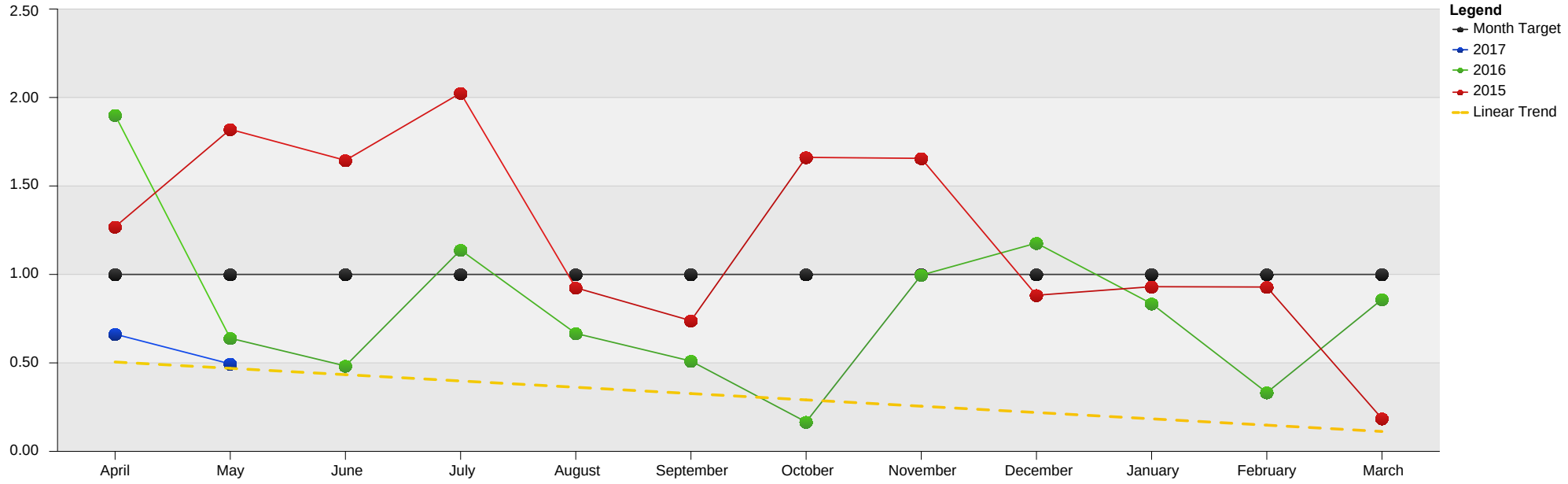

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind) | 93.28% | 92.95% | 94.31% | 93.99% | 95.45% | 94.85% | 92.76% | 91.73% | 83.51% | 82.74% | 89.36% | 92.44% | | |

**Narrative**

The Trust position reported in May relates to April performance. The Trust position for April 2017 is 93.28% which is meeting the target of 92.45% and is a continued improvement on the position in March 2017Only York and Selby and Forensic services are not achieving the target and Forensic services continue to report the poorest performance. Further analysis of the position within Forensic services highlights that the majority of wards surveyed were with in Forensic Mental Health. Of the 9 wards surveyed 3 have met target, however the overall position for the speciality has not. Opportunities to share best practice will be explored within the service.As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).Due to an amendment to the indicator for this year, data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available.

# Trust Dashboard Graphs for TRUST

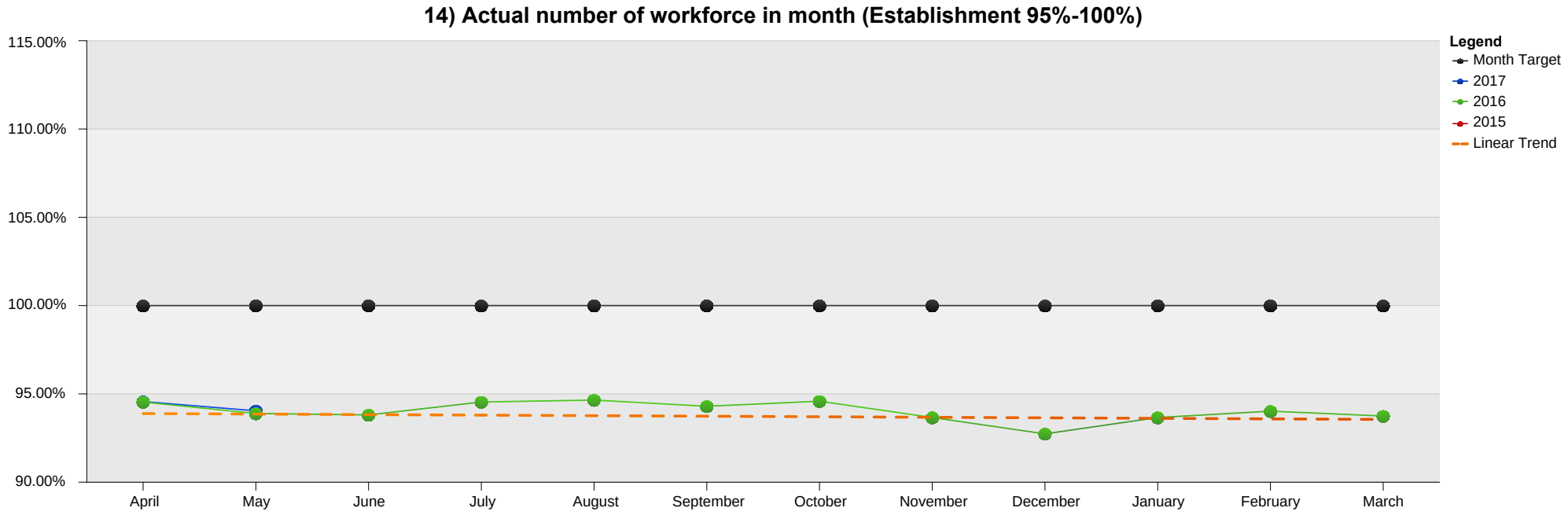
## 11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated | 0.49 | 1.16 | 0.43 | 0.43 | 1.21 | 1.83 | 0.00 | 1.78 | 0.00 | 0.00 | 0.00 | 1.08 | | |

| Narrative |
|---|
| The Trust position for May 2017 is 0.49, which is meeting the target of 1.00. This rate relates to 3 unexpected deaths which occurred in May 2017 and this is a reduction on the 4 reported in April 2017 and an improvement on the position reported in May 2015 and 2016.The 3 unexpected deaths occurred in the following localities:• 2 were within Teesside AMH• 1 was within Durham and Darlington AMHThe overall trend is a reducing one over the previous 3 years. |

# Trust Dashboard Graphs for TRUST

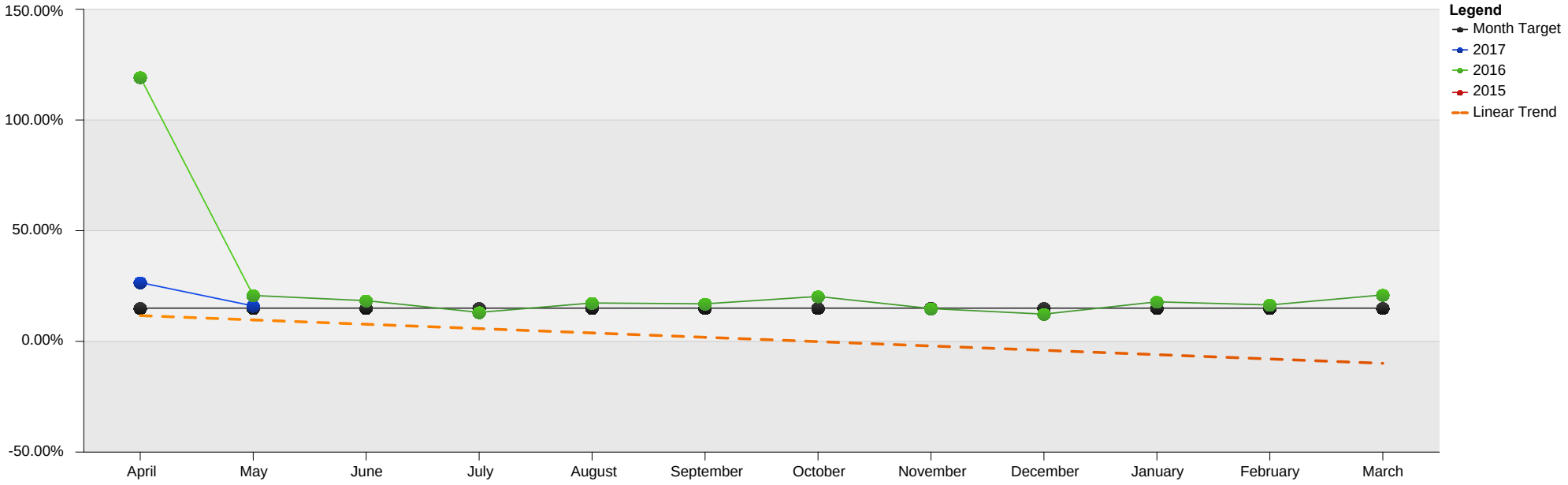



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 14) Actual number of workforce in month (Establishment 95%-100%) | 94.04% | 94.04% | 95.44% | 95.44% | 95.77% | 95.77% | 92.49% | 92.49% | 95.20% | 95.20% | 90.38% | 90.38% | | |

| Narrative |
|---|
| The Trust position for 31 May 2017 is 94.04% which is below the targeted establishment level of 95-100%. It is anticipated that this figure will improve following a number of recruitment events where the Trust have successfully appointed to a number of nursing vacancies. |

# Trust Dashboard Graphs for TRUST

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

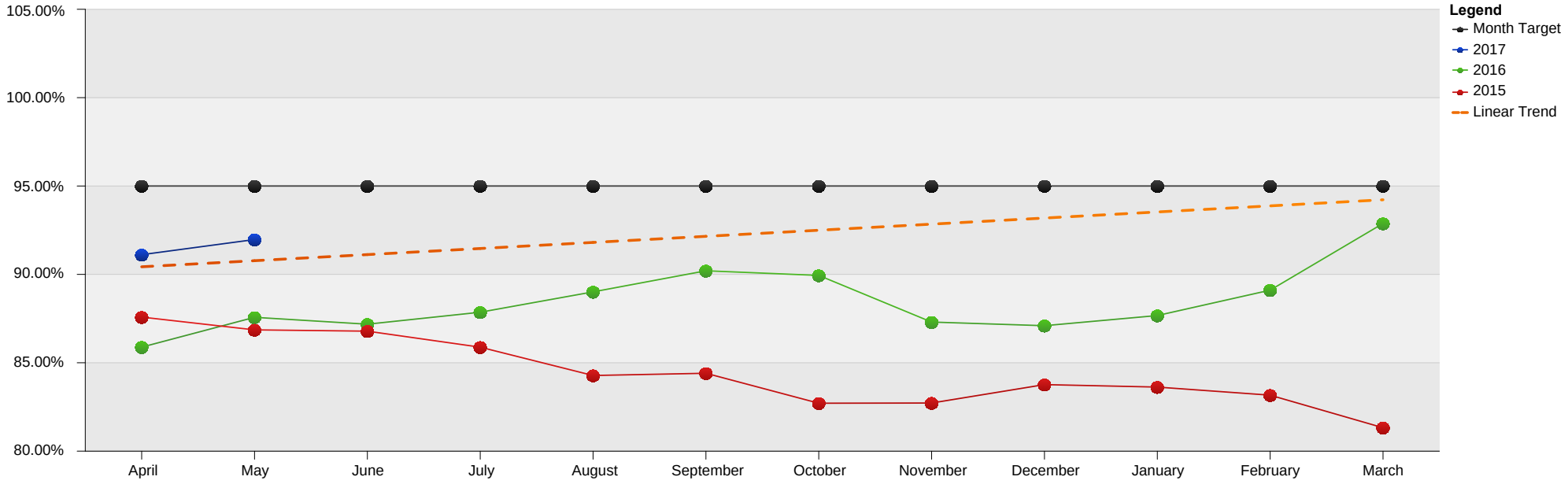



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 15) Percentage of registered healthcare professional jobs that are advertised two or more times | 16.00% | 20.86% | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | |

| Narrative |
|---|
| The Trust position for May 2017 is 16.00% which is 1% over target, however a significant improvement on the previous month's figures. There were 12 jobs re-advertised in May out of a total of 70 posts advertised for registered healthcare professional jobs. The majority of the posts were nursing opportunities in the Band range 5 to 7. Further analysis is planned to improve understanding of the issues that cause posts to require further advertisement, however a date for commencement of this work is to be confirmed by HR. Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available. |

# Trust Dashboard Graphs for TRUST

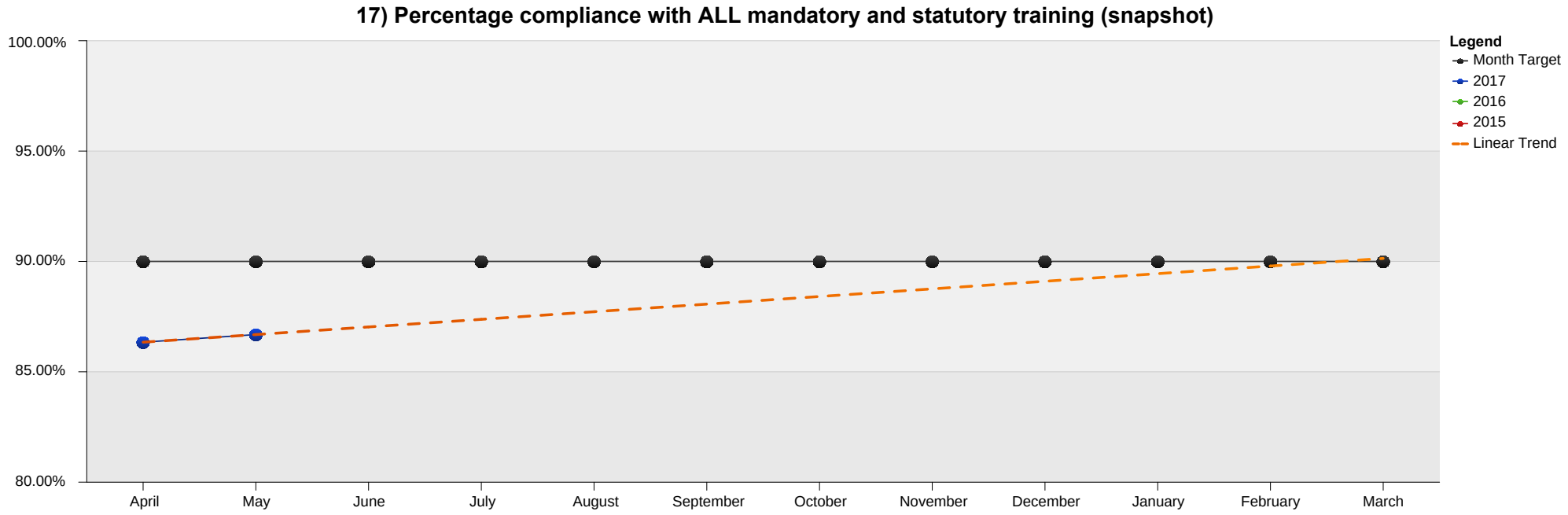
## 16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 16) Percentage of staff in post more than 12 months with a current appraisal (snapshot) | 91.97% | 91.97% | 95.51% | 95.51% | 94.09% | 94.09% | 89.72% | 89.72% | 90.54% | 90.54% | 89.52% | 89.52% | | |

| Narrative |
|---|
| The Trust position for May 2017 is 91.97% which relates to 453 members of staff out of 5642 that do not have a current appraisal. Although this is not meeting the target of 95% it shows an improvement on the previous month and is still the second best position reported since 2015/16 to date.Durham and Darlington are the only locality that is meeting target and York and Selby report the poorest performance, however this is a continued improvement when compared from March 2017.The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels; this has had a positive impact on performance levels being achieved. |

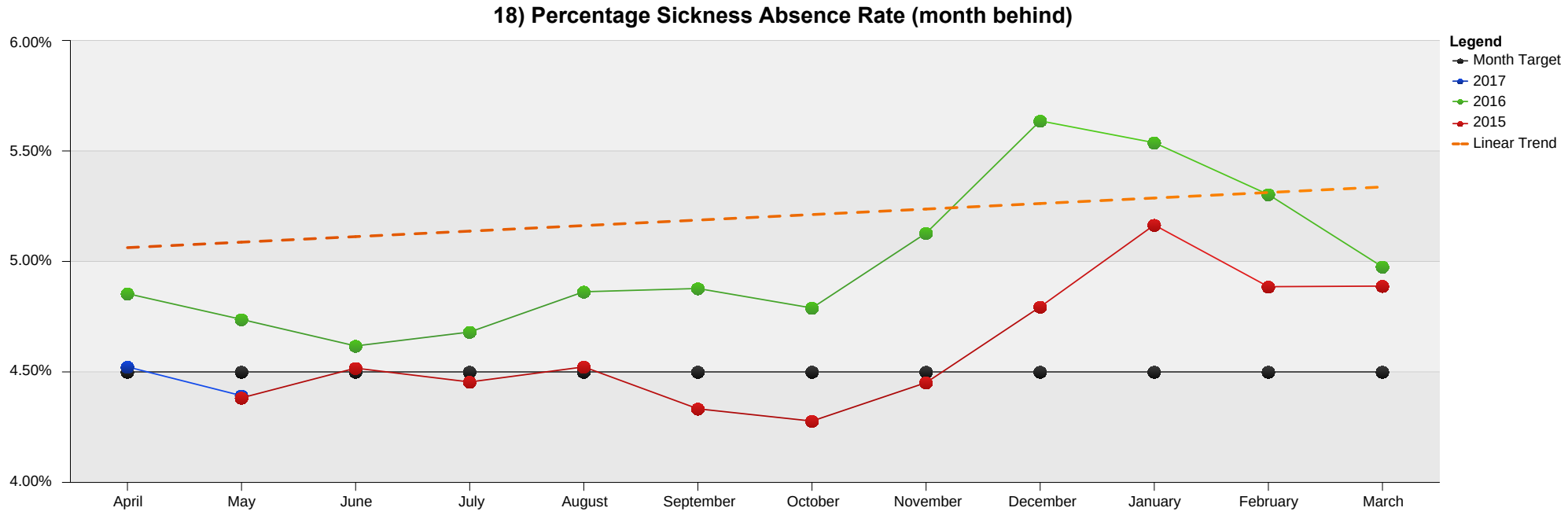
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | UNKNOWN | | YORK AND SELBY | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 17) Percentage compliance with ALL mandatory and statutory training (snapshot) | 86.69% | 86.69% | 84.46% | 84.46% | 89.84% | 89.84% | 85.06% | 85.06% | 85.70% | 85.70% | | | 82.45% | 82.45% |

| Narrative |
|---|
| The position for May 2017 is 86.69%. This is 3.31% lower than the new target of 90%, however a slight improvement on the previous monthAll localities are performing below 90%, York and Selby are achieving the lowest level at 82.45%. This indicator has changed to measure compliance against all mandatory training rather than the Core 7 alone. The requirement to complete some new mandatory training is under review to agree the period of grace allowed ensuring staff have time to complete the requirements before being classed as 'non-compliant' for reporting purposes a performance penalty is applied. In addition discussions are ongoing regarding exclusion of junior doctors.The operational management huddles will re inforce the change to this KPI and drive improvements in performance. |

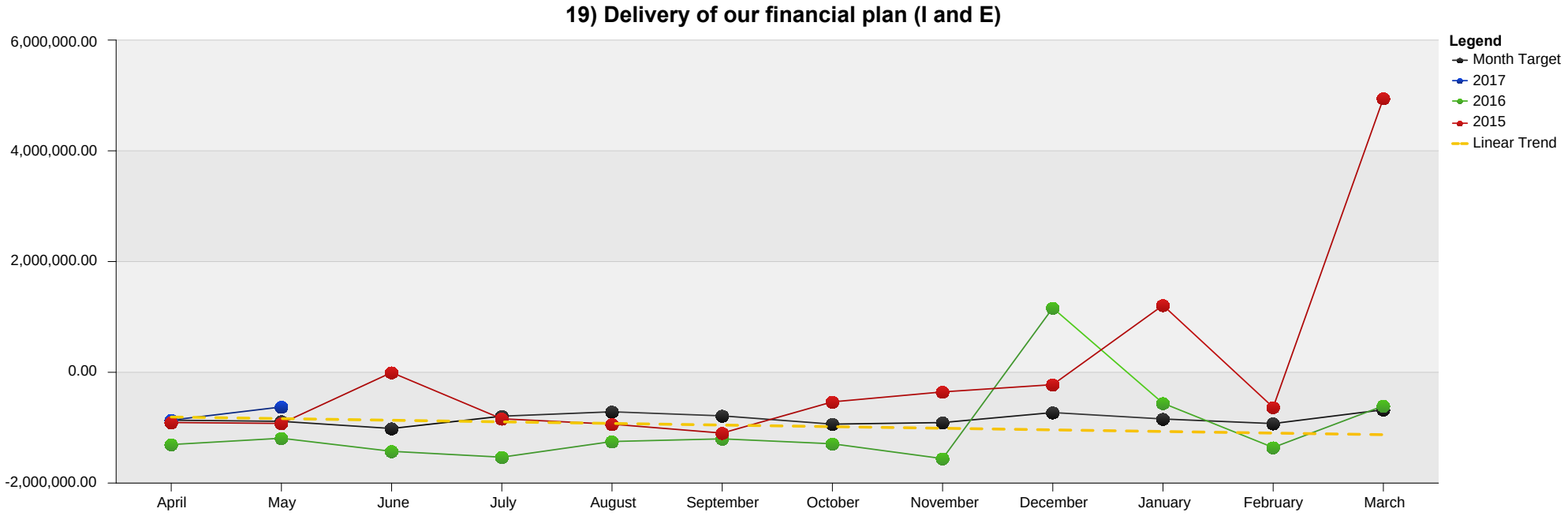
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 18) Percentage Sickness Absence Rate (month behind) | 4.39% | 4.46% | 3.80% | 4.11% | 5.10% | 5.13% | 3.82% | 3.78% | 5.27% | 5.27% | 6.22% | 5.83% | | |

| Narrative |
|---|
| The Trust position reported in May relates to the April sickness level. The Trust position reported in May 2017 is 4.39%, which is meeting the target of 4.50% and a continued improvement on the previous two months and the best performance since November 2015. Only Durham and Darlington and North Yorkshire are meeting target, and the strong performance in these two localities is contributing to the overall good Trust performance. York and Selby report the poorest performance at 6.22%.A paper outlining analysis has been undertaken by HR into short term sickness absence and this is to be considered by EMT to confirm next steps.As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive). |

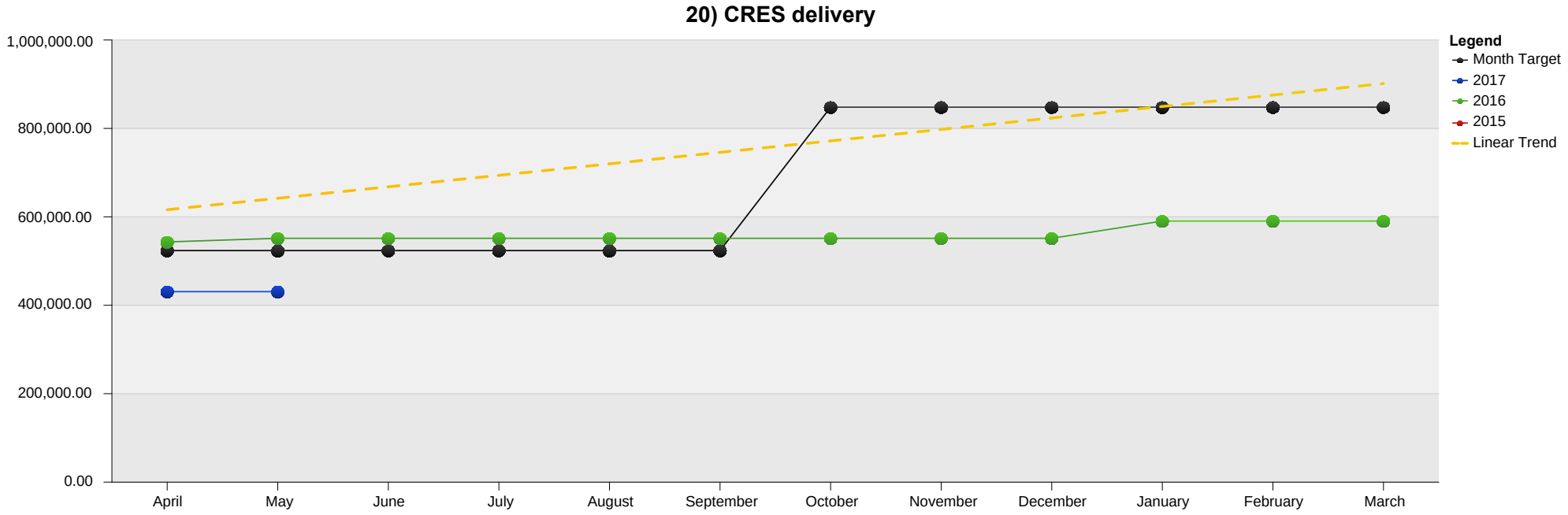
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | UNKNOWN | | YORK AND SELBY | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 19) Delivery of our financial plan (I and E) | -626,000.00 | -1,490,000.00 | NA | NA | NA | NA | NA | NA | NA | NA | | | NA | NA |

| Narrative |
|---|
| The comprehensive income outturn for the period ending 31 May 2017 is a surplus of £1,490k, representing 2.7% of the Trust's turnover and is £261k behind plan. |

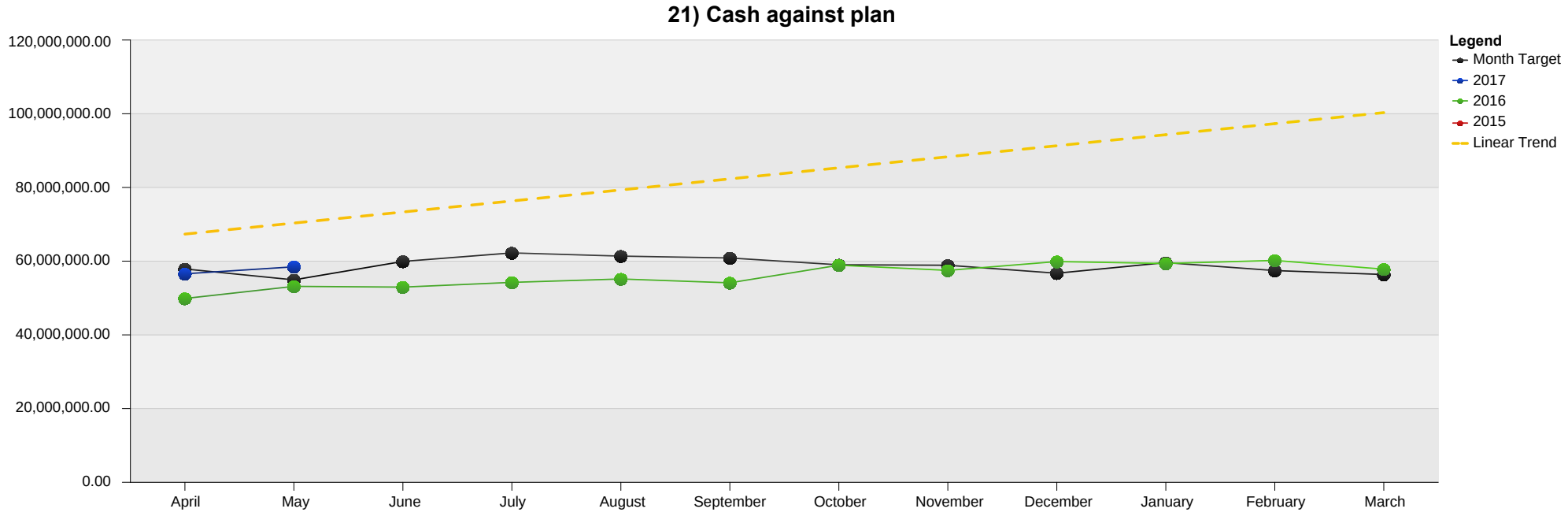
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 20) CRES delivery | 430,822.00 | 861,644.00 | 83,500.00 | 167,000.00 | 159,333.00 | 318,666.00 | 25,000.00 | 50,000.00 | 20,417.00 | 40,834.00 | | | | |

| Narrative |
|---|
| Total CRES delivery by the Trust for 31 May 2017 is £861,644 and is £187,716 behind plan. The Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years. |

# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | UNKNOWN | | YORK AND SELBY | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 21) Cash against plan | 58,464,000.00 | 58,464,000.00 | NA | NA | NA | NA | NA | NA | NA | NA | | | NA | NA |

| Narrative |
|---|
| Total cash at 31 May 2017 is £58,464k and is ahead of plan due to working capital variations. |

## Trust Dashboard - Locality Breakdown for TRUST

**1 - Activity**

| | May 2017 | | | | | | | | | | | | | | April 2017 To May 2017 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 1) Total number of External Referrals into Trust Services | 7,793.00 | 9,103.00 | 1,885.00 | 2,120.00 | 1,916.00 | 2,590.00 | 1,848.00 | 2,233.00 | 585.00 | 665.00 | 1,559.00 | 1,430.00 | | | 15,335.00 | 16,620.00 | 3,709.00 | 3,696.00 | 3,770.00 | 4,689.00 | 3,637.00 | 4,045.00 | 1,152.00 | 1,269.00 | 3,067.00 | 2,808.00 | | |
| 2) Caseload Turnover | 1.99% | 0.08% | 1.99% | -0.46% | 1.99% | 1.60% | 1.99% | -1.36% | NA | NA | 1.99% | 0.40% | | | 1.99% | 0.08% | 1.99% | -0.46% | 1.99% | 1.60% | 1.99% | -1.36% | NA | NA | 1.99% | 0.40% | | |
| 3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards) | 85.00% | 88.44% | 85.00% | 88.88% | 85.00% | 93.11% | 85.00% | 90.59% | 85.00% | NA | 85.00% | 76.18% | | | 85.00% | 87.19% | 85.00% | 89.33% | 85.00% | 90.05% | 85.00% | 90.95% | 85.00% | NA | 85.00% | 72.67% | | |
| 4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards) | 75.00 | 72.00 | 16.00 | 19.00 | 11.00 | 12.00 | 22.00 | 24.00 | | | 24.00 | 16.00 | | | 75.00 | 72.00 | 16.00 | 19.00 | 11.00 | 12.00 | 22.00 | 24.00 | | | 24.00 | 16.00 | | |
| 5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months | 10.00% | 10.25% | 10.00% | 8.03% | 10.00% | 10.56% | 10.00% | 8.97% | | | 10.00% | 14.49% | 10.00% | | 10.00% | 9.67% | 10.00% | 7.59% | 10.00% | 10.64% | 10.00% | 6.86% | | | 10.00% | 14.34% | 10.00% | |
| 6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months | 21.00 | 23.00 | 6.00 | 8.00 | 6.00 | 3.33 | 7.00 | 6.33 | | | 3.00 | 4.67 | | | 40.00 | 44.33 | 11.00 | 13.00 | 11.00 | 7.33 | 13.00 | 12.00 | | | 5.00 | 10.67 | | |

## Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

| | May 2017 | | | | | | | | | | | | | | April 2017 To May 2017 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral. | 90.00% | 88.75% | 90.00% | 86.41% | 90.00% | 98.08% | 90.00% | 81.69% | 90.00% | 99.61% | 90.00% | 70.16% | | | 90.00% | 89.00% | 90.00% | 86.55% | 90.00% | 98.25% | 90.00% | 81.03% | 90.00% | 99.38% | 90.00% | 71.93% | | |
| 8) Percentage of (Clinic) appointments cancelled by the Trust | 10.00% | 8.33% | 10.00% | 11.25% | 10.00% | 5.85% | 10.00% | 9.92% | 10.00% | | 10.00% | 3.12% | | | 10.00% | 9.25% | 10.00% | 11.11% | 10.00% | 7.62% | 10.00% | 11.09% | 10.00% | | 10.00% | 3.76% | | |
| 9) The percentage of Out of Area Placements (Postvalidated) | 20.00% | 15.53% | 20.00% | 8.11% | 20.00% | 0.00% | 20.00% | 32.08% | | | 20.00% | 44.00% | | | 20.00% | 14.16% | 20.00% | 8.78% | 20.00% | 1.10% | 20.00% | 28.28% | | | 20.00% | 39.29% | | |
| 10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind) | 92.45% | 93.28% | 92.45% | 94.31% | 92.45% | 95.45% | 92.45% | 92.76% | 92.45% | 83.51% | 92.45% | 89.36% | | | 92.45% | 92.95% | 92.45% | 93.99% | 92.45% | 94.85% | 92.45% | 91.73% | 92.45% | 82.74% | 92.45% | 92.44% | | |
| 11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated | 1.00 | 0.49 | 1.00 | 0.43 | 1.00 | 1.21 | 1.00 | 0.00 | 1.00 | 0.00 | 1.00 | 0.00 | | | 2.00 | 1.16 | 2.00 | 0.43 | 2.00 | 1.83 | 2.00 | 1.78 | 2.00 | 0.00 | 2.00 | 1.08 | | |

## Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

| | May 2017 | | | | | | | | | | | | | | April 2017 To May 2017 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 14) Actual number of workforce in month (Establishment 95%-100%) | 100.00% | 94.04% | 100.00% | 95.44% | 100.00% | 95.77% | 100.00% | 92.49% | 100.00% | 95.20% | 100.00% | 90.38% | | | 100.00% | 94.04% | 100.00% | 95.44% | 100.00% | 95.77% | 100.00% | 92.49% | 100.00% | 95.20% | 100.00% | 90.38% | | |
| 15) Percentage of registered healthcare professional jobs that are advertised two or more times | 15.00% | 16.00% | 15.00% | NA | 15.00% | NA | 15.00% | NA | 15.00% | NA | 15.00% | NA | | | 15.00% | 20.86% | 15.00% | NA | 15.00% | NA | 15.00% | NA | 15.00% | NA | 15.00% | NA | | |
| 16) Percentage of staff in post more than 12 months with a current appraisal (snapshot) | 95.00% | 91.97% | 95.00% | 95.51% | 95.00% | 94.09% | 95.00% | 89.72% | 95.00% | 90.54% | 95.00% | 89.52% | | | 95.00% | 91.97% | 95.00% | 95.51% | 95.00% | 94.09% | 95.00% | 89.72% | 95.00% | 90.54% | 95.00% | 89.52% | | |
| 17) Percentage compliance with ALL mandatory and statutory training (snapshot) | 90.00% | 86.69% | 90.00% | 84.46% | 90.00% | 89.84% | 90.00% | 85.06% | 90.00% | 85.70% | 90.00% | 82.45% | | | 90.00% | 86.69% | 90.00% | 84.46% | 90.00% | 89.84% | 90.00% | 85.06% | 90.00% | 85.70% | 90.00% | 82.45% | | |
| 18) Percentage Sickness Absence Rate (month behind) | 4.50% | 4.39% | 4.50% | 3.80% | 4.50% | 5.10% | 4.50% | 3.82% | 4.50% | 5.27% | 4.50% | 6.22% | | | 4.50% | 4.46% | 4.50% | 4.11% | 4.50% | 5.13% | 4.50% | 3.78% | 4.50% | 5.27% | 4.50% | 5.83% | | |

**Trust Dashboard - Locality Breakdown for TRUST**

4 - Money

| | May 2017 | | | | | | | | | | | | | | April 2017 To May 2017 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | YORK AND SELBY | | UNKNOWN | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 19) Delivery of our financial plan (I and E) | -886,000.00 | -626,000.00 | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | | -1,751,000.00 | -1,490,000.00 | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | |
| 20) CRES delivery | 523,680.00 | 430,822.00 | 107,322.17 | 83,500.00 | 198,536.25 | 159,333.00 | 148,049.17 | 25,000.00 | 124,378.00 | 20,417.00 | 59,416.00 | | | | 1,047,360.00 | 861,644.00 | 214,644.33 | 167,000.00 | 397,072.50 | 318,666.00 | 296,098.33 | 50,000.00 | 248,756.00 | 40,834.00 | 118,832.00 | | | |
| 21) Cash against plan | 54,926,000.00 | 58,464,000.00 | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | | 117,342,000.00 | 58,464,000.00 | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | |

***Number of unexpected deaths and verdicts from the coroner April 2017 - March 2018 - Appendix B***

| | Number of unexpected deaths in the community | | | | | Number of unexpected deaths of patients who are an inpatient and took place in the hospital | | | | | Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital | | | | | Number of unexpected deaths where the patient was no longer in service | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Durham & Darlington | Teesside | North Yorkshire | Forensics | York & Selby | Durham & Darlington | Teesside | North Yorkshire | Forensics | York & Selby | Durham & Darlington | Teesside | North Yorkshire | Forensics | York & Selby | Durham & Darlington | Teesside | North Yorkshire | Forensics | York & Selby | |
| **Accidental death** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Natural causes** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Hanging** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Suicides** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Open** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Drug related death** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Drowning** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Misadventure** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Awaiting verdict** | | 3 | 2 | | 1 | | | | | | | | | | | 1 | | | | | **7** |
| **Total** | **0** | **3** | **2** | **0** | **1** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **7** |

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

| Number of unexpected deaths total by locality | | | | |
|---|---|---|---|---|
| **Durham & Darlington** | **Teesside** | **North Yorkshire** | **Forensics** | **York & Selby** |
| 1 | 3 | 2 | 0 | 1 |

***Number of unexpected deaths and verdicts from the coroner 2016 / 2017***
This table has been included into this appendix for comparitive purposes only

| | Number of unexpected deaths in the community | | | | | Number of unexpected deaths of patients who are an inpatient | | | | | Number of unexpected deaths where the patient is an inpatient but the | | | | | Number of unexpected deaths where the patient was no longer in | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Durham & Darlington | Teesside | North Yorkshire | Forensics | York & Selby | Durham & Darlington | Teesside | North Yorkshire | Forensics | York & Selby | Durham & Darlington | Teesside | North Yorkshire | Forensics | York & Selby | Durham & Darlington | Teesside | North Yorkshire | Forensics | York & Selby | |
| **Accidental death** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Natural causes** | 1 | 1 | | | | | | | | | | | | | | | 1 | | | | **3** |
| **Hanging** | | | | | 1 | | | | | | | | | | | | 1 | | | | **2** |
| **Suicides** | 5 | 2 | 2 | | 2 | | | | | | | 1 | 2 | | | | | 1 | | | **15** |
| **Open** | | | 1 | | | | | | | | | | | | | | | | | | **1** |
| **Drug related death** | | | | | | | | | | | | | | | | | | | | | **0** |
| **Drowning** | | | | | | | | | | | | | 1 | | | | | | | | **1** |
| **Misadventure** | | | 1 | | | | | | | | | | | | | | | | | | **1** |
| **Awaiting verdict** | 7 | 2 | 7 | 2 | 6 | 1 | | | | | 1 | | | | | | 1 | 1 | 2 | 1 | **31** |
| **Total** | **13** | **5** | **11** | **2** | **9** | **1** | **0** | **0** | **0** | **0** | **1** | **1** | **3** | **0** | **0** | **0** | **3** | **2** | **2** | **1** | **54** |

| Number of unexpected deaths classed as a serious untoward incident | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **April** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** | **January** | **February** | **March** |
| 5 | 4 | 3 | 7 | 5 | 3 | 1 | 6 | 7 | 5 | 3 | 5 |

| Number of unexpected deaths total by locality | | | | |
|---|---|---|---|---|
| **Durham & Darlington** | **Teesside** | **North Yorkshire** | **Forensics** | **York & Selby** |
| 15 | 9 | 16 | 4 | 10 |

Y&S recorded in old Datix not included

***Number of unexpected deaths and verdicts from the coroner 2015 / 2016***
This table has been included into this appendix for comparitive purposes only

**ITEM NO. 13**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **4th July 2017** |
| **TITLE:** | **Report on the Register of Sealing** |
| **REPORT OF:** | **Phil Bellas, Trust Secretary** |
| **REPORT FOR:** | **Information** |

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

## Executive Summary:

This report provides information on the use of the Trust Seal as required under Standing Order 15.6.

## Recommendations:

The Board is asked to receive and note this report.

| | |
|---|---|
| **MEETING OF:** | **The Board of Directors** |
| **DATE:** | **4th July 2017** |
| **TITLE:** | **Report on the Register of Sealing** |

## 1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors of the use of the Trust's Seal in accordance with Standing Orders.

## 2. BACKGROUND INFORMATION AND CONTEXT:

2.1 An entry of every sealing is made and numbered consecutively in a Register specifically provided for the purpose. It is signed by the persons who have approved and authorised the document and those who attested the seal.

## 3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

| Number | Date | Document | Sealing Officers |
|---|---|---|---|
| 301 | 23.5.17 | Renewal of lease of Unit B2, Sovereign Park, Brenda Road, Hartlepool | Mr. D. Kendall, Interim Director of Finance and Information<br>Phil Bellas, Trust Secretary |
| 302 | 23.5.17 | Licence to carry out works at the Acomb Garth Health Centre, 1 Beech Grove, York | Mr. D. Kendall, Interim Director of Finance and Information<br>Phil Bellas, Trust Secretary |
| 303 | 1.6.17 | Contract documents relating to Lime Trees, York | Mr. D. Kendall, Interim Director of Finance and Information<br>Phil Bellas, Trust Secretary |
| 304 | 1.6.17 | Contract documents relating to 4 and 6 Oak Rise, York | Mr. D. Kendall, Interim Director of Finance and Information<br>Phil Bellas, Trust Secretary |

## 4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

## 5. RISKS:

5.1 There are no risks associated with this report.

## 6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

## 7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

**Phil Bellas, Trust Secretary**

**Background Papers:**
The Trust's Constitution
Seals Register

**ITEM NO. 14**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **27 June 2017** |
| **TITLE:** | **Policies Ratified by the Executive Management Team** |
| **REPORT OF:** | **Colin Martin** |
| **REPORT FOR:** | **Information** |

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

## Executive Summary:

The policy paper contains the following information:

2 new policies that have been developed and requires ratification:

- CLIN-0089-v1 Blanket Restrictions Policy
- HR-0020-v4 Conflicts of Interests Policy

2 policies that have had minor amendments:

- MHA-0003-001-v1.2 Leave of absence under S17 MHA and time away from hospital
- PHARM-0001-v8.1 NMP Policy to Practice

## Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 07 June 2017

| | |
|---|---|
| **DATE:** | **27 June 2017** |
| **TITLE:** | **Policies and Procedures Ratified by the Executive Management Team** |
| **REPORT OF:** | **Colin Martin** |
| **REPORT FOR:** | **Information** |

## 1. INTRODUCTION & PURPOSE:

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

## 2. BACKGROUND INFORMATION AND CONTEXT:

**2.1** It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.

**2.2** Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies and procedures.

**2.3** Each policy and procedure ratified by the Executive Management Team will have gone through the Trust's consultation process.

**2.4** Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

## 3. KEY ISSUES:

**3.1** The following new policy has been developed and requires ratification:

**CLIN-0089-v1 Blanket Restrictions Policy**
**Review date: 07 June 2020**

The Trust is committed to ensuring that least restrictive practice is observed at all times. This is in line with Department of Health guidance: *Positive and Proactive Care: reducing the need for physical interventions (2014)* and the Mental Health Act Code of Practice (2015). This new policy describes the arrangements for authorising, monitoring and reviewing restrictive practices, including global blanket restrictions, in use on wards within the Trust. It is also to ensure that the Trust is compliant with its regulated activities as monitored by the Care Quality Commission.

**HR-0020-v4 Conflicts of Interests Policy**
**Review date: 31 May 2020**

This policy has been developed following national guidelines to help trust staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

This replaces the Standards of Business Conduct which has been withdrawn.

**3.2** The following have had minor amendments:

**MHA-0003-001-v1.2 Leave of absence under S17 MHA and time away from hospital**
**Review date: 01 June 2019**

Section 4.3.3 has had wording added to state that prior to section 17 leave outside of hospital grounds being considered, review whether the person meets the criteria for MAPPA notification and refer to the MAPPA guidance.

**PHARM-0001-v8.1 NMP Policy to Practice**
**Review date: 02 November 2019**

Updated to include enhanced information around the required hours for supervisions, protected time to allow this to happen and changes to the prescribing of Controlled drugs for level 1 NMP's.

## 4. IMPLICATIONS:

### 4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

### 4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

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

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is

managed to provide the necessary evidence based operational and practice frameworks.

**4.4 Equality and Diversity:**

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

**4.5 Other implications:**

None identified

**5. RISKS:**

None identified

**6. CONCLUSIONS:**

The decisions detailed above made at the EMT meeting on 07 June 2017 have been presented for ratification.

**7. RECOMMENDATIONS:**

The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

**Author: Colin Martin**
**Title: Chief Executive**