AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 23RD MAY 2017
VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON
AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting of the Board of Directors held on **25th April 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)

Item 6	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 8	To consider a progress report on the Recruitment and Retention Action Plan.	**DL**	**Attached**
Item 9	To consider the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**
Item 10	To consider a report on the refresh of the Trust's Composite Staff Action Plan.	**DL**	**Attached**

Regulatory Items (10.35 am)

Item 11	**NHS Foundation Trust Annual Report and Accounts 2016/17:** (1) To approve the Annual Report, including the Quality Report, and Annual Accounts 2016/17. (2) To approve the Letter of Representation. (3) To authorise the sign-off of:	**CM/DK**	**Previously Circulated**

- The Performance Report
- The Accountability Report
- The Statement on Quality
- The Statement on Directors' Responsibilities for Preparing the Quality Report
- The Annual Governance Statement
- The Remuneration Report
- The Statement on the Accounting Officer's Responsibilities
- The Statement of the Financial Position
- The Letter of Representation
- Any certificates relating to the above as required by NHS Improvement.

(4) To approve the submission of the Annual Report, including the Quality Report, and Annual Accounts, to NHS Improvement and Parliament.

(5) To authorise the submission of the Quality Account to the Department of Health.

(Notes:

(1) The recommendations of the Audit Committee on the above matters will be reported verbally to the meeting. **MH** **Verbal**

(2) The report of the Interim Director of Finance and Information on the Annual Accounts is attached). **DK** **Attached**

Item 12 To approve the Annual Report and Accounts of the Charitable Trust Funds for 2016/17. **CM/DK** **Previously circulated Verbal**

(Note: The recommendations of the Audit Committee on the above matters will be reported verbally at the meeting.) **MH**

Note: Documentation with regard to items (11) and (12) including the Annual Reports and Accounts, the External Auditors' Audit Completion Report, External Assurance Report on the Quality Report and the Summary of Findings of the Independent Review of the Charitable Funds prepared by Mazars LLP has been uploaded into a reading room on the Boardpad system and into a shared folder. Any additional information or updated documents will be tabled at the meeting).

Item 13 On the recommendation of the Audit **PB** **Attached**

Committee to sign-off the annual Board certificates and statements required by NHS Improvement.

(*Note: Board Members are asked to read this report in conjunction with the Audit Committee Report provided in the Confidential Agenda).*

Performance (11.15 am)

Item 14	To consider the Finance Report as at 30th April 2017.	**DK**	**Attached**
Item 15	To consider the Trust Performance Dashboard as at 30th April 2017.	**SP**	**To follow**
Item 16	To consider the Strategic Direction Performance Report for Quarter 4, 2016/17.	**SP**	**Attached**

Governance (11.40 am)

Item 17	To consider the publication of information on compliance with the public sector duty under the Equality Act 2010.	**DL**	**Attached**

Items for Information (11.45 am)

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

Item 20 To note that the next ordinary meeting of the Board of Directors will be held on **Tuesday 4th July 2017** in the Board Room, West Park Hospital, Darlington at 9.30 am.

A special meeting of the Board will also be held on Tuesday 13th June 2017.

Confidential Motion (11.55 am)

Item 21 **The Chairman to move:**

"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the

nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:

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

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

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
17th May 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 25TH APRIL 2017 IN LAKE HOUSE, 20 MANOR COURT, SCARBOROUGH BUSINESS PARK, EASTFIELD, SCARBOROUGH COMMENCING AT 10.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. J. Tucker, Deputy Chairman
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
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mrs. J. Webster, Public Governor for Scarborough and Ryedale
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Mr. S. Scorer, Deputy Director of Nursing (representing Mrs. Moody)

17/91 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. M. Hawthorn, Senior Independent Director, Dr. N. Land, Medical Director and Mrs. E. Moody, Director of Nursing and Governance.

17/92 MINUTES

Agreed *– that, subject to "project" being replaced with "programme" in the title of minute 17/69, the public minutes of the last meeting held on 28th March 2017 be approved as a correct record and signed by the Chairman.*

17/93 PUBLIC BOARD ACTION LOG

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

In relation to the action under minute 17/07 (31/1/17) Mr. Kilmurray considered that the report provided under agenda item 8 on the Stirling Dementia Design Audit required further work and sought permission to withdraw it from the agenda with a view to a revised version being presented to the Board meeting to be held on 20th July 2017.

This was agreed.

Action: Mr. Kilmurray

17/94 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/95 CHAIRMAN'S REPORT

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

(1) Attended the Governor Development Day held on 5th April 2017.

Mrs. Bessant advised that:

(a) The event had been very interesting; however, the low attendance had highlighted the need to review the matters for discussion at future development days.

(b) There had been an excellent briefing on the perinatal service in Teesside.

The Board recognised that there would be significant benefits if this service was also provided in the other Localities.

Mrs. Pickering highlighted that the Trust's bid to access funding from NHS England for the development and expansion of specialist community perinatal mental health services in 2016 had been unsuccessful; however, it was expected that a second wave of bids would be invited.

The Board supported the Chairman's suggestion that a briefing on the Trust's perinatal mental health service should be provided to a future Seminar.

Action: Mr. Martin/Mr. Bellas

(2) Presented a "Living the Values Award" to the Darlington affective disorder team.

It was noted that, during her visit to the service, Mrs. Bessant had received positive feedback from staff on daily lean management and the organisational development support which had been provided to the team.

(3) Her discussions with Teesside University which, in addition to nurse training, had included potential opportunities for developing a broader partnership between the two organisations.

17/96 GOVERNOR ISSUES

No issues were raised.

17/97 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 2nd March 2017 (Appendix 1 to the report).
(2) The key issues discussed by the Committee at its meeting held on 6th April 2017.

Arising from the report:

(1) The Board noted that the reference to CQC compliance in relation to the environment in MHSOP inpatient services in the York and Selby Locality arose from the inspection of Worsley Court in November 2016 and that, with the move to Acomb Garth, the issues had been addressed.
(2) Mrs. Pickering highlighted that feedback provided by the national Intensive Support Team on the IAPT service in North Yorkshire had raised an issue with regard to the Trust's approach to defining the start of treatment which might have adverse implications for the Trust's performance against waiting time targets.

The Board noted that further work was being undertaken on this matter.

(See also minute 17/104).

17/98 NURSE STAFFING REPORT

The Board received and noted the exception report on nurse staffing for March 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").

Mr. Scorer advised that the cumulative severity score (November 2016 – March 2017) for Sandpiper Ward was 72 points and not 39 points as stated in the executive summary to the report.

Board Members sought clarity on the following matters:

(1) When details of the safer staffing steering programme would be presented to the Board.

Mrs. Pickering advised that, under the Trust's Programme Management arrangements (minute 17/69 – 28/3/17 refers), the vision documents for the programme required approval by the Board.

Based on information provided by Mr. Scorer on the timetable for the establishment of the programme office, it was noted that these documents should be available for presentation to the Board in July 2017.

With regard to ongoing workstreams, Mr. Scorer reported that the outcome of the professional judgement reviews of the application of the Hurst tool should be available in Quarter 2, 2017/18.

(2) The position on missed breaks and whether it would be appropriate to report this information as a percentage of shifts worked in addition to the actual number of them.

The Board received assurance that the number of missed breaks had reduced.

The Chairman considered that it was more important for the Board to receive an analysis of the data on missed breaks rather than for further information to be included in the safe staffing reports.

(3) The fill rates on Danby Ward in view of the statement in the report that "Some RN shifts covered by HCAs."

Mr. Scorer advised that, on occasions, where two registered nurses were included in the establishment, a shift could be covered by a healthcare assistant if only one registered nurse was available; however, this was not the preferred position.

It was noted that the detailed staffing report on the North Yorkshire Locality, which was due to presented to the Board in July 2017, would include further information on the ward.

(4) The action being taken to increase bank availability and reduce dependence on agency staff particularly in the York and Selby Locality.

On this matter it was noted that:

(a) Work on flexible staffing would be undertaken through the safer staffing steering programme.

(b) There was a supply issue in the Locality which was reflected in the difficulties being experienced in attracting bank staff.

(c) A number of actions had been taken to seek to increase the number of bank staff including:

- Participation in recruitment fairs in the York and Selby Locality; however, there had been a very poor response.
- Discussions with existing staff about joining the staff bank.
- Actions to attract student nurses.

  Mr. Levy informed the Board that some success had been achieved in attracting student nurses and it was hoped that those due to commence their employment with the Trust in September 2017 might be interested in also becoming bank staff.

(d) Work had been undertaken to improve bank arrangements. A central bank worker service had been introduced and its remit had been extended to cover all temporary staffing. This provided greater opportunities for shifts to be filled by bank staff before seeking agency workers. Arrangements for bank staff to book shifts had also been enhanced.

The Chairman supported Mr. Levy's suggestion that a report on bank staffing arrangements should be provided to the next Board meeting.

Action: Mr. Levy

At the suggestion of the Non-Executive Directors, Mr. Levy also undertook to look into the development of an "app" to support staff book onto bank shifts.

Action: Mr. Levy

(5) Whether the Trust was being successful in encouraging registered nurses to return to practice.

Mr. Levy advised that there had been a lack of success nationally in this area, as shown in a report from the National Audit Office, and the Trust's experiences reflected this position. However, he assured the Board that efforts to encourage nurses to return to practise, including in partnership with the Royal College of Nursing, would continue.

(6) The action being taken to address agency usage at Acomb Garth which equated to approximately 37% of total actual hours.

Mr. Kilmurray responded that the MHSOP inpatient service in the Locality had put itself forward to receive intensive support and action to reduce agency usage would be included in this work.

He also observed that one of the benefits of moving the service, from Selby to York, was that it had become easier to fill vacancies.

(7) The action being taken to address registered nurse fill rates on days at The Orchards and Primrose Lodge.

In response:

(a) It was noted that The Orchards would be included in the in-depth review of staffing in the North Yorkshire Locality.

(b) Mr. Kilmurray advised that staffing issues at Primrose Lodge had been exacerbated by long term sickness absence and a secondment. A new substantive team manager was now in post and greater visibility and oversight of the ward was being provided through daily lean management.

17/99 STIRLING DEMENTIA DESIGN AUDIT

This matter was withdrawn from the agenda in accordance with minute 17/93 above.

17/100 SUMMARY FINANCE REPORT AS AT 31ST MARCH 2017

The Board received and noted the Finance Report as at 31st March 2017 including the Trust's Quarter 4, 2016/17, submission to NHS Improvement.

The Board noted that:

(1) The Trust's financial position at year-end was £4,064k ahead of plan.

Board Members congratulated the Executive Management Team on this performance.

(2) Further information on the items which had contributed to the above position was contained in the Quarterly Finance Report (minute 17/C/116 refers).

(3) Further information on the additional cash income to be awarded to the Trust from the incentivised sustainability and transformation fund would also be provided under the Quarterly Finance Report.

***Agreed** – that the Trust's Quarter 4, 2016/17, submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*

Action: Mr. Kendall

17/101 PERFORMANCE DASHBOARD AS AT 31ST MARCH 2017

The Board:

(1) Received and noted the Performance Dashboard Report as at 31st March 2017.

The focus of discussions was on the decision to remove the indicator on "Percentage of staff in post more than 12 months with a current appraisal" from the key issues/risks section of the report.

The Chairman, whilst recognising the improvements in performance, considered that it remained a critical issue for progressing cultural change in the Trust and needed to be kept under review.

In response, Mrs. Pickering outlined the significant work on improving performance on appraisals, including through the ESR system and daily lean management, and advised that the change was only from a performance reporting perspective.

The Non-Executive Directors also highlighted the position on external referrals in the North Yorkshire Locality.

Mr. Martin recognised that the level of referrals in the Locality was disproportionate to its population and remained a concern.

He advised that work was being undertaken in response to this matter including a pilot based on the provision of a psychologist in a GP practice in Catterick which seemed to be producing beneficial results. Discussions were also being held on undertaking a further pilot in Filey.

The Board noted that the pilot would be compared to the model of attached professionals in GP practices in the Durham Dales.

Overall the Board considered that, in the context of the present environment, the Trust's performance during 2016/17 as shown in the Finance and Performance Dashboard reports was very positive and an article should be included in the next edition of the "Core Brief" to congratulate and thank staff for their efforts.

Action: Mr. Martin

(2) Considered, further to minute 17/12 (31/1/17), an update on the development of the 2017/18 Trust Dashboard including:

(a) Proposed additional targets for the following metrics:

- Percentage of appointments cancelled by the Trust.

  In response to a question, the Board noted that reporting on all missed appointments, rather than only clinic appointments as included in the present definition of the indicator, was linked to the implementation of staff diaries on the PARIS system. Whilst this work was due to be completed in the next six months it was likely that robust reporting on all missed appointments would not be available until 2018/19.
- Percentage compliance with all mandatory and statutory training.

  The Non-Executive Directors highlighted that, notwithstanding the proposal to reduce the target for this indicator to 90% for 2017/18, compliance with mandatory and statutory training remained a critical issue.

  It was noted that the proposed target reflected the short-term effect of extending the definition to all mandatory and statutory training (rather than only the "Core 7" modules) and the 95% target for compliance was due to be reinstated from 2018/19.
- Delivery of the financial plan (I and E).
- CRES delivery.
- Cash against plan.

(b) The work being undertaken to build the new constructions for the following indicators on the Integrated Information Centre which, once completed and tested, would enable the provision of baseline information to support the development of targets and associated RAG ratings:

- Number of current inpatients with a length of stay of greater than 90 days (AMH & MHSOP A&T wards).
- The percentage of inappropriate Out of Area Placements (AMH/MHSOP A&T/PICU).

Agreed –

(1) that the following targets for 2017/18 Board Dashboard be approved:

Indicator	2017/18 Target	RAG ratings		
		Green	Amber	Red
Percentage of appointments cancelled by the Trust	10.00%	10.00% or less	10.01%-12.00% (within 2% of target)	More than 12.00% (more than 2% above target
Percentage compliance with ALL mandatory and statutory training (snapshot)	90%	90% or more	83.00% - 89.99%	Less than 83%
Delivery of our financial plan (I and E)	Surplus of £10,076,000	At or above target	N/A	Below target
CRES delivery	£6,284,000	At or above target	N/A	Below target
Cash against plan	£52,227,000	At or above target	N/A	Below target

(2) that the ongoing work to develop targets and RAG ratings for the key performance indicators on length of stay and out of area placements be noted.

Action: Mrs. Pickering

17/102 QUARTERLY WORKFORCE REPORT

The Board received and noted the Workforce Report for the period January to March 2017 including:

(1) Information about the medical workforce (Appendix 1 to the report).
(2) Information about the non-medical workforce (Appendix 2 to the report).
(3) The results of the latest Staff Friends and Family Test (FFT) survey (Appendix 3 to the report).

Mr. Levy undertook to provide Board Members with an analysis of the themes arising from the survey.

Action: Mr. Levy

The report also sought the Board's agreement to proposals for future performance reporting of workforce issues.

Arising from the report the Board discussed:

(1) The increase in the number of comments received though the FFT survey which contained abusive language.

In relation to this matter:

(a) The Chairman highlighted that there were pockets of negativity within some services and questioned how the Trust should respond to the minority of "negative culture carriers" in view of their impact.

Mr. Levy considered that the number of negative comments received from the FFT survey needed to be kept in perspective and that the Trust should seek to understand why they were being made and how to mitigate them.

(b) Board Members raised the variation in responses to the new ways of working within community teams.

Mr. Kilmurray observed that the daily huddles had increased transparency of staff performance.

(2) The purpose of the introduction of capped pay rates for agency locums, introduced during 2016/17, and whether the approach was likely to be successful.

The Board noted that:

(a) The changes were based on a desire, nationally, to manage costs and to change the employment model so that medical staff were more likely to seek substantive roles.

(b) The effects of the measures had varied between Trusts. There had been implications for some services but the Trust was, generally, less reliant on locums than other Trusts.

(c) In recognition of concerns raised by Trusts, NHS Improvement was gathering information on the impact of the measures.

(d) NHS Improvement had also paused the implementation of new rules which banned Trusts from employing any agency workers who held substantive roles with other NHS employers; however, the proposals were likely to re-emerge.

(e) The recent NHS-wide amendments to off-payroll taxation arrangements, known as IR35, were expected to have a potentially adverse impact upon the recruitment and retention of agency locums.

(3) The reasons, particularly the impact of stress, for the increase in sickness absence rates.

Mr. Levy advised that:

(a) Previously data on the reasons for sickness absence had been included in the quarterly workforce reports and it might be beneficial to, occasionally, provide this information to the Board.

(b) Approximately one-third of sickness absences were related to stress, depression, etc but few absences arose from acute mental ill-health.

(c) The management of long-term sickness absence had been strengthened but the Trust tended to have comparatively higher rates of short-term sickness absence.
(d) The reasons for sickness absence were, proportionately, quite consistent.
(e) The challenge for the Trust was how to respond to the slow increase in sickness absence and fresh approaches might need to be developed.

Board Members also highlighted that:
(a) The Trust had put in place proactive arrangements (e.g. mindfulness and the employee psychology service) to support the mental wellbeing of staff.
(b) Stress usually arose due to factors in both an employee's work and domestic lives.

(4) Whether sickness absence was likely to increase as a result of the Trust's aging workforce.

The Board noted that, as the North-East tended to have a lower disability free life expectancy than other regions, it was likely that, if staff were required to work longer as a result of pension changes, sickness absence rates would increase unless adjustments were made.

Agreed –
(1) that the quarterly Workforce Report to be provided to the Board meeting to be held on 20th July 2017 include key performance indicators on nurse recruitment fill rates and the proportion of staff leaving the Trust for positive reasons; and
(2) that the key performance indicators on recruitment times be removed from future reports.

Action: Mr. Levy

17/103 COMPOSITION OF THE COUNCIL OF GOVERNORS

In view of the decision to transfer Durham University's School of Medicine, Pharmacy and Health to Newcastle University it was:

Agreed –
(1) that the University of Newcastle be designated as a "partnership organisation" and be eligible to appoint a Governor of the Trust;
(2) that Annex 4 to the Constitution be amended to provide a seat on the Council of Governors for the University of Newcastle; and
(3) that the Council of Governors be recommended to approve the decisions set out under (1) and (2) above.

Action: Mr. Bellas

17/104 SINGLE OVERSIGHT FRAMEWORK

Consideration was given to a report on:
(1) The Trust's indicative position against the requirements of NHS Improvement's Single Oversight Framework (SOF) at the end of Quarter 4, 2016/17, recognising

the challenges in relation to internal monitoring as discussed by the Board at its meeting held on 31st January 2017 (minute 17/14 refers).

The Board noted that:

(a) As shown in Appendix 2 to the report, performance on the IAPT recovery indicator for March 2017 had resulted in the Trust achieving target for the Quarter.

(b) Further to minute 17/97 above, there were risks that the issue identified by the national Intensive Support Team, with regard to the approach to starting treatment at first appointment, could impact on the Trust's position on the IAPT waiting times metric.

(2) The Trust's position against the Quality Governance Action Plan, developed at the request of Monitor in January 2016, in relation to the York and Selby transaction.

It was noted that significant progress had been made on the delivery of the actions contained in the plan but that assurance of completion of a few matters remained outstanding.

Agreed – *that in relation to the York and Selby Quality Governance Action Plan:*

(1) those actions identified as completed in Annex 3 to the above report be signed off; and

(2) a further report to provide assurance on the completion of the few remaining outstanding matters be provided to the Board meeting to be held on 20th July 2017.

Action: Mr. Bellas

17/105 USE OF THE TRUST SEAL

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

17/106 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.

17/107 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors would be held at 9.30 am on Tuesday 23rd May 2017 in the Board Room, West Park Hospital, Darlington.

17/108 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 12.50 pm.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd May 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	~~May-17~~ 20/07/2017	Information to be provided in the next Quarterly Workforce report
29/11/2016	16/286	A progress report to be provided to the Board on the Recruitment and Retention Action Plan	DL	May-17	See Agenda Item 8
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	~~May-17~~ Jun-17	Change of date to reflect discussions at the Board Meeting held on 25/4/17

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	To be included in the next Forensic Services LMGB report to the QuAC
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	~~Apr-17~~ 20/07/2017	Change of date to reflect discussions at the Board Meeting held on 25/4/17
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	~~May-17~~ 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	
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	
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 reported in a future nurse staffing report	EM	Jun-17	To be included in the next Forensic Services LMGB report to the QuAC
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	17/100	Approval of the Trust's Quarter 4, 2016/17 financial submission to NHS Improvement	DK	-	Approved
25/04/2017	17/101	In view of year-end positve financial and performance results, an article to be included in the next "Core Brief" to congratulate and thank staff for their efforts during 2016/17	CM	-	Completed
25/04/2017	17/101	Approval of targets for the 2017/18 Performance Dashboard	SP	-	Approved
25/04/2017	17/102	An analysis of the themes from the staff Friends and Family Test to be provided to Board Members	DL	-	Completed
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	17/103	Approval of changes to the Trust's Constitution (subject to ratification by the Council of Governors) to enable Newcastle University to appoint a Governor of the Trust	PB	-	Approved
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	

Item 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 23 May 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 04 May 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 North Yorkshire and Tees where key concerns were around recruitment, nursing home provision, increased referrals, delayed discharges and adult mental health access to PICU.
- Updates from the Patient Safety Group, and Equality, Diversity and Human Rights Group.
- The Infection, prevention and Control Quarterly report, Annual Report for 2016/17 and the Annual Programme for 2017/18.
- CQC compliance and Safeguarding & Public Protection assurance updates.
- Two new reports: a review of the systems used to support the reporting of seclusion and a report on self-harm.
- The Quality Account for 2016/17 and approval of the proposed Quality Account Metrics.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 04 May 2017.
- Note the confirmed minutes of the meeting held on 06 April 2017 (appendix 1).

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 23 May 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 04 May 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 of the Quality Account. 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 North Yorkshire and Tees localities.

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

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

4.1 NORTH YORKSHIRE LMGB

(1) The Committee received the LMGB report for North Yorkshire noting the top concerns around adult mental health access to PICU, the community new model of care linked to the Harrogate Vanguard and delayed discharges due to lack of external placements for patients.

(2) Assurance was provided that recruitment premiums to attract applicants to fill Consultant posts would be pursued.

4.2 TEES LMGB

(1) The Committee received the LMGB report for Tees noting the top concerns around nursing home provision, staff recruitment and increased referrals to the CYPS teams.

(2) A number of patients, including a complex patient from Cumbria have been placed at Hope House, due to little market development and as part of the Transforming Care agenda resulting in a safeguarding alert to the Police, CCG and Local Authority.

(3) Cumbria CCG have been contacted to find alternative suitable accommodation for the patient with complex care needs, however a CQC visit has been requested by the Local Authority.

4.3 **Patient Safety Group Assurance Report**

(1) Assurance was provided to the Committee for the reporting period 1 – 28 February 2017, including The Quality Strategy Scorecard Metrics and the Patient Safety Team KPI's.

(2) A structured case note review has been used as a mortality tool to look at February 2017 cases of deaths of patients whilst subject to CPA who were not classed as serious incidents.
The structured case note review tool had been decided as being the most appropriate mortality tool to be used until further guidance was released, however it was noted that if the inclusion criteria was to be widened then additional resource would be required.
A Trust policy is being drafted on responding to deaths, which will include the mortality review process and best practice for involving service users and carers. The policy is being drafted as part of a wider regional group of Trusts (Mazars Group) to try and ensure some consistency in approach.

4.4 **Safeguarding and Public Protection Exception Report**

(1) The three serious case reviews in Hartlepool, due for publication on 9 May 2017 have 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 once the NY report was received an action plan would be implemented.

4.5 **Infection, Prevention and Control Quarterly Report, Annual Report 2016/17 and Annual Programme 2017/18**

(1) The Committee received assurance on the matters pertaining to the information contained in the report for Quarter 4.
(2) Noted the Infection Prevention and Control Annual Report for 2017/18
(3) Noted the Infection Prevention and Control Annual Programme for 2017/18
(4) 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.
(5) Discussed levels of cleanliness in facilities across the York & Selby area, which would be taken to EMT for further discussion.

4.7 **Equality, Diversity and Human Rights Steering Report**

The Committee noted a report of the Equality, Diversity and Human Rights Steering Group and were assured that all matters pertaining to the report were being addressed.

The key issues covered in this report were:

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 is 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.

(1) A briefing on the accessible information standard had been received, introduced by NHS England in 2016 to ensure that people with a disability or sensory loss receive information they can access and understand.

The Committee agreed that a report will be presented to EMT setting out proposals to ensure compliance against the accessible information standard.

4.8 **Review of the Systems used to support the reporting of seclusion**

(1) The Committee noted that 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 (2015). Enhanced monitoring has also been agreed 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. There will also be a data cleansing exercise to cross check Paris against Datix and this matter will be fed back to the Mental Health Legislation Committee at its meeting to be held on 13 July 2017.
(3) The future reporting of seclusion through the Mental Health Legislation Committee would provide assurance on the appropriateness of individual episodes of seclusion.

4.9 **Self Harm Report**

(1) The Committee noted that there was currently no guidance to support staff across the Trust for patients that self-harm, 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 may be the best approach.
(2) Given the changes to Paris and a move towards narrative based risk assessment and harm minimisation approach there will be a re-audit planned against NICE guidance.
(3) Further work will be undertaken to map out current service provision and approaches to treatment/management across the Trust and consideration will also be given to developing guidance for staff setting out the Trust's approach to harm reduction.
(4) It was discussed that this is potentially a large piece of work which may need scoping out into a project for 2018/19.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 **Compliance with CQC Registration Requirements**

The key issues raised in the report were:

(1) Draft reports following the CQC visit to the Trust in January 2017 were being checked for factual accuracy. A Quality Compliance Group has been set up to

monitor the action plan against CQC findings and to share the findings across the organisation.

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

(3) The Committee were assured that actions were being taken to mitigate against future recurring issues of non-compliance following CQC and MHA inspection visits. Ofsted Registration for Holly and Baysdale had progressed positively with pre-registration visits to both areas.

5.2 Quality Account 2016/17

(1) The draft Quality Account has been sent to stakeholders for comments following a number of presentations to a number of Overview and Scrutiny Committees.

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

5.1 Proposed Quality Account Performance Metrics

(1) 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 existing Clinical Effectiveness measures.

(2) The Committee 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 existing Clinical Effectiveness measures (4-6)

6 GOVERNANCE

6.1 Access to Healthcare Assessment Report

(1) The Committee noted a report provided assurance around 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 and demonstrated compliance with the criteria.

(3) The assessments had been approved by the LMGBs and discussed at the Learning Disability Speciality Development Group.

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:

- Note the issues raised at the Quality Assurance Committee meeting on 04 May 2017 and to note the confirmed minutes of the meeting held on 06 April 2017 (appendix 1).

Jennifer Illingworth
Director of Quality Governance
May 2017

APPENDIX 1

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 6 APRIL 2017, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Mr Brent Kilmurray, Chief Operating Officer
Dr Nick Land, Medical Director
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr Colin Martin, Chief Executive
Mr David Jennings, Non-Executive Director
Mr Richard Simpson, Non-Executive Director
Mr Jim Tucker, Non-Executive Director, (Deputy Chairman of the Trust)
Mrs Shirley Richardson, Non-Executive Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing & Governance
Mrs Nicola D'Northwood, Operational Support Manager
Mrs Ruth Hill, Director of Operations for York & Selby
Ms Donna Oliver, Deputy Trust Secretary
Mr Patrick Scott, Director of Operations for Durham & Darlington
Dr Ingrid Whitton, Deputy Medical Director for Durham & Darlington
Mrs Kathryn Ord, Deputy Trust Secretary
Dr Stephen Wright, Deputy Medical Director for York & Selby

17/36 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Jennifer Illingworth, Director of Quality Governance and Mr Darren Gargen, Head of Nursing, Adult MH and Substance Misuse.

17/37 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 2 March 2017 be signed as a correct record by the Chairman of the Committee.

17/38 ACTION LOG

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

16/169iii) A review of the systems used to support the reporting of seclusion.
This matter would be deferred for a full report to the 4 May 2017 QuAC meeting.

17/11 Progress on initiative to manage the escalation of medicine management challenges.
This matter was covered under agenda item number 9 (see minute 17/45)

17/21(3) Check levels of psychology staffing across the Trust to check if under resourced.

An email had been circulated to members (06.04.17) prior to the meeting with the up to date position on the numbers of Psychologists across localities. It was noted that the Trust was not currently under resourced.

Completed

17/39 DURHAM AND DARLINGTON LMGB REPORT

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

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

(1) Concerns for staff and patient safety due to managing violent and aggressive patients. The Trust would be working closely with the Police and Crisis Care Concordat to agree a collective work plan and the installation of a seclusion room at West Park would alleviate some of these pressures.
Mrs Bessant expressed concerns over the impact of violence and aggressive patients on staff.

(2) Access to Tier 4 beds had been problematic resulting in young people sometimes being placed inappropriately. This was recognised as a national issue, however local bed management and more complex patients across the locality was impacting on patients, their families and staff.
On the matter of rising acuity Mr Scott pointed out that there were multiple influencing factors, including drugs and alcohol and complex personality disorders.

(3) Covering shifts for the specialist care package on Talbot ward had been difficult, however a qualified nurse had been seconded and agency staff had been recruited.

Following discussion Dr Whitton noted that the coroner issues in adult mental health and assurance sought over management of leave at West Park Hospital would be picked up through the thematic review of deaths, which would be part of an overall review of deaths or serious incidents whilst patients on leave over the last 2 years.

Mrs Moody noted that a report on the recording of self-harm would be presented to the QuAC at its meeting on 4 May 2017.

17/40 YORK AND SELBY LMGB REPORT

The Committee received and noted the York and Selby LMGB Report.

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

(1) Safe Staffing, with a significant number of vacancies and difficulties recruiting to some posts in MHSOP.
On this matter it was noted that the York locality had relatively full employment and there were easier jobs for people to take, however on a positive note there were 18 student nurses ready to take up post with the Trust in September 2017. The matter of recruiting to match the level of upcoming retirements would be an issue going forward.

Mrs Bessant expressed concerns over staff morale; however the Committee was assured that despite some inevitable concerns in the locality staff morale was good and support had been provided to teams from Organisational Development and HR.

(2) A contract Performance Improvement Notice and deep dive of the IAPT service had resulted in an action plan to increase the performance and activity. EIP Services had also been reviewed by NHSE and the service would now be considering the recommendations from this visit.
(3) CQC compliance in relation to the environment in MHSOP services on Acomb Garth, about cleanliness, patient safety, training and appraisal compliance.

The Committee were assured that the windows at Acomb Garth would be fixed within a few weeks.

17/41 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group report, including the Patient Safety Quality Report for the period 1 – 31 January 2017.

Arising from the report it was highlighted that:

1. There had been problems accessing historical records for patients previously with LYPFT,
   which had been identified from 4 SI reports. Actions to remedy this matter had been taken.
2. The Behaviours that Challenge policy and new Clinical Procedure for the safe use of physical restraint had been approved by EMT.
3. Harm minimisation face to face training had been extended for a further 6 months to September 2017.
4. The Falls Executive Group now had service user representation.
5. The process of reporting Duty of Candour moderate harm had been discussed to standardise recording on Datix. A Trust wide communication would be cascaded to inform staff of the change.

Following discussion it was noted that the new national guidance on learning from Deaths, March 2017 would inform the work needed to learn from deaths of patients.

Mrs Moody advised that from Quarter 3 evidence of learning would be taken from the dataset and reported through to the Board of Directors.

17/42 PATIENT EXPERIENCE GROUP (PEG) REPORT

The Committee received and noted the Patient Experience Group report relating to meetings held on 14 February and 14 March 2017.

The following matters were highlighted from the report:

1. There were ongoing concerns regarding the number of nursing home closures in the Teesside area, which was impacting on service users being accommodated out of locality.
2. The Forensic service had completed the planning for the implementation of PATTI pilot. There were issues with existing PATTI machines in the Resource Centre with websites required for educational purposes blocked and finding a resolution to this had been proving difficult and impacting on patients.

Dr Whitton considered that there was an issue with informal concerns being raised by MPs in the York & Selby area, which were not currently being captured within PALS and this would be raised with the Complaints Team.

Action: Dr I Whitton

17/43 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 3 serious case reviews in Hartlepool would be published imminently and a communications package was in place.
(2) There had been a homicide in York, which would be dealt with under the serious incident framework as well as through joint commissioning.
(3) A report had been received for factual checking from the CQC - 'Review of Health Services for Children Looked after and Safeguarding' in Durham. Following receipt of the similar reports from York and North Yorkshire a Trust action plan would be devised.
(4) The serious case review in Redcar around child sexual exploitation had been completed, however not published due to the young girls and perpetrator being identifiable.
(5) Consideration would be given for a serious case review of 2 deaths of children in North Yorkshire from suicide with one person receiving care in Norfolk. There did not appear to be any connection between the girls.

17/44 QUALITY ACCOUNT - AUDIT OF QUALITY INDICATORS

The Committee received and noted the Quality Account - Audit of Quality Indicators Report.

As part of the guidance issued by NHS Improvement, NHS FTs were required to undertake a substantive sample testing by External Auditors on 2 mandated performance indicators and 1 locally selected indicator.

The Governors, at a meeting held on 9 March 2017 selected the local indicator 'Percentage of clinical audits of NICE guidance completed' to be subjected to external audit.

There were 3 mandated performance indicators for NHS FTs, of which 2 were considered for audit by the organisation. It was proposed that an audit of Care Programme Approach and crisis indicators would add more value than delayed discharges.

The Committee noted that the draft Quality account 2016/17 would be presented to the 4 May 2017 QuAC meeting.

Agreed:

(1) That the data submitted for the indicator "percentage of clinical audits of NICE guidance completed" which had been selected by the Council of Governors would be subjected to external audit.
(2) That the data submitted for both '100% of enhanced Care Programme Approach patients receiving follow up contact within 7 days of discharge from hospital' and 'the proportion of admissions to inpatient services which had access to crisis resolution home treatment teams' would be subjected to external audit.
(3) That the Director of Planning, Performance and Communications would inform Mazars of the decision.

17/45 DRUG AND THERAPEUTICS REPORT

The Committee received and noted the Drug and Therapeutics (D&T) Report covering issues from its meeting held on 23 March 2017.

Arising from the report it was highlighted that the Pharmacy Leadership Team, with the support of the dispensing Pharmacies would be implementing the formulary for the most cost effective medicines. The D&T Group would receive 6 monthly feedback on progress and the changes would be communicated Trust wide. Mr Williams would provide an update to QuAC at its meeting on 7 September 2017.

Action: Mr C Williams

17/46 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. The action plan following the unannounced CQC visit in November 2016 to MHSOP and AMH services had been finalised and submitted to the CQC.
2. Ofsted registration of Holly and Bilsdale would take place from 3 April 2017 and it was noted that the Regulator had been very complimentary about the services provided.
3. Two further compliance unannounced visits were expected sometime after November 2017.
4. There had been 9 MHA inspections and monitoring reports received in the last reporting period and a thematic report would be presented to the Mental Health Legislation Committee at its meeting on 20 April 2017 around repeated issues raised by the CQC.

Mr Simpson expressed disappointment over the lack of staff engagement reported by several patients on Bilsdale Ward and Mrs Moody was asked to bring back to the Committee feedback from the team on improvements made.

Action: Mrs E Moody

17/47 MEMORANDUM OF UNDERSTANDING THE POLICE USE OF RESTRAINT IN MENTAL HEALTH AND LEARNING DISABILITY SETTING REPORT

The Committee received and noted the Memorandum of Understanding (MoU) – The Police Use of Restraint in Mental Health and Learning Disability Settings Report.

The Committee considered the implications for the Trust and it was noted that:

(1) The MoU set out clear guidance on how Police and Healthcare Services would need to work in a consistent, collaborative way to provide ongoing effective patient care.
(2) This work would be taken through the Crisis Care Concordat and it was anticipated that bi-monthly meetings would be set up with the local Police services to work in partnership, as well as making progress against the recommendations from the report.

Following discussion it was noted that the Police, under extreme circumstances were able to taser a service user whilst on Hospital premises and this would be treated as a serious incident level 4.

17/48 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

17/49 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.

17/50 ANY OTHER BUSINESS

There was no other business to note.

17/51 COMMITTEE MEETING EVALUATION

There was nothing to note.

17/52 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 4 May 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 3.55pm

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ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 23 May 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 April 2017 data.

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

- The number of rosters equates to 68 inpatient wards.
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 27 wards.
- The Forensic directorate have the highest level of 'red' fill rates (12 in April)
- The lowest fill rate indicators in April related to Primrose Lodge (vacancies and sickness), Springwood (vacancies) and Northdale (vacancies and sickness)
- The Highest fill rates in April were observed by Clover / Ivy (patient clinical risk and staff training), Bedale (seclusion) and Merlin (high patient acuity).
- In relation to bank usage there were no wards identified that were utilising in excess of 50% bank during April. The highest bank user was in relation to Clover / Ivy with 38% bank usage (reasons for bank included: enhanced Observations, training and vacancies)
- Agency usage equated to 1.85% in April. The highest user of agency within the reporting period related to Acomb Garth. This equated to 34% of the total hours worked, this is a reduction of 3% when compared to the previous month (37% in March).

- In terms of triangulation with incidents and complaints:
  - There were 3 Serious Incidents (SI) in inpatient areas that occurred within the month of April. Cedar (NY) was cited as having a SI as well as using agency staff. This was also the case last month and was outlined in March's board report. There were 3 level 4 incidents that occurred in April that were also classified as an SI.
  - There were 3 level 3 incidents (self-harm) that occurred in April from areas not highlighted within this report.
  - There were 4 complaints raised in April from areas not highlighted within this report.
  - There were 16 PALS related issues raised with the following featuring within this report as follows:
  - Minster (1 PALS) – cited in this report for agency usage
  - Ward 15 (1 PALS) – bank usage in excess of 25%
  - Cherry Tree (1 PALS) – cited I this report for agency usage
  - A number of incidents requiring control and restraint occurred during April. The highest user was The Evergreen Centre with a total of 91 incidents. The Evergreen Centre has not been cited during this report.

There were 513 shifts allocated in April where an unpaid break had not been taken. From those shifts where breaks were not taken the majority were in relation to day shifts (401 shifts).

There were 11 incidents raised in April citing concern's in relation to staffing levels.

A severity calculation has been applied within this report to highlight any areas of concern from a safe staffing point of view. In April Sandpiper had the highest score with 9 points awarded. A cumulative score has also been applied and highlights Sandpiper as having the highest score with 39 points (November to April). The top 10 for April 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:	**Tuesday, 23 May 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 April 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/about/how-well-are-we-doing/nurse-staffing). The full monthly data set of day by day staffing for each of the 68 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 – April 2017

3.1.1 The daily nurse staffing information aggregated for the month of April 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 27 in April. This is a decrease of 5 when compared to March.

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
April 2017		
Primrose Lodge	56.8% for RN on Days	This indicator is a slight improvement on last month whereby it was reporting at 47.8%. The shortfall is in relation to long term sickness, which was then filled by HCA's and staff from the

		Community Rehab team. They are flexing the HCA staff (123.3%) where appropriate to do so. A discussion took place over the staffing and management arrangements for this location at Aprils board meeting
Springwood	57.0% for RN on Days	The ward is carrying 3 RMN vacancies. In addition the ward has also high patient acuity (4 patients who need 3:1 care for interventions and 2 patients on enhanced observations). The ward are flexing the HCA staff (157.7%) where appropriate to do so.
Northdale Centre	63.3% for RN on Nights	The ward has advised the use of Agency RN to fill vacant night duties as a result of vacancies, sickness and nurses working on non-clinical duties due to pregnancy. Clinical need has meant that extra duties have been created however these are not always filled. Therefore the ward still runs short on occasions. The ward has 5 HCA vacancies and has long term sickness

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In April there were 46 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues. This is no change when compared to March.

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
April 2017		
Clover / Ivy	240.0% HCA on Nights 140.7% HCA on Days	The additional staffing is as a result of patient clinical risk and staff training.
Bedale Ward	216.9% HCA on Days 126.9% HCA on Nights	The additional staffing is as a result of seclusion and RN Shortage.
Merlin	211.7% HCA on Nights 185.8% HCA on Days	Some flexing on night shifts due to a staff nurse vacancy. There was always 1 registered nurse on duty. The ward currently has 2 extra shifts per 24 hour day for seclusion observations and 4 extra shifts per 24 hours period for observations.

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 April. The highest user of bank in April related to Clover / Ivy reporting at 43%. The reasons Clover / Ivy gave for requesting bank are as follows:

- Enhanced Observations (124 shifts)
- Training (22 shifts)
- Establishment Vacancies (20 shifts)
- Sickness (19 shifts)
- Unknown (14 shifts)
- Annual leave (5 shifts)
- Overbooked (4 shifts)
- Redeployment (1 shift)

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

Clover/Ivy	43%
Merlin	37%
Westerdale South	36%
Bedale Ward	32%
Cedar Ward (WPH)	30%
Bransdale Ward	28%
Ward 15 Friarage	27%
Bankfields Court Unit 2	26%

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 April the agency usage equated to 1.85% a decrease of 0.20% when compared to March.

The highest user of agency within the reporting period related to Acomb Garth equating to approximately 34% of the total hours worked. This ward continues to have problems with recruitment of registered nursing staff and is running at a reduced bed occupancy to mitigate some of the risks identified with this.

Wards reporting agency usage in April are detailed below:

Acomb Garth	34%
Cedar Ward (NY)	22%
Springwood Community Unit	18%
Rowan Ward	13%
Meadowfields	12%
Ebor Ward	11%
Oak Rise	8%
Minster Ward	2%
Cherry Tree House	2%

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 April with the following reporting as an exception:

- There were 3 Serious Incidents (SI) that occurred within the month of April. Cedar (NY) was cited as having a SI as well as using agency staff. This was also the case last month in March.
- There were 3 level 4 incidents that occurred in April that were also classified as an SI.
- There were 3 level 3 incidents (self-harm) that occurred in April from areas not highlighted within this report.
- There were 4 complaints raised in April from areas not highlighted within this report.
- There were 16 PALS related issues raised with the following featuring within this report as follows:
  - Minster (1 PALS) – cited in this report for agency usage
  - Ward 15 (1 PALS) – bank usage in excess of 25%
  - Cherry Tree (1 PALS) – cited in this report for agency usage
- A number of incidents requiring control and restraint occurred during April. The highest user was The Evergreen Centre with a total of 91 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 513 shifts in April where unpaid breaks had not been taken. This is a decrease of 3 when compared to March (516 shifts).

The majority of the shifts where breaks were not taken occurred on day shifts (401 shifts). The number of night shifts where breaks were not taken equated to 112 shifts in April.

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 11 incidents reported in April 2017 on Datix citing issues with staffing.

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

- 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.
- Merlin raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report with regards to high staffing levels and bank usage.
- Rowan Ward raised 1 incident in relation to staffing levels. In addition the ward has been cited in this report with regards to agency usage.

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 each month:

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	YTD Total Score (Nov-Apr)
Sandpiper Ward	4	1	1	0	1	0	0	0	0	2	**9**	**39**
Newberry Centre	2	2	0	0	1	0	0	1	0	2	**8**	**25**
Bedale Ward	2	2	1	0	1	0	0	0	0	1	**7**	**24**
Clover/Ivy	2	2	0	0	2	0	0	0	0	1	**7**	**17**
Merlin	2	2	1	0	1	0	0	0	0	1	**7**	**24**
Springwood	2	2	0	1	1	0	0	0	0	1	**7**	**34**
Cedar Ward (NY)	2	0	0	1	0	1	1	0	0	1	**6**	**30**
Lustrum Vale	2	1	0	0	1	1	1	0	0	0	**6**	**10**
Brambling Ward	2	0	1	0	1	0	0	1	0	1	**6**	**11**
Acomb Garth	2	1	1	1	0	0	0	0	0	1	**6**	**13**
Meadowfields	4	0	0	1	1	0	0	0	0	0	**6**	**31**
Rowan Ward	0	2	1	1	1	0	0	0	0	1	**6**	**27**

3.8 Other

The Forensic directorate have the highest number (12 wards' in March) of 'red' fill rates for registered nurses on day shifts. This is an increase of 1 when compared to March. 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. 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
May 2017

APPENDIX 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 30 DAYS IN April							
				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	90.4%	104.2%	100.3%	101.9%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	86.4%	126.0%	103.3%	103.3%
Bedale Ward	Teesside	Adults	10	81.4%	216.9%	117.5%	126.9%
Bilsdale Ward	Teesside	Adults	14	98.1%	117.3%	110.0%	96.7%
Birch Ward	Durham & Darlington	Adults	15	105.7%	100.6%	100.0%	102.4%
Bransdale Ward	Teesside	Adults	14	92.3%	160.7%	100.3%	145.4%
Cedar Ward	Durham & Darlington	Adults	10	105.3%	204.4%	100.0%	162.4%
Cedar Ward (NY)	North Yorkshire	Adults	18	80.7%	110.1%	99.8%	118.0%
Ebor Ward	York and Selby	Adults	12	87.3%	87.7%	96.7%	105.0%
Elm Ward	Durham & Darlington	Adults	20	97.5%	118.4%	100.0%	110.0%
Farnham Ward	Durham & Darlington	Adults	20	127.4%	102.5%	96.7%	103.4%
Kirkdale Ward	Teesside	Adults	16	87.0%	101.3%	100.6%	111.7%
Lincoln Ward	Teesside	Adults	20	95.6%	101.2%	96.4%	117.1%
Lustrum Vale	Teesside	Adults	20	71.0%	131.2%	100.0%	101.7%
Maple Ward	Durham & Darlington	Adults	20	96.8%	106.7%	106.7%	101.7%
Minster Ward	York and Selby	Adults	12	101.3%	93.0%	103.9%	93.9%
Overdale Ward	Teesside	Adults	18	85.6%	90.4%	103.3%	98.3%
Primrose Lodge	Durham & Darlington	Adults	15	56.8%	123.3%	100.0%	100.0%

Stockdale Ward	Teesside	Adults	18	92.5%	109.5%	100.6%	118.5%
The Orchards (NY)	North Yorkshire	Adults	10	95.9%	100.0%	80.0%	86.7%
Tunstall Ward	Durham & Darlington	Adults	20	111.1%	114.2%	133.3%	98.3%
Ward 15 Friarage	North Yorkshire	Adults	12	69.1%	136.5%	100.0%	100.0%
Willow Ward	Durham & Darlington	Adults	15	97.0%	145.0%	100.0%	101.7%
Baysdale	Teesside	CYPS	6	114.8%	106.6%	103.7%	98.3%
Holly Unit	Durham & Darlington	CYPS	4	122.9%	146.6%	111.8%	133.3%
Newberry Centre	Teesside	CYPS	14	75.8%	148.1%	114.0%	150.9%
Talbot Direct Care	Durham & Darlington	CYPS	1	111.9%	97.2%	130.1%	169.2%
The Evergreen Centre	Teesside	CYPS	16	88.4%	136.6%	96.7%	105.0%
Westwood Centre	Teesside	CYPS	12	110.6%	137.1%	106.6%	156.7%
Clover/Ivy	Forensics	Forensics LD	12	84.3%	140.7%	100.0%	240.0%
Eagle/Osprey	Forensics	Forensics LD	10	90.9%	93.8%	94.0%	98.0%
Harrier/Hawk	Forensics	Forensics LD	10	87.1%	107.6%	91.9%	96.6%
Kestrel/Kite.	Forensics	Forensics LD	16	92.5%	125.6%	116.5%	145.1%
Langley Ward	Forensics	Forensics LD	10	90.0%	97.2%	100.0%	100.0%
Northdale Centre	Forensics	Forensics LD	12	95.2%	117.5%	63.3%	94.8%
Oakwood	Forensics	Forensics LD	8	88.3%	129.5%	100.2%	100.0%
Thistle	Forensics	Forensics LD	5	64.8%	122.0%	100.0%	100.0%
Brambling Ward	Forensics	Forensics MH	13	85.8%	108.2%	100.9%	105.0%
Fulmar Ward.	Forensics	Forensics MH	12	101.6%	94.3%	96.7%	100.0%
Jay Ward	Forensics	Forensics MH	5	83.6%	111.6%	100.0%	110.0%
Lark	Forensics	Forensics MH	15	88.2%	102.0%	100.0%	100.4%
Linnet Ward	Forensics	Forensics MH	17	75.9%	104.6%	109.8%	95.1%
Mallard Ward	Forensics	Forensics MH	16	86.6%	113.3%	100.0%	125.9%
Mandarin	Forensics	Forensics MH	16	69.7%	118.9%	103.3%	101.8%
Merlin	Forensics	Forensics MH	10	105.2%	185.8%	86.6%	211.7%

Newtondale Ward	Forensics	Forensics MH	20	97.6%	110.8%	74.6%	150.0%
Nightingale Ward	Forensics	Forensics MH	16	90.3%	94.2%	100.0%	96.7%
Sandpiper Ward	Forensics	Forensics MH	8	85.6%	112.9%	77.6%	175.9%
Swift Ward	Forensics	Forensics MH	10	81.8%	105.6%	99.8%	113.3%
Aysgarth	Teesside	LD	6	127.0%	90.5%	102.3%	96.5%
Bankfields Court	Teesside	LD	19	85.2%	110.3%	102.0%	101.3%
Bankfields Court Unit 2	Teesside	LD	5	102.7%	102.3%	113.2%	120.0%
Bek-Ramsey Ward	Durham & Darlington	LD	11	102.6%	129.0%	100.0%	105.9%
Oak Rise	York and Selby	LD	8	101.0%	72.1%	94.1%	103.6%
Acomb Garth	York and Selby	MHSOP	14	90.0%	81.7%	109.1%	180.3%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	96.8%	116.8%	100.0%	108.3%
Cherry Tree House	York and Selby	MHSOP	18	99.2%	84.5%	100.0%	101.7%
Hamsterley Ward	Durham & Darlington	MHSOP	15	104.0%	119.1%	117.3%	135.2%
Meadowfields	York and Selby	MHSOP	14	71.8%	82.9%	93.1%	116.5%
Oak Ward	Durham & Darlington	MHSOP	12	101.2%	94.2%	100.0%	106.4%
Roseberry Wards	Durham & Darlington	MHSOP	15	90.4%	91.3%	103.3%	98.0%
Rowan Lea	North Yorkshire	MHSOP	20	100.4%	128.9%	109.6%	111.7%
Rowan Ward	North Yorkshire	MHSOP	16	107.7%	126.2%	101.2%	144.9%
Springwood Community Unit	North Yorkshire	MHSOP	14	57.0%	157.7%	100.0%	188.7%
Ward 14	North Yorkshire	MHSOP	10	78.1%	122.5%	100.9%	110.4%
Westerdale North	Teesside	MHSOP	18	96.8%	117.8%	103.6%	102.2%
Westerdale South	Teesside	MHSOP	14	103.3%	124.8%	100.0%	111.4%
Wingfield Ward	Teesside	MHSOP	10	99.7%	101.6%	100.0%	100.0%

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - April 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	2504.00	0.00	0%	2504.00	411.00	16%						8		11	11
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2777.50	0.00	0%	2777.50	391.00	14%						6		9	9
Bedale Ward	Teesside	Adults	10	3874.53	0.00	0%	3874.53	1243.00	32%						15		34	34
Bilsdale Ward	Teesside	Adults	14	2636.00	0.00	0%	2636.00	34.50	1%					1	2		3	3
Birch Ward	Durham & Darlington	Adults	15	3175.08	0.00	0%	3175.08	521.00	16%				1					
Bransdale Ward	Teesside	Adults	14	3215.50	0.00	0%	3215.50	902.50	28%						5		13	13
Cedar Ward	Durham & Darlington	Adults	10	4447.97	0.00	0%	4447.97	1325.17	30%						21	1	44	45
Cedar Ward (NY)	North Yorkshire	Adults	18	3286.75	730.25	22%	3286.75	225.50	7%	1	1				13		15	15
Ebor Ward	York and Selby	Adults	12	2579.75	283.50	11%	2579.75	111.00	4%						1		1	1
Elm Ward	Durham & Darlington	Adults	20	2838.67	0.00	0%	2838.67	557.33	20%					3	6		8	8
Farnham Ward	Durham & Darlington	Adults	20	2882.32	0.00	0%	2882.32	145.00	5%				1		4		7	7
Kirkdale Ward	Teesside	Adults	16	3064.75	0.00	0%	3064.75	258.75	8%						1		2	2
Lincoln Ward	Teesside	Adults	20	2870.00	0.00	0%	2870.00	251.50	9%				1		10		11	11
Lustrum Vale	Teesside	Adults	20	2687.48	0.00	0%	2687.48	462.50	17%	1	1							
Maple Ward	Durham & Darlington	Adults	20	2677.67	0.00	0%	2677.67	449.33	17%						5		5	5
Minster Ward	York and Selby	Adults	12	2604.17	57.50	2%	2604.17	335.50	13%					1				
Overdale Ward	Teesside	Adults	18	2480.25	0.00	0%	2480.25	274.25	11%				1	1	2		3	3
Primrose Lodge	Durham & Darlington	Adults	15	2462.00	0.00	0%	2462.00	300.00	12%									
Stockdale Ward	Teesside	Adults	18	2655.67	0.00	0%	2655.67	410.50	15%					1	5		7	7

The Orchards (NY)	North Yorkshire	Adults	10	2070.50	0.00	0%	2070.50	0.00	0%										
Tunstall Ward	Durham & Darlington	Adults	20	2926.67	0.00	0%	2926.67	48.00	2%					3	1		1	1
Ward 15 Friarage	North Yorkshire	Adults	12	2456.92	0.00	0%	2456.92	653.50	27%					1	1		1	1
Willow Ward	Durham & Darlington	Adults	15	2695.67	0.00	0%	2695.67	261.00	10%									
Baysdale	Teesside	CYPS	6	2643.07	0.00	0%	2643.07	248.19	9%									
Holly Unit	Durham & Darlington	CYPS	4	1271.75	0.00	0%	1271.75	139.59	11%						1		1	1
Newberry Centre	Teesside	CYPS	14	4041.65	0.00	0%	4041.65	565.56	14%			1		1	87	1	145	146
Talbot Direct Care	Durham & Darlington	CYPS	1	2865.68	0.00	0%	2865.68	19.25	1%						4		8	8
The Evergreen Centre	Teesside	CYPS	16	4660.75	0.00	0%	4660.75	254.75	5%						91		131	131
Westwood Centre	Teesside	CYPS	12	5157.82	0.00	0%	5157.82	708.75	14%						50		89	89
Clover/Ivy	Forensics	Forensics LD	12	5152.33	0.00	0%	5152.33	2201.59	43%						36		70	70
Eagle/Osprey	Forensics	Forensics LD	10	3125.58	0.00	0%	3125.58	450.50	14%									
Harrier/Hawk	Forensics	Forensics LD	10	3680.33	0.00	0%	3680.33	246.33	7%					1	1		1	1
Kestrel/Kite.	Forensics	Forensics LD	16	4683.25	0.00	0%	4683.25	1033.50	22%						6		13	13
Langley Ward	Forensics	Forensics LD	10	2067.75	0.00	0%	2067.75	109.75	5%									
Northdale Centre	Forensics	Forensics LD	12	4629.13	0.00	0%	4629.13	1116.17	24%						3		6	6
Oakwood	Forensics	Forensics LD	8	2040.97	0.00	0%	2040.97	56.25	3%									
Thistle	Forensics	Forensics LD	5	2949.95	0.00	0%	2949.95	255.09	9%						2		8	8
Brambling Ward	Forensics	Forensics MH	13	2788.75	0.00	0%	2788.75	464.75	17%			1			27		43	43
Fulmar Ward.	Forensics	Forensics MH	12	2901.25	0.00	0%	2901.25	334.25	12%			1			2		4	4
Jay Ward	Forensics	Forensics MH	5	2764.75	0.00	0%	2764.75	329.50	12%						1		2	2
Lark	Forensics	Forensics MH	15	2697.30	0.00	0%	2697.30	502.50	19%									
Linnet Ward	Forensics	Forensics MH	17	2643.25	0.00	0%	2643.25	415.50	16%									
Mallard Ward	Forensics	Forensics MH	16	3291.50	0.00	0%	3291.50	737.75	22%						6		6	6
Mandarin	Forensics	Forensics MH	16	2752.13	0.00	0%	2752.13	295.75	11%					1				
Merlin	Forensics	Forensics MH	10	5124.25	0.00	0%	5124.25	1917.50	37%						35	1	38	39
Newtondale Ward	Forensics	Forensics MH	20	3983.17	0.00	0%	3983.17	920.75	23%									
Nightingale Ward	Forensics	Forensics MH	16	2638.52	0.00	0%	2638.52	487.75	18%						1		1	1

Sandpiper Ward	Forensics	Forensics MH	8	4173.48	0.00	0%	4173.48	894.48	21%						89	6	217	223
Swift Ward	Forensics	Forensics MH	10	3057.00	0.00	0%	3057.00	582.75	19%						9		14	14
Aysgarth	Teesside	LD	6	2247.58	0.00	0%	2247.58	495.58	22%									
Bankfields Court	Teesside	LD	19	8335.33	0.00	0%	8335.33	930.57	11%						15		19	19
Bankfields Court Unit 2	Teesside	LD	5	2410.92	0.00	0%	2410.92	637.31	26%									
Bek-Ramsey Ward	Durham & Darlington	LD	11	4314.67	0.00	0%	4314.67	119.00	3%						16		19	19
Oak Rise	York and Selby	LD	8	3491.58	264.00	8%	3491.58	235.33	7%									
Acomb Garth	York and Selby	MHSOP	14	3597.50	1223.00	34%	3597.50	57.70	2%						11		12	12
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	3175.83	0.00	0%	3175.83	267.51	8%						5		14	14
Cherry Tree House	York and Selby	MHSOP	18	3060.00	72.00	2%	3060.00	30.00	1%					1	4		4	4
Hamsterley Ward	Durham & Darlington	MHSOP	15	3359.92	0.00	0%	3359.92	506.43	15%	1	1				5		6	6
Meadowfields	York and Selby	MHSOP	14	3001.45	365.00	12%	3001.45	543.50	18%						6		7	7
Oak Ward	Durham & Darlington	MHSOP	12	2596.40	0.00	0%	2596.40	50.67	2%									
Roseberry Wards	Durham & Darlington	MHSOP	15	2646.65	0.00	0%	2646.65	413.49	16%					1				
Rowan Lea	North Yorkshire	MHSOP	20	3841.00	0.00	0%	3841.00	80.85	2%						6		7	7
Rowan Ward	North Yorkshire	MHSOP	16	3089.50	393.50	13%	3089.50	354.00	11%						12		19	19
Springwood Community Unit	North Yorkshire	MHSOP	14	3584.03	656.95	18%	3584.03	439.84	12%						23		27	27
Ward 14	North Yorkshire	MHSOP	10	2574.00	0.00	0%	2574.00	82.70	3%						8		11	11
Westerdale North	Teesside	MHSOP	18	2647.75	0.00	0%	2647.75	120.50	5%						2		3	3
Westerdale South	Teesside	MHSOP	14	4235.42	0.00	0%	4235.42	1529.62	36%						3		7	7
Wingfield Ward	Teesside	MHSOP	10	2427.75	0.00	0%	2427.75	124.00	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	YTD Total Score (Nov-Apr)
Sandpiper Ward	Forensics	Forensics MH	8	4	1	1	0	1	0	0	0	0	2	**9**	**39**
Newberry Centre	Teesside	CYPS	14	2	2	0	0	1	0	0	1	0	2	**8**	**25**
Bedale Ward	Teesside	Adults	10	2	2	1	0	1	0	0	0	0	1	**7**	**24**
Clover/Ivy	Forensics	Forensics LD	12	2	2	0	0	2	0	0	0	0	1	**7**	**17**
Merlin	Forensics	Forensics MH	10	2	2	1	0	1	0	0	0	0	1	**7**	**24**
Springwood Community Unit	North Yorkshire	MHSOP	14	2	2	0	1	1	0	0	0	0	1	**7**	**34**
Cedar Ward (NY)	North Yorkshire	Adults	18	2	0	0	1	0	1	1	0	0	1	**6**	**30**
Lustrum Vale	Teesside	Adults	20	2	1	0	0	1	1	1	0	0	0	**6**	**10**
Brambling Ward	Forensics	Forensics MH	13	2	0	1	0	1	0	0	1	0	1	**6**	**11**
Acomb Garth	York and Selby	MHSOP	14	2	1	1	1	0	0	0	0	0	1	**6**	**13**
Meadowfields	York and Selby	MHSOP	14	4	0	0	1	1	0	0	0	0	0	**6**	**31**
Rowan Ward	North Yorkshire	MHSOP	16	0	2	1	1	1	0	0	0	0	1	**6**	**27**
Cedar Ward	Durham & Darlington	Adults	10	0	2	1	0	1	0	0	0	0	1	**5**	**25**
Ebor Ward	York and Selby	Adults	12	4	0	0	1	0	0	0	0	0	0	**5**	**18**
Primrose Lodge	Durham & Darlington	Adults	15	2	1	1	0	1	0	0	0	0	0	**5**	**17**
Ward 15 Friarage	North Yorkshire	Adults	12	2	1	1	0	1	0	0	0	0	0	**5**	**22**
The Evergreen Centre	Teesside	CYPS	16	2	1	0	0	0	0	0	0	0	2	**5**	**17**
Westwood Centre	Teesside	CYPS	12	0	2	0	0	1	0	0	0	0	2	**5**	**28**
Bankfields Court	Teesside	LD	19	2	0	1	0	1	0	0	0	0	1	**5**	**22**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	1	1	0	1	1	1	0	0	0	**5**	**21**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2	1	0	0	1	0	0	0	0	0	**4**	**28**
Bransdale Ward	Teesside	Adults	14	0	2	1	0	1	0	0	0	0	0	**4**	**26**
Overdale Ward	Teesside	Adults	18	2	0	0	0	1	0	0	0	1	0	**4**	**19**
The Orchards (NY)	North Yorkshire	Adults	10	4	0	0	0	0	0	0	0	0	0	**4**	**26**
Holly Unit	Durham & Darlington	CYPS	4	0	3	1	0	0	0	0	0	0	0	**4**	**15**
Northdale Centre	Forensics	Forensics LD	12	2	0	1	0	1	0	0	0	0	0	**4**	**29**

Oakwood	Forensics	Forensics LD	8	2	1	1	0	0	0	0	0	0	0	**4**	**17**
Lark	Forensics	Forensics MH	15	2	0	1	0	1	0	0	0	0	0	**4**	**8**
Linnet Ward	Forensics	Forensics MH	17	2	0	1	0	1	0	0	0	0	0	**4**	**22**
Mallard Ward	Forensics	Forensics MH	16	2	1	0	0	1	0	0	0	0	0	**4**	**21**
Newtondale Ward	Forensics	Forensics MH	20	2	1	0	0	1	0	0	0	0	0	**4**	**27**
Swift Ward	Forensics	Forensics MH	10	2	0	1	0	1	0	0	0	0	0	**4**	**26**
Ward 14	North Yorkshire	MHSOP	10	2	1	1	0	0	0	0	0	0	0	**4**	**17**
Farnham Ward	Durham & Darlington	Adults	20	0	1	1	0	0	0	0	0	1	0	**3**	**9**
Kirkdale Ward	Forensics	Adults	16	2	0	1	0	0	0	0	0	0	0	**3**	**8**
Harrier/Hawk	Forensics	Forensics LD	10	2	0	1	0	0	0	0	0	0	0	**3**	**28**
Kestrel/Kite.	Forensics	Forensics LD	16	0	2	0	0	1	0	0	0	0	0	**3**	**27**
Thistle	Forensics	Forensics LD	5	2	1	0	0	0	0	0	0	0	0	**3**	**12**
Jay Ward	Forensics	Forensics MH	5	2	0	0	0	1	0	0	0	0	0	**3**	**19**
Mandarin	Forensics	Forensics MH	16	2	0	1	0	0	0	0	0	0	0	**3**	**21**
Oak Rise	York and Selby	LD	8	2	0	0	1	0	0	0	0	0	0	**3**	**17**
Cherry Tree House	York and Selby	MHSOP	18	2	0	0	1	0	0	0	0	0	0	**3**	**16**
Westerdale South	Teesside	MHSOP	14	0	1	1	0	1	0	0	0	0	0	**3**	**14**
Birch Ward	Durham & Darlington	Adults	15	0	0	0	0	1	0	0	0	1	0	**2**	**12**
Elm Ward	Durham & Darlington	Adults	20	0	0	1	0	1	0	0	0	0	0	**2**	**19**
Lincoln Ward	Teesside	Adults	20	0	0	1	0	0	0	0	0	1	0	**2**	**2**
Maple Ward	Durham & Darlington	Adults	20	0	0	1	0	1	0	0	0	0	0	**2**	**16**
Minster Ward	York and Selby	Adults	12	0	0	0	1	1	0	0	0	0	0	**2**	**19**
Stockdale Ward	Teesside	Adults	18	0	0	1	0	1	0	0	0	0	0	**2**	**7**
Willow Ward	Durham & Darlington	Adults	15	0	1	1	0	0	0	0	0	0	0	**2**	**15**
Talbot Direct Care	Durham & Darlington	CYPS	1	0	2	0	0	0	0	0	0	0	0	**2**	**13**
Fulmar Ward.	Forensics	Forensics MH	12	0	0	0	0	1	0	0	1	0	0	**2**	**22**
Aysgarth	Teesside	LD	6	0	1	0	0	1	0	0	0	0	0	**2**	**11**
Bankfields Court Unit 2	Teesside	LD	5	0	1	0	0	1	0	0	0	0	0	**2**	**9**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	0	0	0	0	0	0	1	**2**	**7**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	0	0	0	0	1	0	0	0	0	0	**1**	**24**
Tunstall Ward	Durham & Darlington	Adults	20	0	1	0	0	0	0	0	0	0	0	**1**	**4**
Eagle/Osprey	Forensics	Forensics LD	10	0	0	0	0	1	0	0	0	0	0	**1**	**15**
Nightingale Ward	Forensics	Forensics MH	16	0	0	0	0	1	0	0	0	0	0	**1**	**14**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	0	1	0	0	0	0	0	0	0	**1**	**8**
Oak Ward	Durham & Darlington	MHSOP	12	0	0	1	0	0	0	0	0	0	0	**1**	**6**

Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	0	0	1	0	0	0	0	0	**1**	**6**
Rowan Lea	North Yorkshire	MHSOP	20	0	1	0	0	0	0	0	0	0	0	**1**	**6**
Westerdale North	Teesside	MHSOP	18	0	0	1	0	0	0	0	0	0	0	**1**	**7**
Bilsdale Ward	Teesside	Adults	14	0	0	0	0	0	0	0	0	0	0	**0**	**13**
Baysdale	Teesside	CYPS	6	0	0	0	0	0	0	0	0	0	0	**0**	**3**
Langley Ward	Forensics	Forensics LD	10	0	0	0	0	0	0	0	0	0	0	**0**	**20**
Wingfield Ward	Teesside	MHSOP	10	0	0	0	0	0	0	0	0	0	0	**0**	**15**

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 Incidents	Complaints	Control & Restraint	TOTAL SCORE	YTD Total Score (Nov-Apr)
Bedale Ward	Teesside	Adults	10	2	2	1	0	1	0	0	0	0	1	**7**	**24**
Cedar Ward (NY)	North Yorkshire	Adults	18	2	0	0	1	0	1	1	0	0	1	**6**	**30**
Lustrum Vale	Teesside	Adults	20	2	1	0	0	1	1	1	0	0	0	**6**	**10**
Cedar Ward	Durham & Darlington	Adults	10	0	2	1	0	1	0	0	0	0	1	**5**	**25**
Primrose Lodge	Durham & Darlington	Adults	15	2	1	1	0	1	0	0	0	0	0	**5**	**17**
Ward 15 Friarage	North Yorkshire	Adults	12	2	1	1	0	1	0	0	0	0	0	**5**	**22**
Ebor Ward	York and Selby	Adults	12	4	0	0	1	0	0	0	0	0	0	**5**	**18**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2	1	0	0	1	0	0	0	0	0	**4**	**28**
The Orchards (NY)	North Yorkshire	Adults	10	4	0	0	0	0	0	0	0	0	0	**4**	**26**
Bransdale Ward	Teesside	Adults	14	0	2	1	0	1	0	0	0	0	0	**4**	**26**
Overdale Ward	Teesside	Adults	18	2	0	0	0	1	0	0	0	1	0	**4**	**19**
Farnham Ward	Durham & Darlington	Adults	20	0	1	1	0	0	0	0	0	1	0	**3**	**9**
Kirkdale Ward	Forensics	Adults	16	2	0	1	0	0	0	0	0	0	0	**3**	**8**
Birch Ward	Durham & Darlington	Adults	15	0	0	0	0	1	0	0	0	1	0	**2**	**12**
Elm Ward	Durham & Darlington	Adults	20	0	0	1	0	1	0	0	0	0	0	**2**	**19**
Maple Ward	Durham & Darlington	Adults	20	0	0	1	0	1	0	0	0	0	0	**2**	**16**
Willow Ward	Durham & Darlington	Adults	15	0	1	1	0	0	0	0	0	0	0	**2**	**15**
Lincoln Ward	Teesside	Adults	20	0	0	1	0	0	0	0	0	1	0	**2**	**2**
Stockdale Ward	Teesside	Adults	18	0	0	1	0	1	0	0	0	0	0	**2**	**7**
Minster Ward	York and Selby	Adults	12	0	0	0	1	1	0	0	0	0	0	**2**	**19**
Tunstall Ward	Durham & Darlington	Adults	20	0	1	0	0	0	0	0	0	0	0	**1**	**4**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	0	0	0	0	1	0	0	0	0	0	**1**	**24**
Bilsdale Ward	Teesside	Adults	14	0	0	0	0	0	0	0	0	0	0	**0**	**13**
Newberry Centre	Teesside	CYPS	14	2	2	0	0	1	0	0	1	0	2	**8**	**25**
The Evergreen Centre	Teesside	CYPS	16	2	1	0	0	0	0	0	0	0	2	**5**	**17**
Westwood Centre	Teesside	CYPS	12	0	2	0	0	1	0	0	0	0	2	**5**	**28**
Holly Unit	Durham & Darlington	CYPS	4	0	3	1	0	0	0	0	0	0	0	**4**	**15**

Talbot Direct Care	Durham & Darlington	CYPS	1	0	2	0	0	0	0	0	0	0	0	**2**	**13**
Baysdale	Teesside	CYPS	6	0	0	0	0	0	0	0	0	0	0	**0**	**3**
Clover/Ivy	Forensics	Forensics LD	12	2	2	0	0	2	0	0	0	0	1	**7**	**17**
Northdale Centre	Forensics	Forensics LD	12	2	0	1	0	1	0	0	0	0	0	**4**	**29**
Oakwood	Forensics	Forensics LD	8	2	1	1	0	0	0	0	0	0	0	**4**	**17**
Harrier/Hawk	Forensics	Forensics LD	10	2	0	1	0	0	0	0	0	0	0	**3**	**28**
Kestrel/Kite.	Forensics	Forensics LD	16	0	2	0	0	1	0	0	0	0	0	**3**	**27**
Thistle	Forensics	Forensics LD	5	2	1	0	0	0	0	0	0	0	0	**3**	**12**
Eagle/Osprey	Forensics	Forensics LD	10	0	0	0	0	1	0	0	0	0	0	**1**	**15**
Langley Ward	Forensics	Forensics LD	10	0	0	0	0	0	0	0	0	0	0	**0**	**20**
Sandpiper Ward	Forensics	Forensics MH	8	4	1	1	0	1	0	0	0	0	2	**9**	**39**
Merlin	Forensics	Forensics MH	10	2	2	1	0	1	0	0	0	0	1	**7**	**24**
Brambling Ward	Forensics	Forensics MH	13	2	0	1	0	1	0	0	1	0	1	**6**	**11**
Lark	Forensics	Forensics MH	15	2	0	1	0	1	0	0	0	0	0	**4**	**8**
Linnet Ward	Forensics	Forensics MH	17	2	0	1	0	1	0	0	0	0	0	**4**	**22**
Mallard Ward	Forensics	Forensics MH	16	2	1	0	0	1	0	0	0	0	0	**4**	**21**
Newtondale Ward	Forensics	Forensics MH	20	2	1	0	0	1	0	0	0	0	0	**4**	**27**
Swift Ward	Forensics	Forensics MH	10	2	0	1	0	1	0	0	0	0	0	**4**	**26**
Jay Ward	Forensics	Forensics MH	5	2	0	0	0	1	0	0	0	0	0	**3**	**19**
Mandarin	Forensics	Forensics MH	16	2	0	1	0	0	0	0	0	0	0	**3**	**21**
Fulmar Ward.	Forensics	Forensics MH	12	0	0	0	0	1	0	0	1	0	0	**2**	**22**
Nightingale Ward	Forensics	Forensics MH	16	0	0	0	0	1	0	0	0	0	0	**1**	**14**
Bankfields Court	Teesside	LD	19	2	0	1	0	1	0	0	0	0	1	**5**	**22**
Oak Rise	York and Selby	LD	8	2	0	0	1	0	0	0	0	0	0	**3**	**17**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	0	0	0	0	0	0	1	**2**	**7**
Aysgarth	Teesside	LD	6	0	1	0	0	1	0	0	0	0	0	**2**	**11**
Bankfields Court Unit 2	Teesside	LD	5	0	1	0	0	1	0	0	0	0	0	**2**	**9**
Springwood Community Unit	North Yorkshire	MHSOP	14	2	2	0	1	1	0	0	0	0	1	**7**	**34**
Rowan Ward	North Yorkshire	MHSOP	16	0	2	1	1	1	0	0	0	0	1	**6**	**27**
Acomb Garth	York and Selby	MHSOP	14	2	1	1	1	0	0	0	0	0	1	**6**	**13**
Meadowfields	York and Selby	MHSOP	14	4	0	0	1	1	0	0	0	0	0	**6**	**31**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	1	1	0	1	1	1	0	0	0	**5**	**21**
Ward 14	North Yorkshire	MHSOP	10	2	1	1	0	0	0	0	0	0	0	**4**	**17**
Westerdale South	Teesside	MHSOP	14	0	1	1	0	1	0	0	0	0	0	**3**	**14**
Cherry Tree House	York and Selby	MHSOP	18	2	0	0	1	0	0	0	0	0	0	**3**	**16**

Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	0	1	0	0	0	0	0	0	0	**1**	**8**
Oak Ward	Durham & Darlington	MHSOP	12	0	0	1	0	0	0	0	0	0	0	**1**	**6**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	0	0	1	0	0	0	0	0	**1**	**6**
Rowan Lea	North Yorkshire	MHSOP	20	0	1	0	0	0	0	0	0	0	0	**1**	**6**
Westerdale North	Teesside	MHSOP	18	0	0	1	0	0	0	0	0	0	0	**1**	**7**
Wingfield Ward	Teesside	MHSOP	10	0	0	0	0	0	0	0	0	0	0	**0**	**15**

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd May 2017**
TITLE:	**Nurse Recruitment & Retention Plan Update**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information and Decision**

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

Executive Summary:

Since the last update a further nine recruitment events have taken place. As a result, 218 potential candidates were interviewed, 181 were appointable, 14 withdrew, 123 are students who have been offered posts subject to qualifying and satisfying any employment checks

As at 31st March 2016 the current fill rates for bands 5 and 6 are 86% and 92% respectively.

In total there are 28 actions within the action plan. Three actions have been completed, eight actions were due to complete on or before 31 March 2017, an update on progress against these outstanding actions is presented. The remaining 17 actions have a later completion date and have therefore not been included in this report.

Recommendations:

7.1 To note level of centralised recruitment activity undertaken since the last report

7.2 To note progress made with implementation of the Recruitment and Retention Action Plan

7.3 To receive a further report in November 2017

MEETING OF:	**Board of Directors**
DATE:	**23rd May 2017**
TITLE:	**Recruitment & Retention Action Plan Update**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide an update on centralised recruitment activity and progress made with implementing the Recruitment and Retention Action Plan

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In October 2016 the Executive Management Team endorsed a TEWV Recruitment and Retention Action Plan (Appendix A) and Directors received a report about recruitment in November 2016. It was agreed by Directors that they receive an update about progress made with implementation of the action plan at the May 2017 meeting.

3. KEY ISSUES:

3.1 A further nine recruitment events have taken place since the autumn of 2016. 218 potential candidates have been interviewed, 181 were deemed to be appointable, 14 withdrew and 123 students have been offered posts subject to qualifying and satisfying any employment checks standards. It is anticipated that these students will complete their training in September 2017 and January 2018.

3.2 As at 31st March 2017 the fill rate for bands 5 and 6 nursing vacancies were 86% and 92% respectively. Band 5 fill rates are affected by the times of the year when students complete their university courses.

3.3 In February 2017, the Recruitment and Retention Action Plan was shared at the Leadership and Management network meetings. Group work addressed the following questions:

a) What are the key recruitment and retention issues for your service?
b) Does the recruitment and retention plan address all of the key recruitment and retention issues affecting your service? If no, what activities do you suggest the Trust should consider?
c) Are there any actions within the recruitment and retention plan that we ought not to be pursuing?

Key themes included;

a) training nurses in ward and community settings, lots of inexperienced staff moving to higher posts too quickly, band 7 roles are unattractive from both a financial and clinical perspective, HCAs paid more on the central bank service, make retire and return information readily available and a process that is accessible and open to all, psychometric testing maybe a barrier to progression, recruitment process is still too cumbersome and takes too long.

b) Other activities to consider included: consider internal rotation of nurses, focus on retention of band 6 roles, link talent management conversations with recruitment process, consider access to shorter shifts, identify earlier those teams with high turnover of staff, community staff support to build confidence to return to inpatient environment, make band 6 roles more attractive, greater

diversification of roles, allow internal recruitment based on ability during acting posts, consider trust nurse training, contract with employees to stay with the trust on completion of training, RGN/RMN conversion courses, use bank staff to backfill for maternity cover in order to reduce length of time to recruit, bank cover community services and other disciplines.

c) In terms of the question relating to stop doing – the responses included: offering incentives to a select group of nurse students – spread recruitment problems to other services, psychometric testing

3.2 There are a total of 28 actions within the Recruitment and Retention Action Plan. Three actions have been completed, eight actions were due to complete on or before 31 March 2017 an update on progress against these outstanding actions is provided. The remaining 17 actions have future completion date and have therefore not been included in this report.

3.4 The three actions that have been completed are:

3.4.1 Review the need to offer financial incentives to student nurses at York University.

Feedback from the Head of Nursing with the support of the Director of Operations, confirmed that as we undertake early recruitment of 2nd year students, this in conjunction with the improving position re TEWV's reputation as an employer of choice does allow us to recruit successfully without financial incentives.

3.4.2 Implement bank worker direct booking system

Recently re-advertised the internal fast track process for existing Trust employed nurses. The nurse conversations have resulted in some staff being signposted to join the bank. Externally, a rolling advert for nurses has been placed on NHS jobs (April 2017). A full breakdown of fill rates for registered nursing shifts will be included in the Temporary Staffing Service's Annual Performance Report due at the end of April 2017.

3.4.3 Develop a Derbyshire responsive workforce model within TEWV by 31 March 2017

Following a teleconference with Derbyshire Community Health Services NHS FT on the 7th November 2016, a further meeting was arranged with the Heads of Nursing, Associate Director of Psychology and Deputy Director of Nursing to share the concept and discuss the relevance to TEWV. The Derbyshire CHS NHS FT, developed a responsive workforce or pool of band 6 staff that were multi-skilled, could work in either a patient or community settings. Staff in the pool are allocated to different roles as the need arises. They are on annualised hours contracts and are required to work anywhere across the trust, albeit, from lessons learned they are moving towards a locality pool. This resource is used to address longer term gaps in workforce i.e. maternity, secondments etc. and compliments the use of bank staff who are used to address short term need.

On exploring the issues and/or similarities to TEWV, none were identified. It was felt that addressing the longer term resource need was not an issue for us. The real issues were related to:

- Immediate need – to fill last minute gaps in resource for whatever reason that arose last minute, including increased observations, absence etc.

Work has already commenced in Forensic Services to pilot bank over booking service that may well address this issue

- Lack of access to bank facility to support community teams

  Has this been considered as part of PPCS project, in order to do this funding to provide this facility would need to be identified

Final outcome – not to proceed with the Derbyshire model

3.5 The eight actions to be completed by 31 March 2017, but which have been delayed, are:

3.5.1 The nurse conversations exercise. The target completion date of the nurse conversations exercise, key activities/actions 8 and 9 in the Recruitment and Retention Action Plan, was extended from 31st March 2017 to 31st May 2017 in recognition of the impact upon Head of Nursing capacity of the CQC inspections that were held in January 2017. Details of the nurse conversations exercise can be found in Appendix C. The email response of nurses to the nurse conversation exercise offer was much higher than anticipated which meant that the original intention to hold one to one meetings between Heads of Nursing and nurses to discuss retention and capacity issues was not practicable. Alternative arrangements have been implemented including the holding of group meetings with nurses and nurses being given an opportunity to provide their views in writing to the Heads of Nursing. To date these alternative approaches have resulted in direct engagement with only 20% of the 375 nurses who expressed an interest in having a conversation about increasing their part-time contracted hours and/or later career development. Those nurses that have engaged directly to date have wished to speak about retire and return only. To date the Heads of Nursing have not encountered any further interest in part-time nurses increasing their contracted hours.

3.5.2 The nurse conversation exercise includes offering nurses the opportunity to register with the TEWV Temporary Staffing Service and this option is currently being pursued via Karen Kendall the Temporary Staffing Service Manager.

3.5.3 Increase the numbers of registered nurses on the Central Nurse Bank by 28 February 2017

Recently re-advertised the internal fast track process for existing Trust employed nurses. Nurse conversations have resulted in some staff being signposted to join the bank. Externally, a rolling advert for nurses has been placed on NHS jobs (April 2017). A full breakdown of fill rates for registered nursing shifts will be included in the Temporary Staffing Service's Annual Performance Report that is due at the end of June 2017.

We have successfully offered HCA bank posts to 181 student nurses who are/were on placement with TEWV within the past 12 months. The students will undertake all mandatory training and gain valuable ward experience in advance of applying for registered nurse positions. The rules around RNs working bank shifts whilst under TEWV preceptorship have changed. Staff in this group are now able to work as a registered nurse on the bank, this is restricted to their own service area and site, but allows wards access to more bank workers that can offer consistent and familiar cover.

3.5.4 Evaluate the pilot in Forensic Services Mental Health and Learning Disabilities re overbooking of bank workers by December 2016

The pilot has been a success from both a fill rate perspective and the "feeling on the ground" with many reporting that there does not appear to be as many pressures due to short staffing. The new approach has been well received by both ward staff and bank workers alike, many preferring to have more notice of shifts. To date we have seen an average improvement of 15% fill rate for shifts requested within 24 hours of start time. This has been helped by the direct booking service roll out. Most of the "overbooked" shifts have been absorbed into real demand on the day. Due to early benefits noted from the pilot this pilot has been offered to West Park Hospital to alleviate some of the staffing pressures on that site.

The full evaluation report will be available in June 2017, the delay is linked to extracting March 2017 figures.

3.5.5 Develop a process to register staff interested in retire and return, increase awareness of options via Heads of Nursing and consider developing a trust wide approach to match up part-time hours and signpost

A paper providing an update on the Extending Working Lives Procedure was produced and considered by EMT on 22nd March 2017. The paper included proposals to develop and implement a revised TEWV Retire and Return Scheme. The proposal was supported and agreement was reached to further work up details of the scheme. A draft scheme has now been drafted and consulted upon. The draft scheme is due to be considered by the Executive Management Team at its meeting on 24th May 2017.

3.5.6 Produce and circulate TEWV leaver information and exit questionnaire feedback to localities

In April 2016, an exit questionnaire was implemented using Survey Monkey. However, the exit questionnaire is only triggered once the manager ends the leaver's employment details onto ESR. At this point, the workforce information team forward the link to the exit questionnaire to the employee. As the majority of managers complete the required activity on ESR on the day the person is due to leave or has already left, the leaver is not receiving the exit questionnaire. Improvements to the response rate are being encouraged by raising awareness using e-bulletin and in-touch.

A report highlighting leavers information and exit questionnaire responses based on the reporting period January 2017 to March 2017 will be produced and shared with OMT in June 2017.

3.6 Appendix B provides a summary of 2016/17 nurse recruitment activity and fill rates. It can be seen that the improvements made to the nurse Band 5 and Band 6 vacancy fill rate rates during quarters two and three of 2016/17 have been maintained during the final quarter of 2016/17 with the Band 5 nurse fill rate remaining at 86% and the Band 6 fill rate increasing to 92%. A majority of nurse appointments have been in respect of Band 5 prospective appointments with newly qualified nurses commencing with TEWV in either September 2017 or January 2018. Some twenty Learning Disability Nurses are due to qualify in September

along with seventy one Mental Health nurses. A further five learning Disability nurse and five mental health Nurses are due to qualify and join TEWV in January 2018.

3.7 The importance of TEWV developing with a university its own NMC recognised nurse training programme that can increase the quality and pace of supply is acknowledged. Consultation with Northumbria NHS Foundation Trust, which has made significant progress with such an initiative, has recently taken place. The Executive Management Team will be consulted shortly about proposals to develop such an approach within TEWV. It is anticipated that the associated planning and preparatory work requirements would mean that a potential programme commencement date in early 2018 can be achieved, subject to a number of conditions being satisfied.

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 Without clarity about the impact of the Purposeful and Productive Community Services initiative and the Safe Staffing Review upon future nurse numbers the ability of TEWV to match nurse workforce demand with supply may be compromised. .

6. CONCLUSIONS:

6.1 Since the last update a further nine recruitment events have taken place. As a result, 218 potential candidates have been interviewed, 181 were deemed appointable, 14 withdrew and 123 are students have been offered posts subject to qualifying and satisfying any employment checks standards.

6.2 As at 31st March 2016 the current fill rate for bands 5 and 6 were 86% and 92% respectively.

6.3 In total there are 28 actions, three actions have been completed, eight actions were originally due to complete on or before 31 March 2017, an update on progress against these outstanding actions is presented. The remaining 17 actions have a later completion date and have therefore not been included in this report.

6.4 Though some good progress has been made to date and there has been plenty of recruitment activity the need to keep refreshing the approach of TEWV to recruitment and retention is apparent. A number of recruitment initiatives concerning increasing access to nurse training will take in all probability several years to have a significant impact upon the supply of nurses joining TEWV and a greater focus upon retention measures is believed to be needed to help maintain

nurse workforce numbers over the next three to four years including further efforts to increase the number of nurses participating in the Return to Practice initiative.

7. RECOMMENDATIONS:

7.1 To note level of centralised recruitment activity undertaken since the last report.

7.2 To note the progress made with implementation of the Recruitment and Retention Action Plan

7.3 To receive a further report in November 2017

Angela Collins, Deputy Director Human Resources and Organisational Development
David Levy, Director of Human Resources and Organisational Development

Background Papers:

EMT papers –

- Recruitment and Retention Plan and update – 26th October 2016
- Nurse Recruitment and Retention Plan Update – 25th April 2017

Board papers –

- Recruitment, Development and Retention of Nurses – 21st June 2016
- Nurse Recruitment and Retention update – 29th November 2016

APPENDIX A

Recruitment and Retention Action Plan – Update on Progress as at April 2017

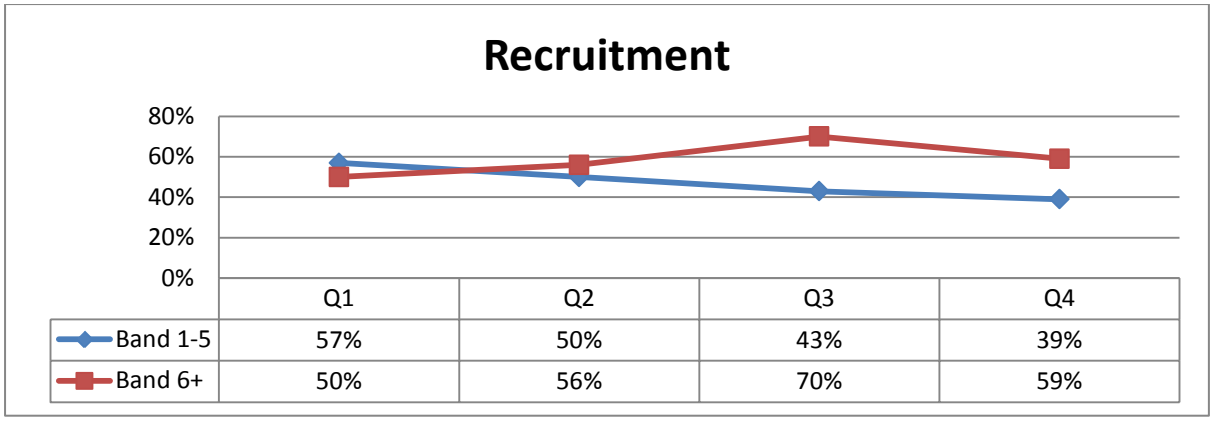
Tasks	Key activities	Date Task to be completed	Responsible person	Thoughts/Comments/Update
Recruitment	1. Continue to offer permanent contracts to all new nurses and then review	30 September 2017	Beverley Vardon-Odonkor	
	2. Review the need to offer financial incentives to student nurses at York university	**Completed**	Angela Collins	Confirmation received from Darren Gargan and Ruth Hill that incentive is **not** to be offered to the second year students
	3. Engage with Generation Z to align recruitment policy, practice and approach with workforce of the future	30 September 2018	Beverley Vardon-Odonkor	Work ongoing
Recruitment and Retention Premia (RRP)	4. Develop a TEWV RRP business case review process	30 September 2017	Beverley Vardon-Odonkor	Scoping document completed, agreed with EMT.
	5. Review the case for pursuing international recruitment	30 September 2017		Scoping document completed, agreed with EMT.
Internal movement	6. Develop an alternative process to manage the number of nurses seeking to take up a post in the same pay band making links with Talent Management information	30 September 2017	Nicola Rutherford and Michelle Brown	Scoping document completed, agreed with EMT
	7. Develop registration scheme to manage internal movements			QIS activity utilising QIS tools to review and improve on recruitment process
Extending Working Lives	8. Increase the numbers of contracted hours of part-time staff 9. Complete Nurse Conversations	~~28 February 2017~~ May 2017 ~~28 February 2017~~ May 2017	David Levy	Group meetings underway.
Bank	10. Increase the numbers of registered nurses on the Central Nurse Bank	28 February 2017	Karen Kendall	Advertising campaign is underway
	11. Pilot - planned overbooking of bank workers in FMH and FLD	Evaluation in November 2016	Karen Kendall	Waiting for March figures to include in evaluation
	12. Implement bank worker direct booking system	**Completed**	Karen Kendall	
Workforce responsive team	13. Develop a Derbyshire responsive	31st March 2017	Stephen Scorer and	Discussed with Heads of Nursing,

	workforce model within TEWV	model confirmed **Completed**	Angela Collins	Deputy Director of Nursing and Associate Director of Psychology on 5 January 2017.
Return to Practice	14. Gain greater understanding of current activity 15. Identify opportunities to maximise activity – how can flexible working play a part in encouraging return to practice	30 September 2017 30 September 2017	Stephen Scorer Stephen Scorer and Angela Collins	
Retire and Return	16. Develop a process to register staff interested in retire and return 17. Increase awareness of options via Heads of Nursing 18. Consider developing a trust wide approach to match up part-time hours and signpost	30 May 2017 30 May 2017 30 May 2017	Nicola Rutherford Heads of Nursing Nicola Rutherford	EMT considered and agreed proposals to develop a TEWV Retire and Return scheme on 22nd March 2017. Policy working group to further develop scheme and present to JCC in May 2017 and EMT prior to end of May 2017.
HR related activities	19. Undertake a review of sickness absence, short and long term, to identify the extent to which working conditions impact upon sickness absence and retention 20. Review flexible working procedure 21. Develop relocation policy	30 September 2019 30 September 2017 30 September 2017	Lesley Hodge Nicola Rutherford Lesley Hodge	Work has commenced on analysing sickness absence data and a report is due to be produced for OMT in May 2017. The report will include a number of recommendations for consideration by OMT. Presented to JCC on 7th March 2017 following a review by the Policy Working Group. Presented to JCC on 3 January 2017, further work was required. Present to JCC in May 2017
Information	22. Produce new recruitment and retention information reports for localities and TEWV 23. Produce and circulate TEWV leaver information and exit questionnaire feedback to localities	30 September 2017 ~~31 January 2017~~ 30 May 2017	Beverley Vardon-Odonkor Beverley Vardon-Odonkor	Aim to have the first reports available in July 2017 based on Q1 data. Amendment made to Exit Questionnaire to incorporate Equality and Diversity monitoring. Amended questionnaire went live 1st January 2017 and reports produced and circulated based on 1st quarter data as at end of March 2017.

Development activities to Grow Our Own workforce

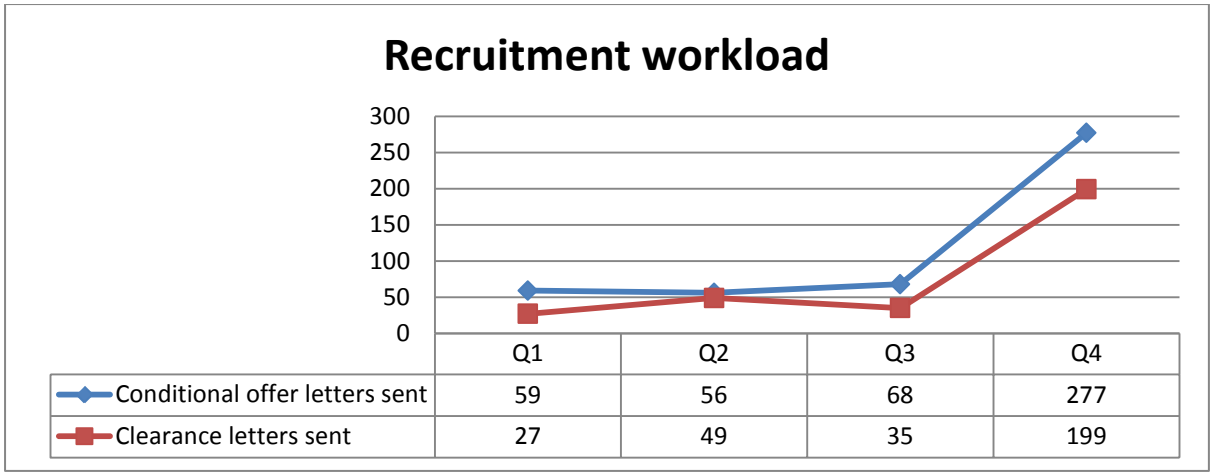
Tasks	Key activities	Date Task to be completed	Responsible person	Comments/Update
Engagement with School and Colleges	24 Consider and if appropriate, develop an engagement strategy to increase awareness of/interest in working in the NHS	30 September 2019	Stephen Scorer, Jane Buckle, and Angela Collins	Requests from schools and colleges are passed to Assistant Project Manager – recruitment, who notifies the relevant Heads of Nursing. Heads of Nursing contact the School/college
Grow Your Own	25 Subject to EMT decision, support up to 100 current Band 4 Associate Practitioners to complete two years pre-registration programme	30 September 2020	Stephen Scorer , Jane Buckle, Judith Hurst and Angela Collins	Work continuing. Need to identify 100 starts by September 2018
	26 Develop revised nurse training agreements with HEIs to train TEWV HCAs as new nurses in addition to commissioned nurse training numbers	30 September 2017	Stephen Scorer/Jane Buckle	
	27 Utilise apprenticeship levy to replace current HEE Talent for Care funding for all HCA Career framework, consider links to pre-reg training	30 September 2017	Judith Hurst	Apprenticeship paper presented to EMT on 25th January 2017. Update paper due April 2017, including impact on HCA role
	28 Participate in the National Nursing Associate Programme (pilot)	30 September 2019	Stephen Scorer, Jane Buckle, Judith Hurst	10 nursing associates recruited, to commence training on 24th April 2017. Allocation model agreed for placements. On track with the requirements of the regional steering group

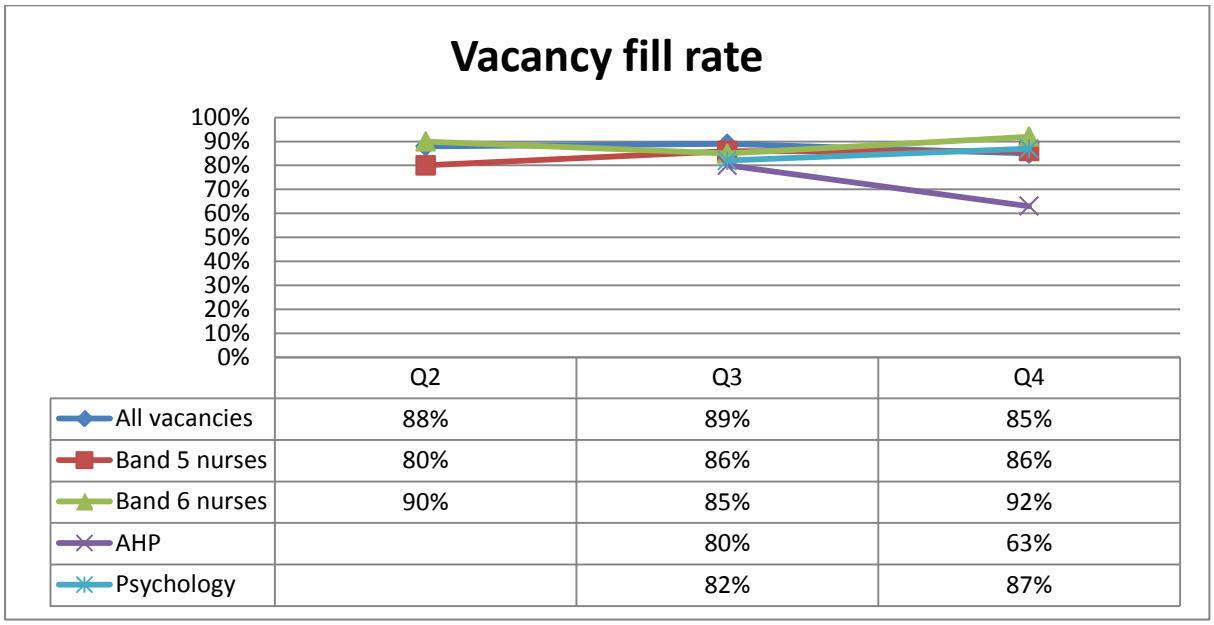
Appendix B



As at March 2017

	Trust	Durham & Darlington	Forensic	North Yorkshire	Teesside	York & Selby	EFM	Corporate
1-5	39%	59%	21%	57%	29%	12%	43%	67%
6+	59%	80%	57%	56%	58%	67%	na	14%





	Teesside	Forensic Services	Durham & Darlington	York & Selby	North Yorkshire	Trust Wide	Total	
Should you work **part time** at the moment, whether you would be interested in **increasing your contracted hours**. This does not necessarily mean working whole-time hours but it could mean more part time working	12	5	8	0	12	0	37	
Should you not be registered with the TEWV Nurse Bank a the moment whether you would be **interested in registering with the Nurse Bank**	22	6	16	5	12	1	62	
Should you not be interested in registering with the Nurse Bank, **what we could do to make it more likely that you may join the TEWV Nurse Bank**	40	10	11	5	19	1	86	
Should you be registered with the TEWV Nurse Bank at the moment but you do not also have a permanent contract with TEWV whether you would be interested in **having a permanent contract with TEWV**	4	0	0	0	0	0	4	
Should you be in your **mid-forties or older** whether you would be interested in a discussion about planning working arrangements for your later career including **later career development, potential role changes and retire and return**	112	32	94	21	73	6	338	
Bank Conversations Only	43	15	14	6	15	2	**94**	18%

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 23rd May 2017**
TITLE:	**To consider the report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 4, 2016-17.

Key areas for consideration:

- CQC MHA specific inspections summary report
- Report on use of Section 136, Street Triage and CAS activity
- Reports on Discharges from Detention by Associate Hospital Managers and MHT
- Seclusion activity report
- Report on MCA and DoLS update and activity
- Impact of the Policing and Crime Act 2017
- Deprivation of Liberty Law Commission proposals
- Update on Code of Practice implementation
- The annual Committee assessment performance results

Recommendations:

The Board of Directors is asked to:

i) Receive and note the assurance report, following the MHLC meeting held on 20 April 2017 and to note the approved minutes of the MHLC meeting held on 19 January 2017. (Annex 1)

ii) Note the potential risk of breaches of the 24 hour time limit for section 136 once the changes to the MHA by the Policing and Crime Act 2017 are in force.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 23 May 2017**
TITLE:	**To consider the report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 4, 2016-17; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 20 April 2017.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

(i) The confirmed minutes of the Mental Health Legislation Committee held on 19 January 2017 are attached as Annex 1.

The MHLC also met on 20 April 2017. The key issues considered at this meeting were as follows:

3.2 CQC MHA Visits Feedback Summary Report

The Committee considered the CQC MHA Visits Feedback report**.**

(i) A thematic review has been carried out which identified the top five issues emerging following MHA visits from April 2016 – April 2017. The issues will be communicated Trust wide in order to prevent recurring non-compliance on future MHA visits by the CQC. There are currently 59 on-going MHA actions across the Trust over 11 wards.

(ii) The Committee was assured that the completed Provider Action Statements (PAS) are then approved by Executive Management Team (EMT) prior to return to the CQC and any required actions not completed at the time the PAS is sent to the CQC will be monitored through the Quality Assurance Groups (QuAG) and any overdue actions re-visited by EMT.

3.3 Section 136, Crisis Assessment Suite (CAS) and Street Triage Report

The Committee considered data and trends around S136, CAS and Street Triage.

(i) In total there were 192 uses of section 136 across the whole Trust area, an increase of 16% this quarter. Those being taken into police custody remains low, 6% across the whole Trust area, compared to 8% last quarter, a continuation of a downward trend. There were 9 under 18 years old brought to a mental health hospital based place of safety. There was also a 14 year old girl taken into police custody under

s136 in the Durham area. This was due to the high levels of aggression displayed (later arrested after s136 assessment for assaulting a police officer). This is highly unusual and relevant in terms of the Policing and Crime Act set out later in the report.

(ii) In terms of Street Triage activity there were 201 contacts in the quarter across Teesside, Scarborough and York. This includes minimal activity in Teesside due to sickness in January and February 2017 and no activity information available from York. Of those contacts, 6 resulted in the use of s136.

(iii) Within the Crisis Assessment Suite (CAS) at Roseberry Park activity continues to be significant with 573 assessments undertaken (18% rise), this does not include those assessed subject to s136. The numbers attending 'voluntarily' with the police and not subject to s136 continues to be high and far exceeds the number subject to section 136 with 142 attending voluntarily with the police, compared to 53 brought subject to s136. Of the total 573 assessments 109, 19%, were discharged without mental health follow up or sign-posting to other services, this is unchanged from last quarter.

(iv) The Committee agreed that further discussion at OMT from an operational perspective would be useful around the impact of S136 and the activity around the Crisis Assessment Suite, Street Triage and TEWV Places of Safety.

3.4 Discharge from Detention Report

(i) Discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. From 1 April 2016 to 31 March 2017 there have been 655 Mental Health Tribunals (MHT) held and 793 Hospital Managers reviews of detention.

(ii) Of the 655 MHTs, 51 resulted in discharge (just under 8%) and of the 793 HM reviews, 6 resulted in discharge, less than 1%.

(iii) No trends have been identified from the data for the year.

(iv) The Committee was informed of 6 occasions where there had been professional differences within the MDT regarding the decision to discharge. The Committee discussed the need for an escalation process to the Head of Service where this occurred to provide assurance that this did not adversely impact the care of the service user.

3.5 Seclusion Report

(i) From the information sources, there were 75 episodes of seclusion involving 40 patients with multiple episodes for 16 patients. It was agreed that this will also be cross referenced with Datix seclusion information.

(ii) There are 2 episodes of long term seclusion, one ongoing since September 2016 at the time of report and one that ended in March 2017 after 22 weeks.

(iii) Of the 75 episodes, 47% were under 24 hours and of those, 35% were under 12 hours. Additional safeguards for monitoring long term seclusion have been agreed and will be included within the procedure following an RPIW in July 2017 where they will be finalised.

3.6 Mental Capacity Act and DoLS Report and DoLS Law Commission Proposals

(i) Based on the recommendations in the recently published Law Commission Report, there will potentially be a new legislative system replacing the current DoLS regime. In its current form, this will remove the availability of the Liberty Protection Safeguards (the replacement for DoLS) being used in mental health hospital settings and the MHA will be the only available option.

(ii) There are currently 58 cases of active DoLS authorisations in place across the Trust.

(iii) From Monday 3 April 2017, the death of a person subject to DoLS is no longer considered a death in custody and so is not reportable to the Coroner. Such deaths will only be reported to the Coroner if the cause of death is unknown, or where there are concerns that the death was violent or unnatural.

(iv) It was agreed that the identification of MCA Champions across the Trust would be taken for discussion at OMT

3.7 Impact of the Policing and Crime Act 2017 (PaCA)

(i) PaCA received Royal Assent 31 January 2017. The Act amends the Mental Health Act in terms of section 135 – 138. Due to Purdah, the implementation of the MHA changes will not come into force until possibly sometime in July, when is not clear.

(ii) The s136 policy has been re-drafted to reflect the changes and is out for a wide consultation with partner agencies.

(iii) Whilst not a matter for formal escalation, the Committee recommended that the Board of Directors note the following potential impact of the Policing and Crime Act 2017:

(a) Reduction in time from up to 72 hours to up to 24 hours.
This may cause issues in terms of people under 18 years requiring admission to a CAMHS bed, particularly out of hours, due to the issues with both identifying and then accessing a bed. Similar issues may arise with people requiring admission to a medium secure bed. There may also be issues, though not as difficult to resolve, for people with learning disabilities requiring admission due to the reduction in beds as part of the Transforming Care agenda. This could potentially give rise to breaches of the 24 hour period and contingency arrangements need to be identified.

(b) Requirement for police officer to consult prior to use of s136.
This will require the Trust to identify single points of contact across each Force area to enable this to occur. The Committee received assurance that this work was being taken forward through the re-draft of the section 135 policy.

3.8 Update on implementation of MHA Code of Practice

The Committee considered the update on the implementation of the MHA Code of Practice.

(i) Assurance was provided that the Trust has now carried out a further review of the policies, procedures, guidance and arrangements required by the Code of Practice and is now in a position of almost total compliance. The training that was mandated is ongoing and there is sufficient provision available within the Rolling Training Programme to attain 100% compliance from the current position of 85%.

3.9 Annual Committee Performance Assessment Results 2016/17

A discussion took place around the Committee Performance Results 2016/17.

(i) The results of the Annual Committee Assessment have shown that whilst there were 10 areas of overall improvement, 10 areas members were questioned on had scored lower.

(ii) These areas were around providing assurance to the Board on the Code of Practice, overlap with QuAC, the need to be more assured on compliance with the MH Act and Mental Capacity Act and members feeling they have enough knowledge of the MHA and MCA to be able to identify risk areas in order to challenge management on critical and sensitive matters.

(iii) The Chairman of the Committee agreed to forward the results to committee members for feedback and is currently reviewing these matters within the Terms of Reference of the Committee.

4. IMPLICATIONS:

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

CQC MHA visit reports do not indicate any significant issues with regard to compliance with the Fundamental Standards in terms of the MHA and MCA.

4.2 **Financial/Value for Money:**

There are no implications.

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

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

4.4 **Equality and Diversity:**

There are no implications.

5. CONCLUSIONS:

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

6. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) Receive and note this report including the confirmed minutes of the meeting of the MHLC held on 19 January 2017.

(ii) *Note the matter of escalation to EMT around potential breaches of the 24 hour time period and ability to source and access beds for under 18 year olds, those requiring medium secure beds and those with a learning disability due to the introduction of the Policing and Crime Act 2017 and the amendments it makes to the Mental Health Act.*

Richard Simpson
Chairman of the Committee

Background Papers:
Annex 1 – Approved minutes of the 19 January 2017 MHL Committee Meeting

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 19 JANUARY 2017 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 1 PM.

Present:
Mrs L Bessant, Chairman of the Trust,
Dr N Land, Medical Director
Mrs E Moody, Director of Nursing & Governance
Mr P Murphy, Non-Executive Director
Mr R Simpson, Non-Executive Director, Chairman of the Committee
Mr B Kilmurray, Director of Operations
Mrs S Richardson, Non-Executive Director

In Attendance:
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation
Mrs R Down, Mental Health Legislation Advisor (MCA Lead)
Ms P Griffin, Mental Health Legislation Advisor

Apologies: Apologies for absence were received from, Miss J Clark, Public Governor, Ms S Talbot-Landon, Public Governor and Mrs J Illingworth, Director of Nursing & Governance.

The Chairman welcomed Mrs Down to her first meeting as MH Legislation Advisor (MCA Lead).

17/01 MINUTES

Agreed – *That the minutes of the last meeting held on 24 October 2016 be approved as a correct record and signed by the Chairman.*

17/02 ACTION LOG

The Committee noted the actions and following updates:

16/29 This item would be deferred until the 20 April 2017 meeting when Mrs Illingworth would be present.

16/29 Repeated issues had been raised by the CQC, including old leave forms being left on patients files. The solution for scanning leave forms to be raised by Mrs Moody. It was noted that the scanning solution was currently in a queue of other corporate products and an update would be brought back to the 20 April 2017 MHLC meeting.

16/29 Training around the Code of Practice to be publicised again, including Core Brief. It was noted that a monthly summary of uptake around this training would be sent to Mr D Levy, Director of HR & OD.
The Chairman added that it would be useful for Committee members to hear updates on the Code of Practice as appropriate, especially in light of sitting on Hospital Managers Panels.

Miss Wilkinson provided assurance to the Committee that the Code of Practice had changed from a point of case law, rather than being specifically related to details

around Hospital Managers and that all relevant policies and training had been updated in accordance with changes to the Code of Practice.

The Committee noted that there had been changes to Chapter 19 of the Code of Practice in relation to CAMHS and Mr Kilmurray would pick that up.

Completed

17/03 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT

The Committee considered and noted the Care Quality Commission (MHA) visit feedback summary report for the period 1 October to 31 December 2016.

Arising from the report it was noted that:

(1) There had been 11 visits in Q3, one more than in Q2.
Reports had been received for 9 of the visits held in Q3 and 4 had been received from Q2 visits. From the 3 reports, there had been 42 issues raised by the CQC and 6 issues raised by patients.

Future reports would include a summary table of completed and outstanding actions.

Action: Mrs E Moody

It was agreed to undertake a piece of work to look at commonly recurring themes raised by the CQC following MHA visits and to bring back an action plan to the next Committee with recommendations as to how best to take a Trust-wide approach to reducing such incidences.

Agreed: That a review of common recurring themes following CQC MHA inspections would be brought back to the 20 April 2017 meeting.

Action: Mrs E Moody

17/04 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

(1) There had been 162 uses of section 136 across the whole Trust, a significant decrease of 40% in the Quarter, from 271 in the previous Quarter. This represented, however, only a 13% decrease when compared to the same Quarter last year.
(2) Those being taken into police custody remained low at 8% across the whole Trust. There had been 2 individuals under 18 years old, aged 16 and 13, both brought to a hospital place of safety and both had been discharged with follow up.
(3) In terms of Street Triage activity there had been 112 contacts during the Quarter in Teesside, compared to 95 in the previous Quarter, of which 1 had resulted in the use of section 136.
(4) In York there had been 85 contacts, compared to 88 during the last Quarter, of which 4 had resulted in the use of section 136.
(5) Scarborough had seen 112 contacts, compared to 101 in the last Quarter of which 1 had resulted in a section 136.

On this matter the Committee noted that it had recently been clarified that the Scarborough STT had been entering each contact with an individual onto the STT spreadsheet, including any follow-up contacts with that person; therefore the figures for Scarborough included each individual visit and not just initial contact. This meant that the reported data for Scarborough had been higher due to the method of data collection.

It was noted that future reports would only show initial contact with individuals.

(6) Within the Crisis Assessment Suite at Roseberry Park activity continued to be significant, however had dropped by 24% in Quarter 3 with 485 assessments, compared to 559 assessments undertaken in the previous Quarter, (that did not include those assessed subject to section 136).
(7) The numbers attending 'voluntarily' with the police and not subject to section 136 continued to be high and far exceeded the number subject to section 136 – in Quarter 3 there had been 131 attending voluntarily with the police, compared to 40 brought subject to section 136. Of the total 485 assessments 95, 19%, had been discharged without mental health follow up or sign-posting to other services.

Following discussion it was noted that the Police and Crime Bill would be active from April 2017 and there would potentially be an impact on the Trust, particularly the S136 policy.

Agreed: that there would be a stand-alone report to the 20 April 2017 meeting on the impact of the Police and Crime Bill.

Action: Miss M Wilkinson

17/05 MHA DISCHARGES FROM DETENTION REPORT

The Committee considered and noted the MHA Discharges Report.

Arising from the report it was noted that:

(1) The report focussed on discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers.
(2) There had been 2 patients discharged by the Associate Hospital Managers during the Quarter, equating to 1% from the 170 hearings held.
(3) Of the 168 FTTs held, the Tribunal had ordered 9 discharges in total (5%) – 5 discharged from section 2, 3 discharged from section 3 and 1 discharged from a Community Treatment Order.
(4) One of the section 3 discharges had been deferred discharge to allow for DoLS to be put in place instead of the Mental Health Act.

This decision had been challenged by the Trust on the basis that the MHT had erred in law in that the patient was not eligible for DoLS due to objection and that the MHT should have adjourned to ascertain whether DoLS was actually available. The decision was set aside by the Second Tier Tribunal to be reconvened and heard by a fresh panel. The DoLS MH Assessor determined that the patient was not eligible for DoLS due to objection however the patient had been discharged to a care home placement before the adjourned MHT was set to be reconvened.

Although 2 of the patients had the same RC, they had different Care Coordinators and their cases had been heard by different Tribunal Panels.

The Committee were assured around the low discharge rate.

17/06 SECLUSION REPORT

The Committee considered and noted the Seclusion Report.

Arising from the report it was highlighted that:
(1) From the information available, there had been 27 patients secluded in the period with 37 reported episodes of seclusion in total 1 patient with 4 episodes and 7

patients with 2 episodes); all episodes extended beyond 12 hours with 32 episodes extending beyond 24 hours.

(2) It was noted that 1 patient had been secluded on 26 October 2016 and that continuous seclusion episode had still been running on 19 January 2017.

Mr Murphy expressed his concerns over the episodes of seclusion lasting over 24 hours,

Mrs Moody assured the Committee that there was an interim procedure around seclusions lasting over 24 hours, however matters would be formalised through Trust policy and an update would be brought back to the 20 April 2017 meeting.

Action: Mrs E Moody

Mr Kilmurray suggested that it would be helpful to look at some individual case studies around episodes of seclusion over 24 hours.

17/07 CQC SOAD LETTER

The Committee received and noted a letter from the CQC – Second Opinion Appointed Doctors (SOADs)

Following discussion it was noted that the Trust currently had 2 SOAD's, against the requirement based on population of around 4 or 5.

Dr Land commented that encouragement would be given to Trust Doctors to increase the numbers, particularly those who would be coming up to retirement.

Agreed:

(i) That Dr Land would respond to the letter, following discussion with Deputy Medical Director Colleagues.

(ii) That Dr Land would complete the required action plan and return to the CQC.

(iii) That Miss Wilkinson would also provide a response before the deadline date of end of February 2017.

17/08 MENTAL CAPACITY ACT AND DOLS REPORT

The Committee received and noted the Mental Capacity Act and DoLS Report.

Arising from the report it was noted that:

(1) An audit and monitoring tools had been developed to enable a clearer view of MCA implementation, to provide additional practical training to staff, to provide a central point for the collation and monitoring of DoLS activity and to provide support and guidance for clinical operational staff in relation to the use of DoLS.

(2) Audits, both case file audits and a number of staffing questionnaires, had been carried out across the Trust. The outcomes of these audits had shown that whilst there was a level of understanding around MCA and DoLS, the depth of understanding was variable across different localities and services of the Trust. Action plans to address the issues would be produced and implemented before the end of Quarter 4.

(3) In terms of DoLS, it continued to be extremely difficult to monitor activity, which was currently a manual process, and was heavily reliant on operational staff contacting the MHL team regarding the use of DoLS, prior to using it, to enable support and

guidance to be provided. A DoLS recording module has been developed for Paris to capture DoLS authorisations in a similar way that MHA activity was recorded which would hopefully ensure that DoLS status was clearly visible on individual care records. This would enable reporting of activity to become clearer and more accurate.

(4) DoLS activity from manual data collection – from Q1 to the end of Q3 there had been 65 applications made to Supervisory Bodies for Standard Authorisations, with 10 applications awaiting assessment at the end of Q3. There were currently 99 active DoLS Standard Authorisations in place across the Trust at Q3.

Following discussion it was noted that:

(i) The appointment of Mrs R Down as Mental Health Legislation Advisor (MCA Lead) was welcomed and an update would be brought to the Committee on a quarterly basis
(ii) That the report should include a record of the number of section 49 assessment records being requested.

Action: Mrs R Down

17/09 ANY OTHER BUSINESS

There was no other business to note.

The meeting concluded at 2.50pm

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Richard Simpson
Chairman – Mental Health Legislation Committee
20 April 2017

ITEM NO 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd May 2017**
TITLE:	**Composite Staff Action Plan**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Decision**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their 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:

This report provides Directors with information about progress made with implementing the current Composite Staff Action Plan and locality action plans and proposes a new Composite Staff Action Plan in response to the Trusts 2016 staff opinion survey results and Staff Friends and Family Test (Staff FFT) results. A large proportion of the actions within the previous Composite Staff Action Plan and locality action plans were achieved within the agreed timescales.

Recommendations:

1. To note the contents of the report and to comment accordingly.
2. To endorse the proposed Composite Staff Action Plan subject to any changes being made by Directors.
3. To receive a progress report at the November 2017 meeting.

MEETING OF:	**Board of Directors**
DATE:	**23rd May 2017**
TITLE:	**Composite Staff Action Plan**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with an update about progress made with completion of the current Composite Staff Action Plan and a summary of locality action plans progress (appendix 1). A proposed Composite Staff Action Plan in response to the 2016 annual staff survey opinion results and the Staff FFT results is attached.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The current Composite Staff Action Plan was agreed by Directors in May 2016 and an update about progress made with implementation was provided at the November 2016 meeting.

3. KEY ISSUES:

3.1 Excellent progress has been made with completion of all the 60 actions outlined within the Composite Staff Action Plan.

3.2 The completion rate for the localities and corporate directorates has been 98% with 296 out of 302 actions being achieved throughout the year.

3.3 The draft Trust Composite Staff Action Plan 2017/18 (appendix 2) has been put together in response to the 2016 annual staff opinion survey and the Staff FFT results. The plan includes a total of three Themes and 17 actions.

3.4 Consultation has identified that there is a consensus that we ought to have fewer themes and actions within the plan than has previously been the case. We aim to achieve results by producing high level actions to help address the issues arising within the survey and from intelligence made available from across the organisation.

3.5 The production of the draft Composite Staff Action Plan has been achieved by the valuable input of various forums including the Joint Consultative Committee, the Board of Directors and Investors in People Leads.

3.6 The Investors in People Leads have continued to provide valuable locality and corporate directorate input into the production of the local action plans. The deadline for submission of these plans is the 30th June 2017.

3.7 The intention is to provide Directors with an update about progress made with both the Composite Action Plan and locality and corporate directorate actions plans at the November 2017 meeting.

3.8 A review of the Trust staff survey results from 2012 to 2016 highlighted those issues that it is believed ought to be included within the new Composite Staff Action Plan. These are outlined below:

1.) Whilst there has been a 22% increase in staff reporting the most recent experience of harassment it is believed that this must and can be further improved. The 2015 Composite Staff Action Plan included several actions to address the reporting of bullying and harassment including consideration about developing a prevention of bullying and harassment procedure that would be separate from the Grievance Procedure. This has since been agreed and has also been included within the proposed new action plan as part of efforts by TEWV to respond to the national call to action to do more to tackle bullying and harassment within the NHS.

2.) There has been a 6% increase in the number of staff reporting that despite feeling unwell they have felt pressure to attend work from either their manager, other colleagues or themselves. Upon further investigation of the survey findings it has been established that the main source of this pressure would appear to be the employees themselves. The results also highlight that the main staffing groups reporting in this way are registered nurses and health care assistants, closely followed by occupational therapists. The localities in which these members of staff are likely to work within are York and Selby, Durham and Darlington and the Forensic Directorate. As part of the action plan it is thought that it would be helpful to better understand in more detail why staff are attending work despite their feeling too unwell to be there.

3.) There has been a slight decrease in the overall TEWV staff engagement score i.e. 3.88 in 2016 down from 3.95 in 2015. Following the agreement of the previous Composite Action Plan the Organisational Development Team developed a process that highlights teams via the Staff FFT results that may require support and assistance to improve the level of staff engagement. This process has been in place since March 2016 and so far has received positive feedback with some forty teams engaged to date. It is believed that there could be opportunities to better share and triangulate information between the Organisational Development team and other TEWV staff support services to help tackle issues at an earlier stage, to encourage staff to participate both in providing feedback and speaking up should they have concerns and to provide assurance that we are addressing these issues in a comprehensive way. An action to help strengthen this process is included within the Composite Staff Action Plan.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** There will be no financial implications to introducing the recommendations.

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

4.4 **Equality and Diversity:** The need to continue to address the disparity in the experiences of disabled and BAME staff remains a subject of particular attention.

4.4 **Other implications:** None identified.

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 Excellent progress has been made with completing the 2016 Trust and locality action plans. The proposed Composite Staff Action Plan addresses three themes and includes 17 actions.

7. RECOMMENDATIONS:

7.1 To note the contents of the report and to comment accordingly.

7.2 To endorse the proposed Composite Staff Action Plan, subject to any changes being made by Directors.

Author: Kerry Jones,
Title: HR Manager (Staff Experience)

Appendix 1

LOCAL ACTION PLANS END OF QUARTER 4 - 2016/17 UPDATE

Service Area	Number of actions allocated overall	Achieved	Yet to be achieved	Examples of Good Practice
1. Durham and Darlington	16	16		1. Staff now up to date with their positive behavioral support training. 2. Datix reports are regularly reviewed to ensure that staff who have been subjected to physical violence are debriefed and support offered.
2. Estates and Facilities Management	12	12		1. Programme of quarterly drop in sessions by Associate Directors has been completed.
3. Finance and Information	38	38		1. Equality and Diversity champions established and trained within the Directorate. 2. A senior staff representative to be visible within the department at all times.
4. Forensic Services	44	43	1 partially met, moved into 2017/18	1. The safe wards project has been fully implemented across all in patient wards. 2. Force reduction de-briefing processes have been fully implemented across the services.
5. Human Resources/Organisational Development	55	50	5 unable to be achieved due to being linked to a research programme that has yet to commence. Moved to 2017/18	1. Findings from the bullying and harassment survey reported to the WDG and recommendations for a separate prevention of bullying and harassment procedure were agreed. 2. Six retreats were delivered throughout the year, and increase from four.
6. Medical Directorate	9	9		1. The associate medical director has met with all staff 1:1 to discuss progression within their roles to help improve staff experience.

				2. An away day has taken place to review ways of working.
7. North Yorkshire	60	60		1. The safe wards project has been rolled out across locality. 2. The new Harm Minimisation policy has been implemented. 3. An in-patient learning event has been hosted across the units showcasing the learning and experiences of incident management.
8. Nursing and Governance	14	14		1. The new appraisals system for Band 5 and above has been implemented. This has been linked to the age profiles of those involved to ensure relevant support and development is provided to the various age groups.
9. Planning, Performance and Communications	7	7		1. Daily Huddles commenced within the team with effect from January 2017 along with the implementation of the VCB.
10. Teesside AMH	35	35		1. All the senior management team have weekly time scheduled into their diaries for 'Gemba' visits and the locality managers and assistant locality managers have regular Huddles. 2. All staff within the locality are encouraged to access clinical and managerial supervision which offers advice on the support mechanisms available to them.
11. Teesside MHSOP	13	13		1. Band 4 roles piloted within memory clinics to support caseloads and pressures on staff. 2. Senior management team continue to undertake regular 'Gemba' walks to support PPCS.

COMPOSITE STAFF ACTION PLAN 2016-2017
(Developed from the Staff Survey 2015 results, Staff Friends and Family Test results and Investors in People Report)

NO.	THEME	INTENDED OUTCOME/ RESULT	SOURCE OF ACTION			ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
			IIP	SS	SFFT					
1	Encourage more staff to report harassment, bullying or abuse when it happens	Improve related responses in the 2016 Staff Survey results and Staff FFT results. A reduction in reported bullying and harassment cases in the long term. Greater staff awareness of how to report bullying and harassment and of the Trust support available. Improved morale within teams.	X	X	X	Establish a Task and Finish Group to include the following actions: 1. Undertake a survey monkey survey to try to understand why staff do not report harassment, bullying or abuse. Link to the under reporting of errors, near misses or incidents. 2. Report the findings to the Workforce and Development Group and make recommendations for action. 3. Review the way bullying and harassment is covered in the Grievance Procedure and identify if a separate policy is needed. 4. Include reference to the importance of reporting bullying into the refreshed mandatory training on Equality and Diversity and Human Rights. 5. Explore developing the role of the Equality and Diversity champions to become contact officers for bullying and harassment issues. 6. Undertake 'How to handle Productive Conversations' training. 7. Undertake Values based Conversations workshops on request as part of team development. 8. Investigate a potential link between manipulative behaviour at work and management style. **9.** Develop a plan to address if agreed appropriate. **10.** Identify if there is clear evidence of a reduction in reported bullying and harassment cases. .	Kerry Jones Kerry Jones Kerry Jones Sarah Jay Sarah Jay Michelle Brown Michelle Brown Michelle Brown Michelle Brown Beverley Vardon-Odonkor/Emma Haimes	Q3 Q4 Q2 Q2 Q3 Q1-Q4 Q1-Q4 Q2 Q3 Q4	Surveyed developed and circulated Report submitted Meeting held with HR Manager - Operations to discuss current process Training updated Discussed with champions Training delivered twice so far June and October Delivered as ½ sessions Paper produced for the Board Plan developed	**Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed**
2	Reduce the number of staff experiencing physical violence from patients, relatives or the public	Improve related responses in the 2016 Staff Survey results and Staff FFT results. A reduction in reported violent incidents on Datix. Timely access to PAT training for staff and good training evaluation. More staff confident about ability to report incidents. .	X	X	X	1. Following the creation of an incident dashboard for managers to use via IIC, develop an electronic QUAG report 2. Commence roll out to the QUAGs. 3. Revise the current management of violence and aggression training in conjunction with Force Reduction to include de-escalation and debrief training in accordance with new NICE guidance (NG10). 4. Pilot the new training. 5. Continue the roll out of Positive Behaviour Support Training across MHSOP, AMH and C&YPS (Tier4) until March 2017. 6. From June, run 10 'Behaviour Clinics' every month in locations across the Trust to offer coaching/support to staff in developing/implementing Behaviour Support Plans. Aim for 100 clinics by the end of the year. 7. Hold 4 Safewards sharing practice events over the year to support services to use the Safewards model. These events will offer frontline staff the opportunity to share good practice and support each other in developing the model. 8. Identify if there is clear evidence of a reduction in reported violent incidents.	Emma Haimes Emma Haimes Judith Hurst Judith Hurst Stephen Davison Stephen Davison Stephen Davison Emma Haimes	Q1 Q2 Q3 Q3 Q4 Q4 Q4 Q4	Dashboard on IIC Rolled out Programme revised Deadline moved to Q1 2017 Training delivered across multiple Trust locations In excess of 100 clinics offered, waiting Trust wide PBS audit In excess of 100 clinics offered, Awaiting outcome of Trust wide PBS audit Evidence of increased reporting	**Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed**

	Increase the proportion of staff who report errors, near misses or incidents that they witness	Improve related responses in the 2016 Staff Survey results and Staff FFT results. Greater level of staff confidence that incident reports will be acted upon appropriately.	X	X	X	1. Ensure the revised Incident Reporting and Investigating Policy is ready for re-launch following consultation. 2. Re- launch the revised Incident Reporting and Investigating Policy by holding briefing sessions across the Trust. 3. Monitor the initial impact of the revised Incident Reporting and Investigating Policy and its impact on incident reporting. 4. Prepare for the York and Selby locality move onto the new Datix system wef 1 June by undertaking reinforcement briefing sessions. 5. Identify if there is clear evidence of an increase in staff reporting errors, near misses or incidents that they witness.	Catherine Lee-Cowan Catherine Lee-Cowan Catherine Lee-Cowan Emma Haimes Emma Haimes	Q2 Q3 Q4 Q1 Q4	The policy is now being launched in Q3**.** Briefing sessions delivered	**Completed** **Completed** **Completed** **Completed**
4	Continue to reduce the numbers of staff suffering from work related stress	Improve related responses in the 2016 Staff Survey results and Staff FFT results. Reduction in sickness absence due to work related stress. Increased staff awareness of support that is available within TEWV. Staff can access TEWV support services in a timely way.	X	X	X	1. Deliver 4 Stress Busting events and monitor take up. 2. Develop a 'What helped me' information leaflet from contributions by Trust staff who have lived experience of mental ill health. 3. Distribute the leaflet. 4. Complete a 12 month review of the Employee Psychology Service pilot and include recommendations regarding the future of the service. 5. Deliver 6 retreats throughout the year and monitor take up. 6. Embed the Employee Support Service in the York and Selby locality. 7. Establish a baseline for the activity levels of the Employee Support Service to measure capacity levels and introduce Key performance Indicators. 8. Design a training package to support managers in embedding health and wellbeing principles in the workplace. 9. Implement the new national CQUIN on Health and Wellbeing 10. Deliver 2 mindfulness programmes during the year to staff in the York and Selby locality with priority given to staff with work related stress 11. Deliver at least 20 days of mindfulness that staff can access to refresh their practice. 12. Pilot 3 month follow up post mindfulness programmes. 13. Run 12, 8 week mindfulness programmes across the year with priority given to staff with work related stress. 14. Identify if there is clear reduction in work related sickness absence.	Lisa Cole Lisa Cole Lisa Cole Barry Speak Paul Walker Lisa Cole Lisa Cole Sheila Jones Elinor Morgan Elinor Morgan Elinor Morgan Elinor Morgan Beverley Vardon-Odonkor	Q4 Q1 Q2 Q1 Q4 Q3 Q4 Q2 Q4 Q4 Q4 Q1 Q4 Q4	Events held Leaflet on InTouch Report gone to EMT Retreats facilitated Referrals being received Draft KPIs produced Training updated to include support for staff Objectives agreed Report gone to Mindfulness Steering Group	**Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed**

5	Supporting managers and staff to deal with high pressure/work-load demands placed on them	Improve related responses in the 2016 Staff Survey results and Staff FFT results. Managers and staff are asked to only generate and act upon information that is necessary. TEWV information enables managers and staff to carry out their roles more effectively than would otherwise be the case.	X	X	X	1. Review and amend team briefing guidance to encourage the discussion and acknowledgement of positive progress and achievement to be discussed and acknowledged during team meetings. (Carried over from 15/16) 2. Develop detailed project plans for final sign off by the Purposeful and Productive Community Services Board. They are: a. Leadership development/coaching b. Information c. IT/Use of technology d. Team processes e. Clinical pathways/workforce design and skills optimisation 3. Develop and communicate a regular requests calendar and adhoc requests log and associated processes/guidance 4. Develop proposals to improve the efficiency and effectiveness of narrative collection and collation regarding standards which are reported to commissioners. 5. Request the Directors of Performance Planning & Communication; Nursing and Governance, HR & OD, Finance and Information and the Director of EFM to review all current reports to ascertain whether any of these can be superseded by use of live data on IIC. 6. Request that the Information Domain Strategy Group decide if they are going to add personalised IIC dashboards for team managers to the IIC development log.	Julie Jones Brent Kilmurray Patrick Scott Ruth Hill Adele Coulthard Ruth Briel Sharon Pickering Sharon Pickering Chris Lanigan Chris Lanigan	Q2 Q2 Q2 Q2 Q2 Q2 Q2 Q4 Q2 Q2	Survey results collated. Recommendations for EMT in Q3 PM3 document approved PM3 document approved PM3 document approved PM3 document approved PM3 document approved Work taken place with IT, require EMT to agree Proposal development, require EMT to agree Reports received from relevant areas Achieved via new IIC	**Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed/Ongoing** **Completed** **Completed**
6	Ensure that members of the senior management team continue to be visible in the workplace/around the Trust	Improve related responses in the 2016 Staff Survey results and Staff FFT results. More front-line staff involved in Director visits.	X	X	X	1. Review what is 'good communication between senior managers and staff and understand what staff expectations are at local level and take the results and proposed action plan to EMT. (Carried over from 15/16)	Julie Jones	Q2	Survey undertaken, results analysed. Report for EMT in Q3.	**Completed**
7	Improve staff experience for disabled and BAME staff	Improve related responses in the 2016 Staff Survey results and Staff FFT results. TEWV has a better understanding of why disabled and BAME staff experiences are poorer that those of not disabled and white staff. Actions are taken by TEWV that make a positive difference to disabled and BAME staff.	X	X	X	1. Undertake research to better understand the causes of any differences where staff who share similar characteristics report lower levels of satisfaction in either the Staff Friends and Family Test or the Staff Survey and to take steps to reduce or eliminate any lower levels of satisfaction. Specific actions are: 2. Develop actions to be included in the staff survey action plan to address any areas where known differences exist and are understood 3. Establish baseline data based on the 2015 Staff Survey and corresponding Staff Friends and Family Test. 4. Commission and undertake reliable research based on the base line data 5. Report the findings of this research to the Diversity Engagement Group, Workforce and Development Group and the Equality and Diversity Steering Group. 6. Design the format of the protected characteristics mini conferences/workshops for consideration by the Equality and Diversity Steering Group. 7. If agreed, commence the implementation plan.	Sarah Jay Sarah Jay Sarah Jay Sarah Jay Sarah Jay Angela Collins Angela Collins	Q4 Q1 Q2 Q4 Q4 Q4 Q4	Move to Q1 2017 Actions included in plan Baseline data established To be transferred to 2017/18 To be transferred to 2017/18 To be transferred to 2017/18 Changed from Q1 to Q4 DEG agreed to wait until research completed	 **Completed** **Completed**

8	Improve staff experience amongst the different workforce ages	Improve related responses in the 2016 Staff Survey results and Staff FFT results. More retention of key skills and experience without disadvantaging younger workers.	X	X	X	1. Hold a feedback event following the recently completed first stage of a field study of TEWV clinical staff about extending working lives and gain views to inform recommendations to EMT about our future approach. 2. Take the recommendations regarding our future approach to EMT. 3. Review the findings from the 2015/16 workforce equality monitoring data and identify any areas of concern. 4. Where areas of concern are identified, take recommendations to the Equality and Diversity Steering group, Diversity Engagement Group and WDG	David Levy David Levy Sarah Jay Sarah Jay	Q1 Q2 Q1 Q2	Event held in May and consultation taken place Move to Q3 delay in Trust report Presented to E&D steering group Demographic reports from Picker shared with groups	**Completed** **Completed** **Completed**
9	Improve the impact of the Staff Friends and Family Test and start preparations for the Investors in People reaccreditation.	Ensure the Staff FFT results are user friendly and relevant. Staff FFT results are used by all teams to improve working arrangements. Staff and Patient FFT results are jointly upon.	X	X	X	1. Hold a QIS event to consider the future Trust approach to the Staff FFT including refreshing the non- core questions and the assurance process. 2. Revised proposals are taken to EMT for consideration. 3. Prepare for the implementation of the agreed approach. 4. Arrange for 2 staff to be trained in the revised IiP National Standard Framework and Assessment Process. 5. Undertake the IiP mid-term review with the Lead Assessor. 6. Inform EMT of the options available for the next IiP assessment and agree the way forward. 7. Review the effectiveness of the Local Consultative Committees in implementing organisational change. (Carried over from 15/16)	Sheila Jones David Levy Kerry Jones Sheila Jones Sheila Jones David Levy David Levy	Q1 Q1 Q2 Q1 Q1 Q2 Q4	Event held Report gone to EMT Recommendations in place Training undertaken Mid-term review undertaken Report to Nov Board As part of partnership agreement review	**Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed**

As this is a Trust wide action plan each individual action owner requires reasonable cooperation from others across the Trust to ensure that actions can be implemented as effectively as possible. There will be regular monitoring and reporting of progress made with implementaton of the Trust Action Plan and Local Action Plans.

New Draft Composite Action Plan 2017/18

No	Theme	Staff Survey	Staff FFT	Action	Action owner	Target date	Progress update
1	**Prevention of bullying and harassment**	√	√	Develop a separate draft TEWV wide anti bullying and harassment procedure, via the policy working group, that will apply to all TEWV staff.	Nicola Rutherford	Q2 2017/18	
				Ensure that there is appropriate consultation about the draft procedure at the relevant forums.	Nicola Rutherford	Q2 2017/18	
				Secure Joint Consultative Committee and Executive Management Team support for the proposed terms of the anti-bullying and harassment procedure.	David Levy	Q3 2017/18	
				Develop and implement a communications plan to raise awareness amongst TEWV staff of the anti-bullying and harassment procedure and related actions.	Julie Jones	Q3 2017/18	
				Incorporate the keys issues and requirements of the anti-bullying and harassment procedure within Trust leadership and management development Programmes.	Michelle Brown	Q4 2018	
				Design and deliver informal training sessions to staff o how to use and interpret the procedure.	Angela Collins	Q4 2017/18	
2	**Understanding the impact of presenteeism within the Trust**	√		Arrange and facilitate focus groups with registered nurses and health care assistants within the York & Selby, Durham & Darlington and Forensic Directorate to establish contributing factors which make staff feel under pressure to attend work when feeling unwell.	Paul Walker	Q2 2017/18	
				From the data identify themes that could be contributing to the way staff have reported in the staff survey 2016 results.	Paul Walker	Q3 2017/18	
				Explore with local higher educational institutes the potential for and interest in undertaking research with TEWV into the causes of presenteeism.	David Levy	Q3 2017/18	
				Share findings of the focus groups with the Executive Management Team and identify what additional	David Levy	Q3 2017/18	

				support can be put in place.			
				Pilot the introduction of short term reasonable adjustments in the identified hotspots for staff who are exhibiting symptoms of 'presenteeism'.	Sheila Jones	Q3 2017/18	
				Understand from managers their interpretation of the sickness absence management procedure, if necessary provide refresh sessions on the key messages of the procedure.	Lesley Hodge	Q3 2017/18	
				Include information to assist managers to recognise presenteeism and to discourage a culture of staff working when unwell within TEWV leadership and management development programmes.	Michelle Brown	Q3 2017/18	
				Work in collaboration with the Health and Wellbeing CQUIN Project Manager to further promote opportunities within the identified areas.	Russell Smith	Q3 2017	
3	**Improving staff engagement across the Trust**	√	√	Arrange and facilitate an RPIW to identify how and when to share/triangulate key staff experience/engagement information/intelligence between the Organisational Development Team and other staff support services. Agree which delegates to invite including HR staff, employee support, union representatives, contact officers etc.	David Levy	Q3 2017/18	
				As a result of the RPIW develop a standard process for how and when to share key staff experience/engagement information and with whom whilst maintaining the confidence of those who share the information.	Michelle Brown	Q4 2017/18	
				Develop electronic guidance for managers and other staff providing information about the TEWV staff engagement resources that are available.	Michelle Brown	Q3 2017/18	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23 May 2017**
TITLE:	**Approval of accounts for the financial year ended 31 March 2017**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**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 Board is required to approve and formally adopt the accounts for the period ended 31 March 2017 for submission to NHS Improvement.

The Trust achieved an operating surplus of £19,222k, which 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.

Recommendations:

The Board of Directors is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2017 to NHS Improvement.

The Board of Directors is requested to adopt the recommendation of the Audit Committee that the Trust should be considered as a going concern and that the year end accounts should be prepared on that basis.

MEETING OF:	**Board of Directors**
DATE:	**23 May 2017**
TITLE:	**Approval of accounts for the financial year ended 31 March 2017**

1. PURPOSE OF REPORT

1.1 The purpose of this report is to ask the Board of Directors to approve the accounts for the period ended 31 March 2017 to the Trust Board.

2. BACKGROUND

2.1 In line with statutory requirements the Board is required to approve and formally adopt the accounts for the period ended 31 March 2017 for submission to NHS Improvement, the Independent Regulator for NHS Foundation Trusts.

2.2 Mazars LLP has carried out an audit of the accounts and they presented the outcome of the audit to the Audit Committee on the 18 May 2017.

3. KEY ISSUES

3.1. Statutory Obligations

The Trust achieved all of the requirements of a Foundation Trust as set out in the Trusts authorisation, in relation to finance;

- Remain as a going concern
- Ensure financial planning incorporates surpluses
- Achieve a use of resources rating in line with plan and above a 2 rating. The Trust has achieved this, with a rating of 1 in 2016-17.
- Pay Public dividend capital repayments to the Department of Health, currently defined as 3.5% on net relevant assets.

3.2 Key areas of Performance

The Audit Committee received a copy of the audited accounts on 18 May 2017. A copy of the latest audited accounts for 2016-17 are enclosed within Appendix 1 (please note at time of delivery these are not signed off by Audit – any changes will be tabled). The highlights are summarised below;

Income
Total operating income for the twelve months ended 31 March 2017 was £345,888k which was higher than the previous year mainly due to the full year effect of the York and Selby contract, sustainability and transformation funding and contract variations with commissioners.

Operating Expenses
Total operating expenses increased during 2016-17, mainly due to the full year effect of the York and Selby contract and non-recurrent expenditure linked to IT infrastructure and buying out property leases identified as no

longer required by the Trust. Excluding these items operating expenses remained consistent with 2015-16.

Operating Surplus
The Trust achieved an operating surplus of £19,222k, which 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.

Statement of Financial Position
Property, Plant and Equipment have increased over the year by £1,932k due to due to investment in the capital programme being higher than depreciation charged and impairments.

Cash at Bank and in hand has increased by £3,697k to £57,845k. The increase in cash is mainly due the underlying operating surplus.

3.3 Items of note in the accounts

There are items of special note in the accounts for 2016-17 which have been discussed with the Trust's auditors.

- The Trust has received £7,251k of incentivised sustainability and transformation fund income from NHS Improvement due to its surplus in excess of its agreed control total.

3.4 Explanations to some notes in the accounts

Some of the notes contained in the accounts require some guidance and the following explanation may be of assistance;

- After the main statements in the accounts there are notes on accounting policy (commencing page 5) which describe the basis on which the accounts have been completed. It summarises the methodology used and highlights any change in policy from last year.
- The supporting note to property, plant and equipment (note 12.1) shows a column headed 'assets under construction' this relates to schemes in the capital programme that were not completed at 31 March 2017 and in line with capital accounting policy these cannot be capitalised. The £3,732k at the end of 2016-17 related largely to developments at Harrogate, and Huntington House in York.
- The 'financed by' section of the statement of financial position is predominately supported by the Statement of Changes in Taxpayers' Equity (page 3) and details the changes in the year.
- Details of the Trusts PFI schemes in operation are shown under note 36, page 27.

3.5 Annual Governance Statement

The Annual Governance Statement included within item 11 of the agenda has been reviewed by Mazars LLP and the Audit Committee.

3.6 Going Concern

NHS Foundation Trusts are required to prepare their accounts in accordance with relevant accounting rules. One of the requirements is to prepare the accounts on a going concern basis unless an organisation is to cease trading or there are significant doubts on the organisations ability to continue as a going concern.

Those charged with governance (i.e. the Board) need to consider whether this Trust is clearly a going concern. A Trust is considered a Going Concern provided it meets the following criteria:

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

The Audit Committee recommended that the Trust should be considered as a going concern and that the year end accounts should be prepared on that basis

4. IMPLICATIONS

4.1 There are no direct financial implications associated with this paper.

4.2 The Trust is required within the terms of its authorisation as a Foundation Trust to submit accounts to Parliament by 26 June 2017.

5. RISKS

5.1 There are no risks associated with this paper.

6. CONCLUSION BASED ON KEY ISSUES AND FINANCIAL IMPLICATIONS

6.1 The Trust has achieved all of its statutory and non statutory financial obligations with the audit process only making minor changes from the accounts submitted on the 26 April 2017.

7. RECOMMENDATIONS

7.1 The Board of Directors is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2017 to NHS Improvement.

7.2 The Board of Directors is requested to adopt the recommendation of the Audit Committee that the Trust should be considered as a going concern and that the year-end accounts should be prepared on that basis.

7.3 The Board of Directors is asked to confirm that as far as they are aware, there is no relevant information of which the Trust's auditors are unaware.

Drew Kendall
Interim Director of Finance and Information

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23 May 2017**
TITLE:	**Approval of Charitable Trust Fund accounts for the financial year ended 31 March 2017**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**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:

In line with statutory requirements the Board is required to approve and formally adopt the Charitable Trust Fund accounts for the period ended 31 March 2017 for submission to The Charities Commission.

The Charitable Trust Fund had a closing balance of £527k.

Recommendations:

The Board of Directors is requested to approve the Accounts and Annual Report for submission to the Charities Commission.

The Board of Directors is requested to sign and date the Statement of Trustee Responsibilities and the Balance Sheet within the Charitable Trust Fund accounts.

MEETING OF:	**Board of Directors**
DATE:	**23 May 2017**
TITLE:	**Approval of Charitable Trust Fund accounts for the financial year ended 31 March 2017**

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Board of Directors with the final Charitable Trust Fund Accounts and Annual Report for the period ended 31 March 2017 to the Trust Board.

2. BACKGROUND

2.1 The Trust has one General Charitable Umbrella Trust Fund registered with the Charities Commission. This charity was formed as a result of the former Tees & North East Yorkshire NHS Trust merger with County Durham and Darlington Priority Services NHS Trust.

2.2 The Accounts and Report comply fully with the Statement of Recommended Accounting Practice: Accounting and Reporting by Charities (SORP FRS 102), issued in January 2015, UK Accounting Standards and the Charities Act 2011.

2.3 In line with statutory requirements the Board is required to approve and formally adopt the Charitable Trust Fund accounts for the period ended 31 March 2017 for submission to The Charities Commission.

2.4 Mazars LLP has carried out an independent examination of the accounts and they presented the outcome of this to the Audit Committee on 18 May 2017.

3. KEY ISSUES

3.1 The Charitable Trust Fund had a closing balance of £527k.

The attached accounts and annual report have been subject to an independent review by Mazars LLP with the outcome reported to the Audit Committee on 18 May 2017.

4. FINANCIAL, LEGAL AND EQUALITY & DIVERSITY IMPLICATIONS

4.1 There are no direct financial implications associated with this paper.

4.2 The Trust is required to submit Charitable Trust Fund accounts to The Charities Commission by 31 January 2018.

5. CONCLUSION BASED ON KEY ISSUES AND FINANCIAL IMPLICATIONS

5.1 The Trusts external auditors completed an independent examination concluding there are no significant areas of concern for the Trust with regards the Charitable Trust Funds at 31 March 2017.

6. RECOMMENDATIONS

6.1 The Board of Directors is requested to approve the Accounts and Annual Report for submission to the Charities Commission.

6.2 The Board of Directors is requested to sign and date the Statement of Trustee Responsibilities and the Balance Sheet within the Charitable Trust Fund accounts.

Drew Kendall
Interim Director of Finance and Information

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd May 2017**
TITLE:	**Annual Board Certificates**
REPORT OF:	**Phil Bellas, Trust Secretary/Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**Assurance/Decision**

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

Executive Summary:

This report seeks the confirmation of, and authority to sign off, the following annual Board certificates required by NHS Improvement (NHSI):

(1) The certificate that the Board has taken all precautions necessary to comply with the Licence, NHS Acts and NHS Constitution - Licence Condition G6 (3).
(2) A Corporate Governance Statement - Licence Condition FT4 (8).
(3) The certificate on the training of Governors – S. 151 of the Health and Social Care Act 2012.
(4) The certificate that the Board has a reasonable expectation that required resources will be available to deliver designated Commissioner Requested Services - Licence Condition CoS7 (3).

The Audit Committee, following an assurance review, has recommended that the Board should confirm and sign off the above certificates.

The Board is asked to note that, to comply with NHSI guidance, approval of the certificates should take into account the views of Governors. This is being sought at the Council of Governors' meeting held on 25th May 2017.

Recommendations:

The Board is asked to confirm and approve the signing off of the Annual Board Statements required by NHS Improvement subject to no material issues being raised by the Council of Governors.

MEETING OF:	**Board of Directors**
DATE:	**23rd May 2017**
TITLE:	**Annual Board Certificates**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek the Board's approval to sign off the annual certificates required by NHS Improvement.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Board Members will be aware that NHS Improvement requires the Boards of Foundation Trusts to self-certify, annually, the following certificates:

(a) The certificate that the Board has taken all precautions necessary to comply with the Licence, NHS Acts and NHS Constitution - Licence Condition G6 (3).
(b) A Corporate Governance Statement - Licence Condition FT4 (8).
(c) The certificate on the training of Governors – S. 151 of the Health and Social Care Act 2012.
(d) The certificate that the Board has a reasonable expectation that required resources will be available to deliver designated Commissioner Requested Services - Licence Condition CoS7 (3).

2.2 Unlike previous years, the signed certificates are not required to be submitted to NHS Improvement; however, the regulator will be undertaking spot audits, from July 2017, to test that Foundation Trusts have carried out the self-certification process.

3. KEY ISSUES:

3.1 At its meeting held on 11th May 2017 the Audit Committee reviewed the assurances provided to it to support the signing off of the certificates.

(Note: copies of the Audit Committee report are available on Boardpad or on request).

3.2 The Audit Committee has recommended to the Board that it should confirm and sign off:

(a) The certificate of compliance with General Condition 6 of the Licence 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."

(Note: once approved the certificate is required to be published on the Trust's website.)

(b) Each element of the Corporate Governance Statement (attached as Annex 1 to this report) required under Licence Condition FT4 of the Licence.

(c) The statement on the Training of Governors 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) The certificate on compliance with Condition CoS7 of the Licence 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."

As recommended by NHSI, the Board is asked to approve the following statement in relation to the above certificate:
"*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."*

3.3 In signing off the self-certification the Board should take into account the views of Governors. Due to the late provision of guidance on the self-certification process from NHSI (received on 21st April 2017) this has not yet been possible. The Board is, therefore, asked to confirm and authorise the signing-off of the certificates subject to no material issues being raised by the Council of Governors at its meeting held on 25th May 2017.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The Trust is required to be registered with the CQC under Licence Condition G7.

4.2 **Financial/Value for Money:** Under the Licence, the Trust has a duty to operate efficiently, economically and effectively.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust is required to hold a Licence in order to provide NHS services. Failure to comply with the Licence conditions can result in enforcement action.

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks that, if following testing, NHS Improvement does not consider that the Trust's approach to self-certification is sufficiently robust it would consider this to be a potential breach of the Licence and review the Trust's segmentation under the Single Oversight Framework.

6. CONCLUSIONS:

6.1 The annual self-certifications are required by NHS Improvement. The responses agreed by the Board may be used by the Regulator to determine its approach to oversight of the Trust.

7. RECOMMENDATIONS

The Board is asked:

(1) To approve the recommendations of the Audit Committee and confirm and sign off:
   (a) The certificate in relation to Licence Condition G6 (compliance with the Licence, NHS Acts and NHS Constitution)
   (b) The Corporate Governance Statement required under Licence Condition FT4 (8) as set out in Annex 1 to this report
   (c) The certificate relating to the training of Governors
   (d) The certificate in relation to Licence Condition CoS7(3) that the Board has a reasonable expectation that required resources will be available to deliver designated Commissioner Requested Services

   subject to no material issues being raised by the Council of Governors at its meeting to be held on 25th May 2017.

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

Phil Bellas, Trust Secretary
Drew Kendall, Interim Director of Finance and Information

Background Papers:
The Trust's Provider Licence
Email from NHS Improvement to the Chief Executive dated 21/4/17 on the self-certification process for 2017/18

Annex 1

Draft Corporate Governance Statement (May 2017)

	Corporate Governance Statement Component	Risks & Mitigating Actions	Proposed Response (Confirmed/Not Confirmed)
1	The Board is satisfied that Tees, Esk & Wear Valleys NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	The Trust's corporate governance arrangements have not been subject to an independent review since 2014. *Mitigating Action* *An external governance review, based on NHS Improvement guidance, will be undertaken by the end of Quarter 2, 2017/18*	Confirmed
2	The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	See (1) above	Confirmed
3	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	See (1) above	Confirmed
4	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny	See (1) above	Confirmed

	and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern; (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements		
5	The Board is satisfied that: (a) There is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) The Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of	See (1) above	Confirmed

	care; (d) It receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) Tees, Esk & Wear Valleys NHS Foundation Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) There is clear accountability for quality of care throughout the Tees, Esk & Wear Valleys NHS Foundation Trust including, but not restricted to, systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		
6	The Board is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	The Trust has recognised that difficulties in recruiting and retaining sufficient staff in all its Localities could impact on its ability to provide high quality care. *<u>Mitigating Actions</u>* *A range of mitigating actions have been developed in response to this risk including:* ▪ *The refresh of the Trust's workforce strategy.* ▪ *The delivery of the Trust's recruitment plan (by March 2018)* ▪ *The establishment of the Safer Staffing Programme* ▪ *The PPCS and model wards programmes* ▪ *Systematic reviews of all consultant vacancies* ▪ *Campaigns and*	Confirmed

		initiatives to attract junior medical staff *Assurance on the delivery of these mitigating actions is being provided regularly to the Board.*	

Item 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23 May 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 30 April 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 30 April 2017 is a surplus of £864k, representing 3.1% of the Trust's turnover and is in line with plan.

Identified Cash Releasing Efficiency Savings at 30 April 2017 are behind plan. The Trust continues to progress schemes to deliver CRES for current and future years.

The Use of Resources Rating for the Trust is assessed as 3 for the period ending 30 April 2017 and is in line with plan. The 3 rating arises due to the ITFF loan payment 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:	**23 May 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 30 April 2017**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2017 to 30 April 2017.

2. BACKGROUND INFORMATION

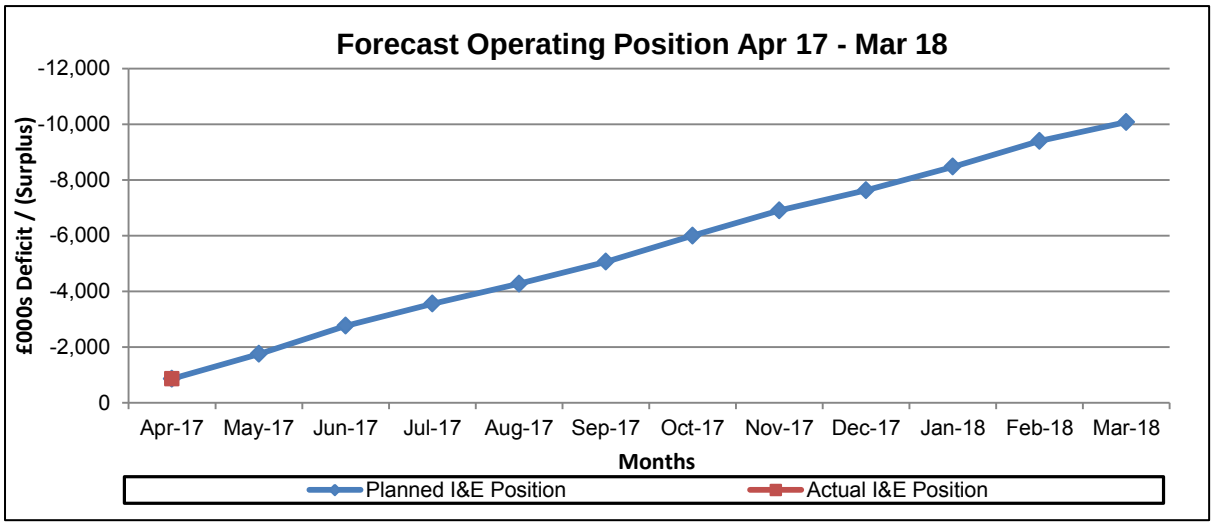
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

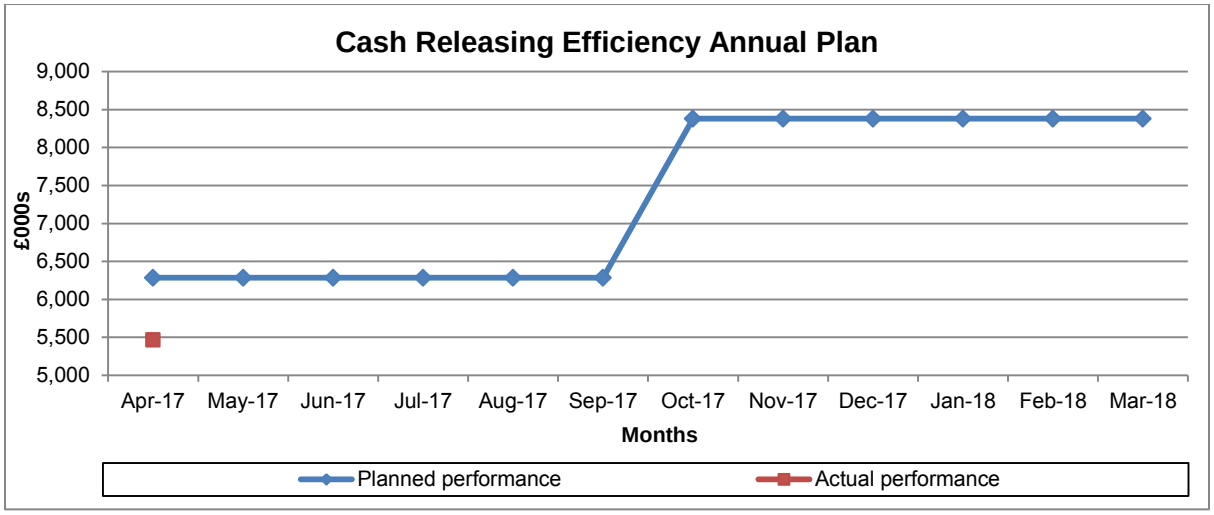
The comprehensive income outturn for the period ending 30 April 2017 is a surplus of £864k, representing 3.1% of the Trust's turnover and is in line with plan.

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

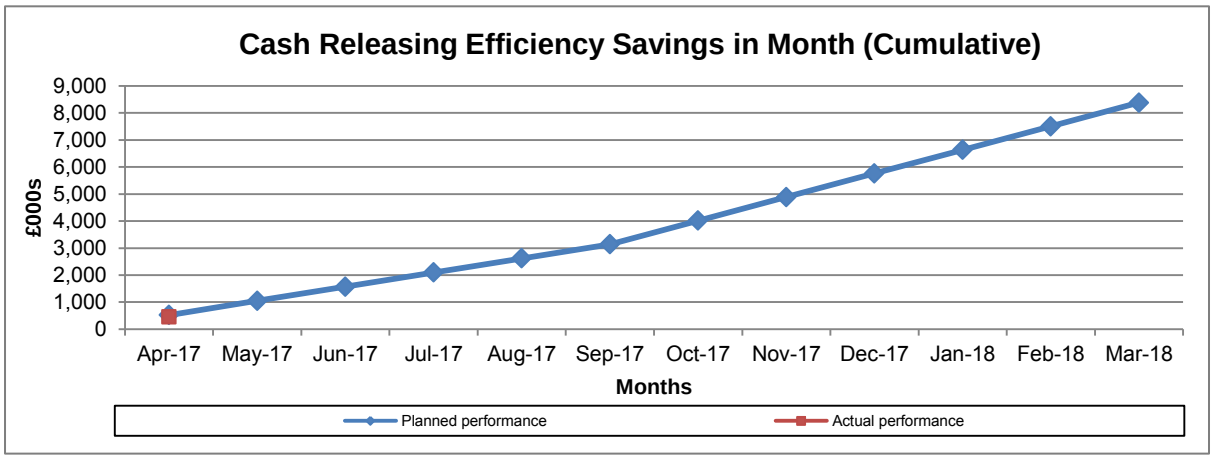


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 30 April 2017 is £5,467k and is behind plan, though the Trust continues to identify and progress schemes to deliver CRES in full for current and future years.

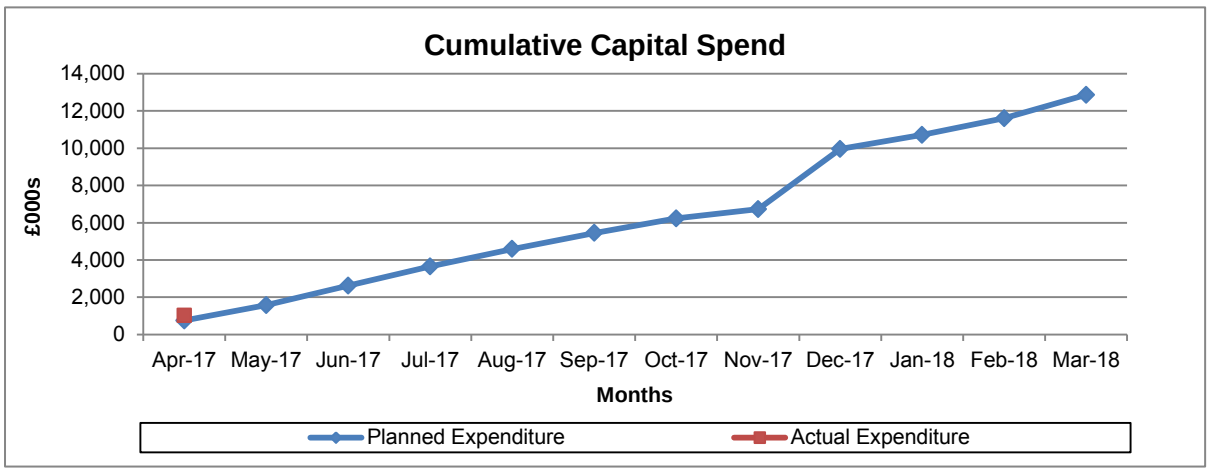


The monthly profile for CRES identified by Localities is shown below.



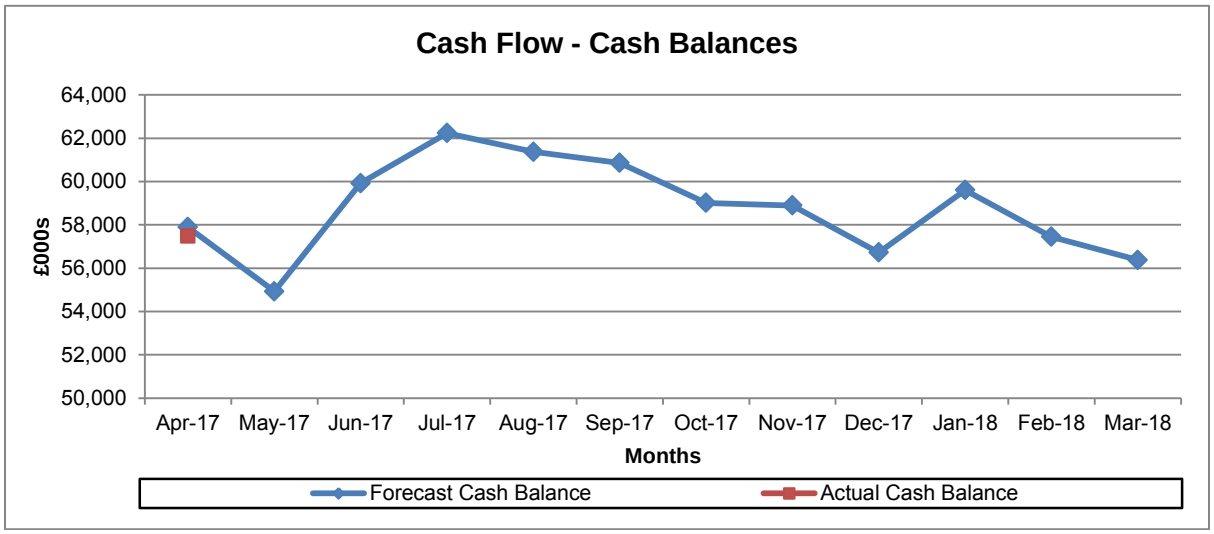
3.3 Capital Programme

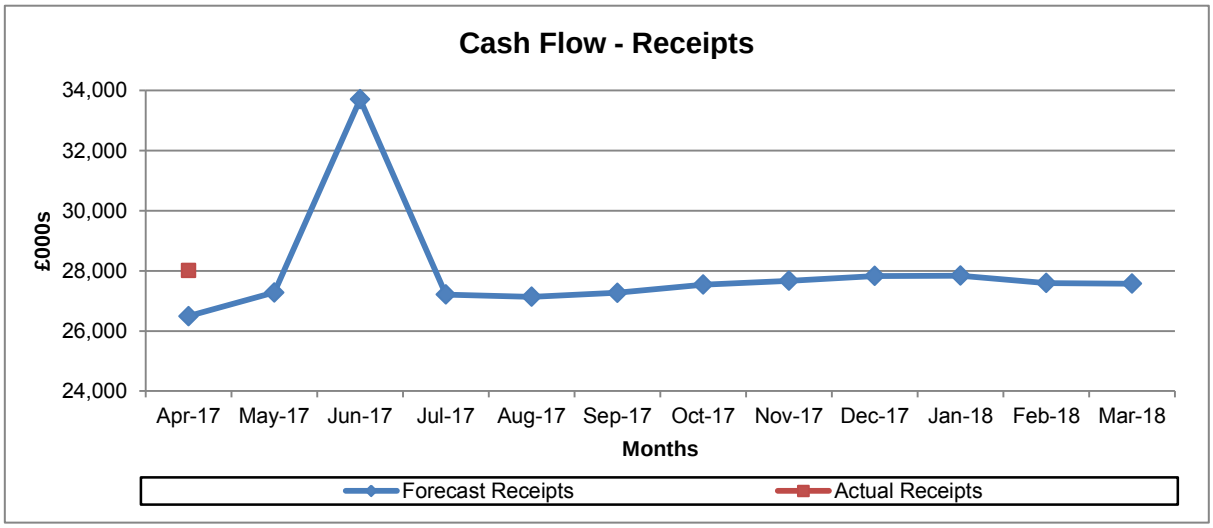
Capital expenditure to 30 April 2017 is £1,017k and is ahead of plan largely due to a number of small schemes which did not complete carrying forward from 2016/17.

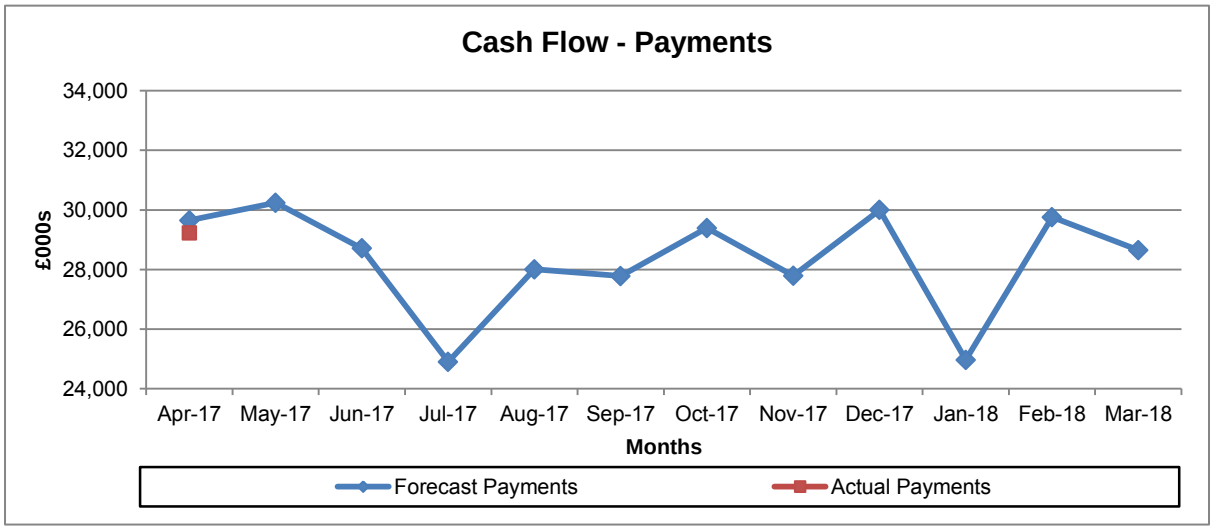


3.4 Cash Flow

Total cash at 30 April 2017 is £57,482k and is in line with plan.

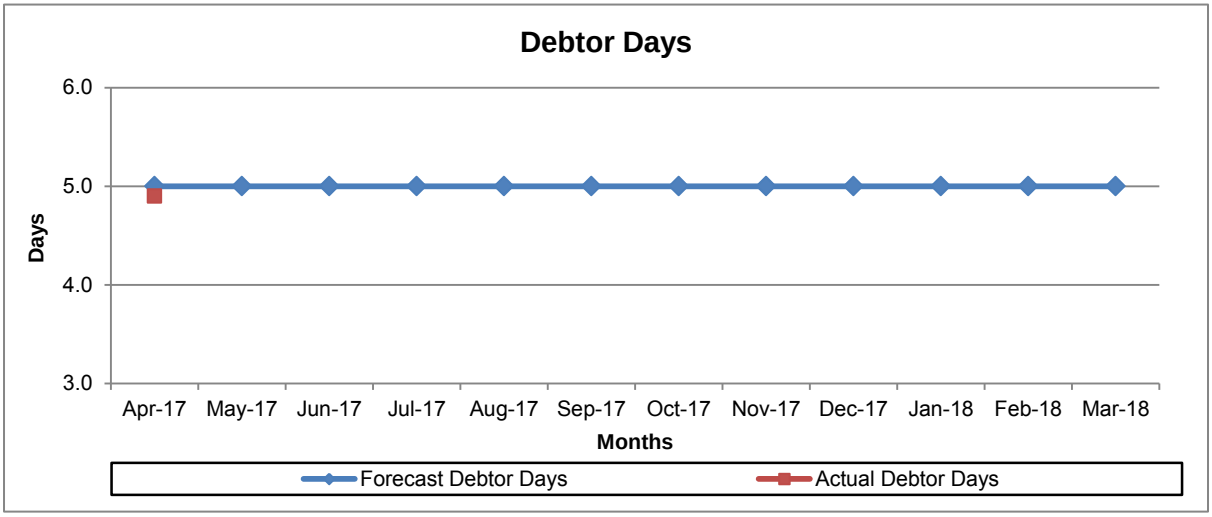






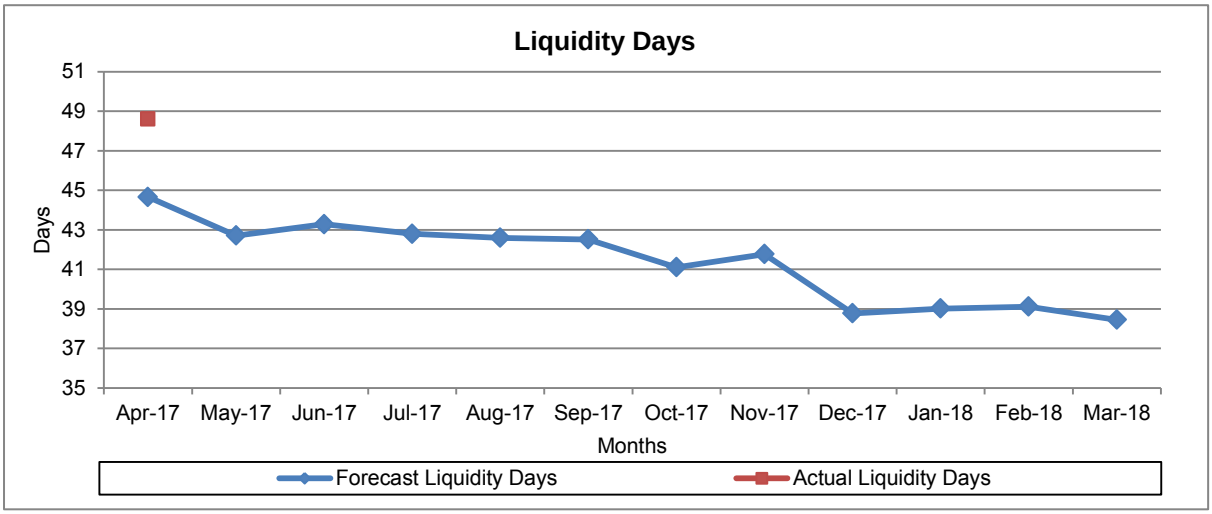
The payments profile fluctuates over the year for Sustainability and Transformational Fund incentive receipts (June), PDC dividend payments, financing repayments and capital expenditure.
Working Capital ratios for period to 30 April 2017 are:

- Debtor Days of 4.9 days
- Liquidity of 48.6 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 69.88%
  Non NHS 30 Days – 98.06%



The Trust has a debtors' target of 5.0 days, and actual performance of 4.9 days at 30 April 2017, which is marginally ahead of plan.

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



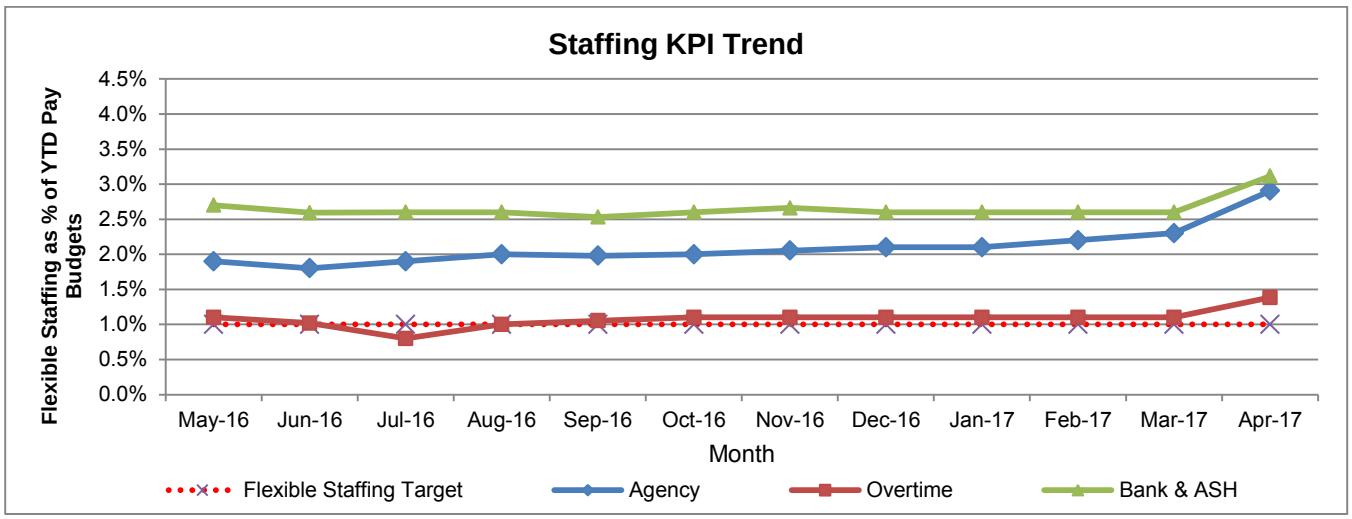
3.5 Financial Drivers

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

Tolerance	Nov	Dec	Jan	Feb	Mar	Apr
Agency (1%)	2.1%	2.1%	2.1%	2.2%	2.3%	2.9%
Overtime (1%)	1.1%	1.1%	1.1%	1.1%	1.1%	1.4%
Bank & ASH (flexed against establishment)	2.7%	2.6%	2.6%	2.6%	2.6%	3.1%
Establishment (90%-95%)	93.7%	93.7%	93.5%	93.9%	93.7%	94.6%
Total	**99.5%**	**99.5%**	**99.3%**	**99.8%**	**99.8%**	**102.0%**

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 April 2017 the tolerance for Bank and ASH is 3.4% of pay budgets.

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



Additional staffing expenditure is 7.4% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (45%), enhanced observations (19%) and sickness (11%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating is assessed as 3 at 30 April 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 0.79x (can cover debt payments due 0.79 times), which is marginally ahead of plan and rated as a 4. The deterioration in this rating from March 2017 arises due to the ITFF loan payment falling due in April 2017.

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 48.6 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 3.1% 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 0.1% 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 £1,152k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £3,453k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £586k is required.
- Variance from control total from plan – to increase to a 1 an operating surplus increase of £17k is required.
- Agency Cap rating – to increase to a 1 a decrease in agency expenditure of £98k is required.

Use of Resource Rating at 30 April 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	20	<=0%	-25%	-50%	>50%

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	0.79x	4	0.78x	4	
Liquidity	48.6	1	44.7 days	1	
I&E margin	3.1%	1	3.2%	1	
Variance From Control total	-0.1%	2	0.0%	1	
Agency	£611k	2	£514k	1	
Overall Use of Resource Rating		**3**		**3**	

3.6.7 11.9% of total receivables (£568k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as £373k 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 4.1%.

3.6.8 0.9% of total payables invoices (£112k) 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 30 April 2017 is £57,482k and represents 67.4 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 30 April 2017 is a surplus of £864k, representing 3.1% of the Trust's turnover and is in line with plan.

6.2 Identified Cash Releasing Efficiency Savings at 30 April 2017 are behind plan. The Trust continues to progress schemes to deliver CRES for current and future years.

6.3 The Use of Resources Rating for the Trust is a 3 for the period ending 30 April 2017 which is in line with plan. The 3 rating arises due to the ITFF loan payment 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

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 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd May 2017**
TITLE:	**Board Dashboard as at 30th April 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 30th April 2017 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. The report also contains suggestions for the two outstanding targets for 2017/18.

As at the end of April 2017, 5 (26%) of the indicators reported are not achieving the expected levels and are red. Given the changes in some of the constructions of the indicators and targets it is not possible to make a direct comparison with the position as at end March 2017. Of the 5 red indicators, 3 relate to the financial targets and more detail is given below. There were no indicators that were red within the Quality dimension.

Recommendations:

It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.
- Agree to the proposals for the two outstanding targets for the 2017/18 targets.

MEETING OF:	**Board of Directors**
DATE:	**23rd May 2017**
TITLE:	**Board Dashboard as at 30th April 2017**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 30th April 2017 in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 Outstanding Targets

The Board agreed the KPIs to be included in the 2017/18 via the development of the Business Plan. As part of this there were some changes agreed to the construction of some of the indicators which meant that we needed to review the targets previously set. The vast majority of the targets have been agreed previously by the Board but two are outstanding. The following are the recommendations for these:

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% -25.0% (within 5% of target)	More than 25% (more than 5% of target)

- The proposed targets are based on a 10% improvement on the 2016/17 baseline which is consistent to the approach made in previous years and with other indicators. It should be noted that the enclosed dashboard does include the above targets as an interim prior to Board approval. If the Board does not feel the targets are appropriate then these will be amended and a revised report will be published.

2.2 Performance Issues

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

- As at the end of April 2017, 5 (26%) of the indicators reported are not achieving the expected levels and are red. Given the changes in some of the constructions of the indicators and targets it is not possible to make a direct comparison with the position as at end March 2017. Of the 5 red indicators 3 relate to the financial targets and more detail is given below. There were no indicators that were red within the Quality dimension.

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 as at the end of April 2017 the Trust did not achieve 2 of those that could be reported on as follows:
  - IAPT recovery – the Trust achieved 49.5% compared to the target of 50%. The areas of concern remain Scarborough and Ryedale and York and Selby. The first meeting of the Trust wide Steering Group has been held and this will continue to provide a forum for sharing of ideas/good practice across the Trust. The final report from the National IST visit to the York and Selby service is still awaited. The national IST carried out their visit to Durham and Darlington earlier in May and the report is currently being drafted.
  - CPA 7 day Follow Up – the Trust achieved 94.7% compared to the target of 95%. On examining those cases that did not comply with the requirements there are still a small number that are due to a breakdown in processes. A detailed conversation regarding this indicator is planned, with all localities and the Chief Operating Officer and Director of Planning, Performance and Communications, on the 25th May 2017.

- The Data Quality Scorecard is included in Appendix B. There has been no change from the previous month to highlight to the Board.

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

2.3 The key risks are as follows:

- Referrals (KPI1) – the number of referrals has decreased considerably and is at target for the first time since December 2016. Whilst this is positive it should be noted that the two Bank Holidays within April will have contributed to this position in month and therefore it will be important to track any subsequent impact on the position in May. Work is being undertaken to develop some statistical control charts to enable us to clearly see where levels of referrals are changing outside the expected variation.
- Bed Occupancy (KPI 3) – The Dashboard shows that bed occupancy at a Trust level has remained similar to that in March and is slightly above target. However it should be noted that there is considerable variation across the localities with Durham and Darlington and North Yorkshire being significantly worse than target. A contribution to this position will be the number of patient occupying a bed with a length of stay greater than 90 days with these two localities accounting for 66% of the total number. Durham and Darlington are introducing additional monitoring in Adult Mental Health to review patient at an earlier point in the inpatient stay. North Yorkshire has established a weekly call with the Local Authority to ensure we are tackling delays within the discharge process.

- External Waiting Times (KPI 7) – The position across the Trust has improved further, although it should be noted that in line with national definitions around Children and Young People waiting times and the operational policy around Single Points of Access we are now classifying telephone assessments as 'stopping the clock.' The main areas of concern continue to be Children and Young Peoples Services in North Yorkshire and York and Selby and the agreed action plans are continuing to be implemented. The North Yorkshire service continues to work towards a trajectory for recovery by June 2017. A detailed capacity and demand modelling is being completed for York and Selby and this will inform the development of further options that could be taken to improve the position.
- %age of registered Healthcare professional jobs that are advertised tow or more times (KPI15) – The was significant deterioration in the position in April. Work is ongoing to This indicator is continuing to report as amber and there has been a slight deterioration in March. York and Selby continue to be the areas of greatest concern and work is continuing to improve the recruitment of staff within all localities with a number of recruitment fayres planned over the next quarter. In addition there are 100 students who have been recruited to commence work with the Trust when they qualify in September 2017.
- Finance Indicators (KPIs 19,20 and 21) Whilst all of the indicators are showing as red it should be noted that KPI 19 (Delivery of our Financial Plan) and KPI 21 (Cash against Plan) are considered by the Finance Department to be within acceptable tolerance levels and therefore are considered to be in line with the plan. In terms of KPI 20 (CRES delivery) work is continuing to identify schemes for the current and future years.

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 proposed targets for 2017/18 Board Dashboard as outlined in section 2.1.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Appendix A

Activity

	April 2017				April 2017 To April 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,542.00	7,509.00			7,542.00	7,509.00		91,759.00
2) Caseload Turnover	1.99%	0.91%			1.99%	0.91%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	87.72%			85.00%	87.72%		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	77.00			75.00	77.00		75.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	9.18%			10.00%	9.18%		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	19.00	21.33			19.00	21.33		237.00

Quality

	April 2017				April 2017 To April 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%	89.23%			90.00%	89.23%		90.00%
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	10.34%			10.00%	10.34%		10.00%
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	13.21%			20.00%	13.21%		20.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	92.73%			92.45%	92.73%		92.45%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.66			1.00	0.66		12.00

Trust Dashboard Summary for TRUST

Workforce

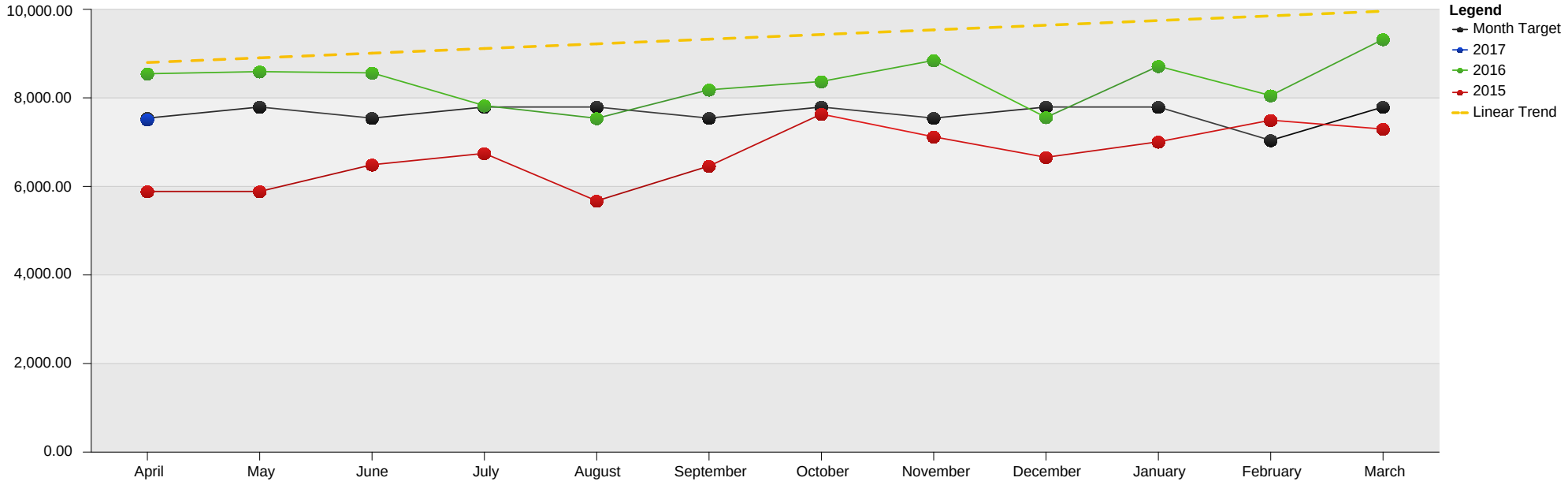
	April 2017				April 2017 To April 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	94.56%			100.00%	94.56%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	26.56%			15.00%	26.56%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	91.08%			95.00%	91.08%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	86.66%			90.00%	86.66%		90.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.49%			4.50%	4.49%		4.50%

Money

	April 2017				April 2017 To April 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-865,000.00	-864,000.00			-865,000.00	-864,000.00		-10,076,000.00
20) CRES delivery	523,680.00	455,573.00			523,680.00	455,573.00		6,284,160.00
21) Cash against plan	57,887,000.00	57,482,000.00			57,887,000.00	57,482,000.00		56,376,000.00

Trust Dashboard Graphs for TRUST

1) Total number of External Referrals into Trust Services

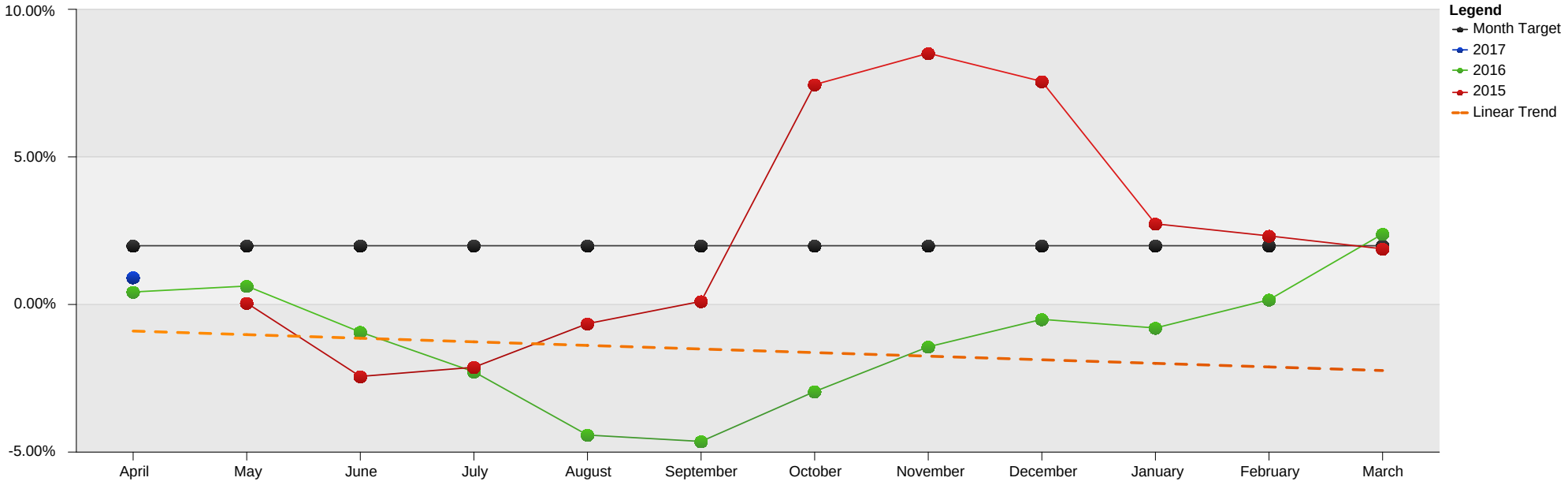


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Total number of External Referrals into Trust Services	7,509.00	7,509.00	1,573.00	1,573.00	2,077.00	2,077.00	1,812.00	1,812.00	625.00	625.00	1,375.00	1,375.00		

Narrative
The Trust position for April 2017 is 7,509 which is meeting the Trust target of 7,542. Whilst this is a decrease on the number of referrals in March 17 and also a decrease when compared to the number recorded for April 16 it does bring the number more in line with target..The number of referrals has decreased in all localities.

Trust Dashboard Graphs for TRUST

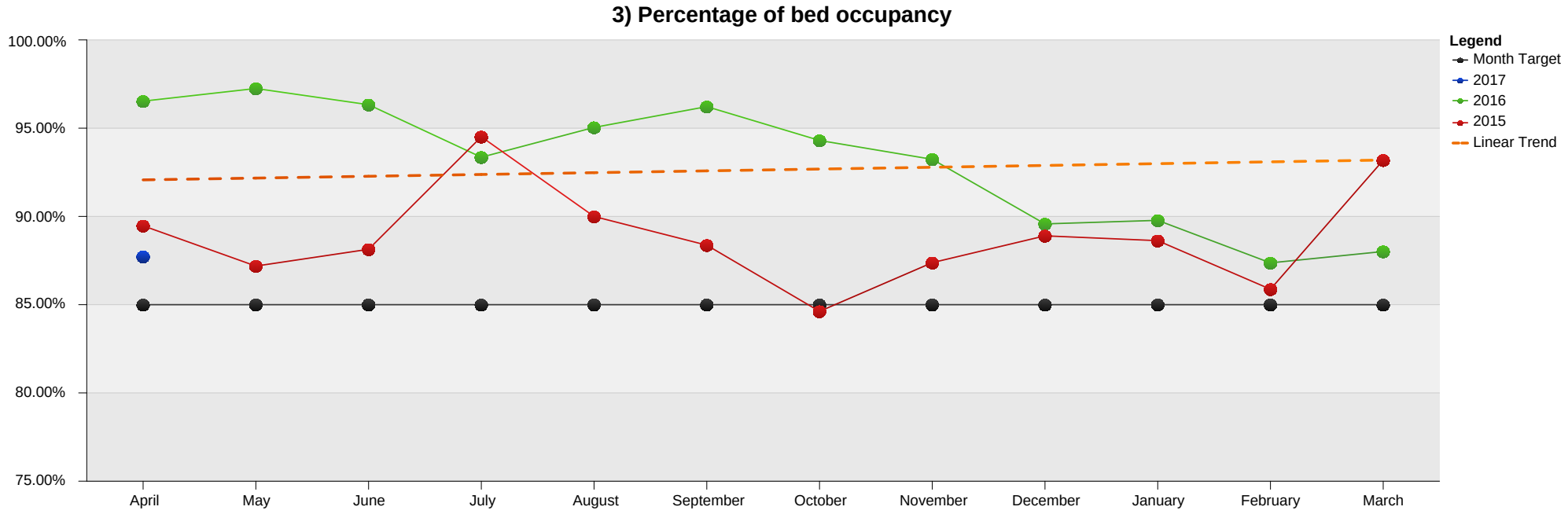
2) Caseload Turnover



	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	0.91%	0.91%	-1.09%	-1.09%	2.09%	2.09%	-1.06%	-1.06%	NA	NA	5.89%	5.89%		

Narrative
The Trust position for April 2017 is 0.91% and meeting the Trust target of 1.99%. This is an improvement to that reported in March 2017; however a deterioration compared to April 2016.Only Teesside and York and Selby are not meeting target. York and Selby report the lowest position at 5.89%. The overall improvement in performance suggests that the use of the caseload management tool is improving; however this position is also likely to be reflective of the decrease in the number of referrals received by the Trust, highlighted above. A revised caseload management tool is currently being tested as part of the Purposeful and Productive Programme.

Trust Dashboard Graphs for TRUST

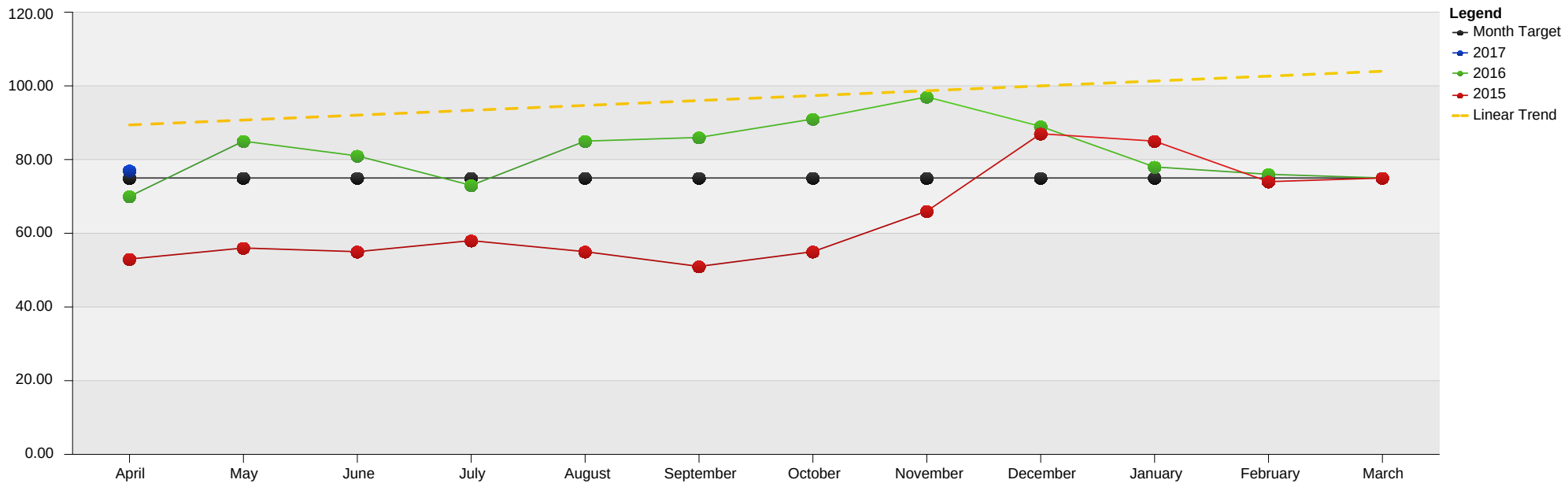


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	87.72%	87.72%	89.80%	89.80%	86.88%	86.88%	91.64%	91.64%	NA	NA	79.24%	79.24%		

Narrative
The Trust position for April 2017 is 87.72% which is 2.72% worse than the Trust target of 85.00% and a similar position to that reported in March 2017. However this position continues the improvement that was seen in the latter part of 2016/17 and is lower than the position reported in April 2015 and 2016. All localities are exceeding the 85% target with the exception of York and Selby which have an occupancy level of 79.24%.

Trust Dashboard Graphs for TRUST

4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH

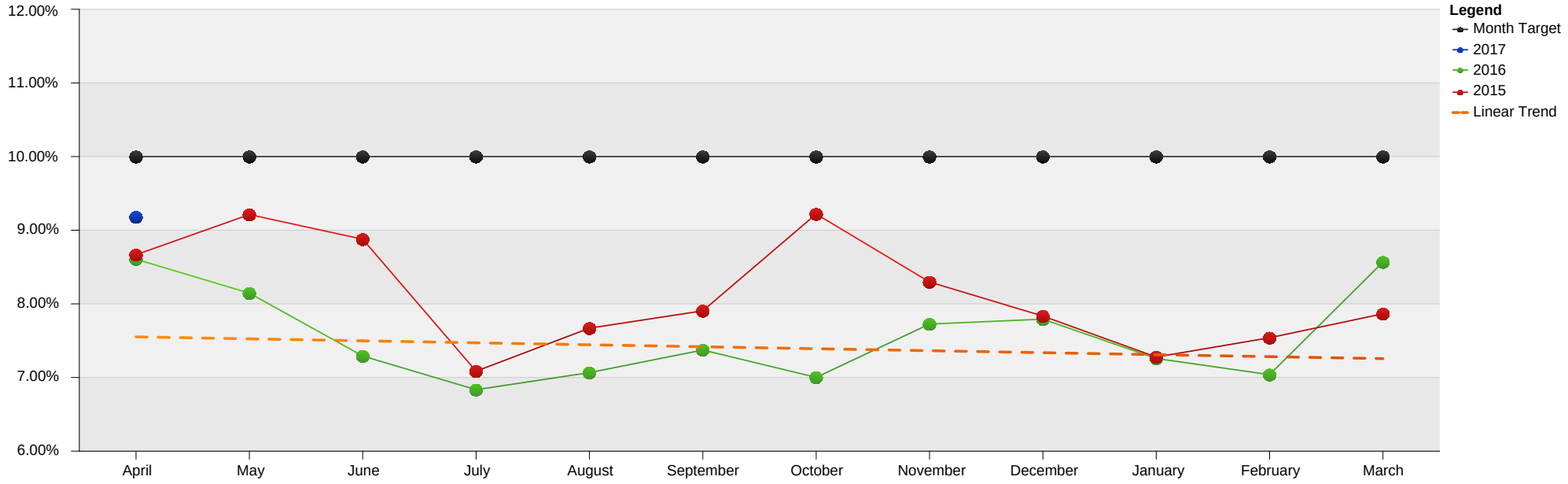


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	77.00	77.00	25.00	25.00	6.00	6.00	24.00	24.00			20.00	20.00		

Narrative
The Trust position for April 2017 is 77 and is not meeting the target of 75. All localities are achieving target with the exception of Durham and Darlington and North Yorkshire. Of the 77 patients occupying a bed with a LoS greater than 90 days:• 26 (34%) were within Durham and Darlington (9 MHSOP and 16 ADULTS) • 20 (26%) were within York & Selby (11 MHSOP AND 13 ADULTS) • 6 (8%) were within Teesside (3 MHSOP and 3 ADULTS) • 25 (32%) were within North Yorkshire (11 MHSOP and 13 ADULTS) In Durham and Darlington MHSOP patients with a length of stay 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.In North Yorkshire issues around delayed transfers of care in both AMH and MSHOP services linked to availability of community placements are impacting on discharge. Weekly calls are now in place with the local authority to review and prioritise placements and resolve barriers to discharge.

Trust Dashboard Graphs for TRUST

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



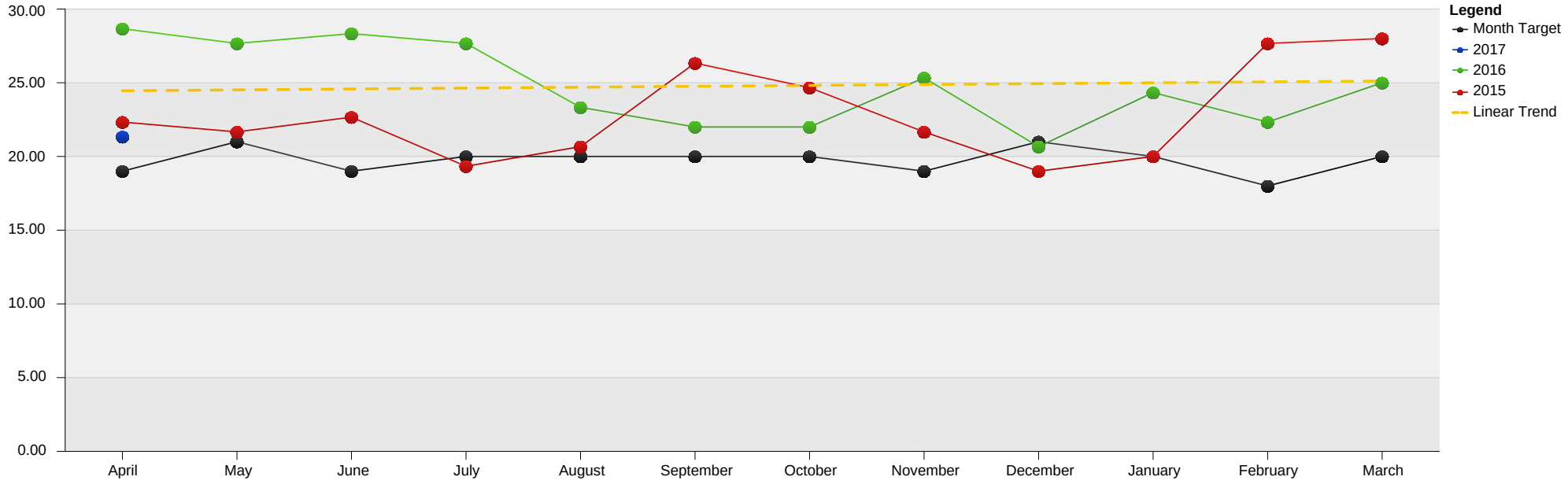
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	9.18%	9.18%	7.46%	7.46%	10.73%	10.73%	4.67%	4.67%			14.18%	14.18%		

Narrative

The Trust rolling 3 month position ending April 2017 is 9.18%, which relates to 21.66 patients out of 236 that were readmitted within 30 days. This is meeting the target of 10% however it is a slight deterioration on the position reported in March 17 and the worst position recorded from 2016/17 to date.Of the 21.66 patients re-admitted:• 5.66 (25%) were within Durham & Darlington (4.66 AMH and 0.66 MHSOP) • 6.66 (34%) were within York and Selby (6.66 AMH and 0.66 MHSOP).• 2.33 (13%) were within North Yorkshire (2.66 AMH and 0.33 MHSOP) • 6.33 (28%) were within Teesside (5.33 AMH and 0.66 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 14.18% and this relates to the complex nature of patient presentation

Trust Dashboard Graphs for TRUST

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

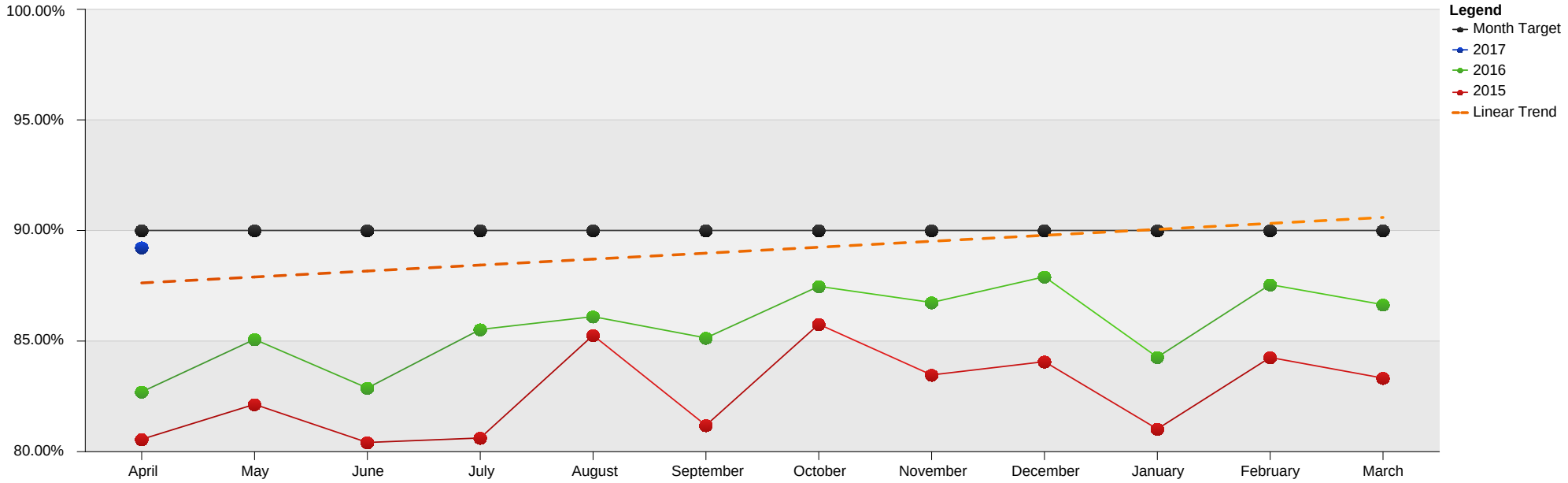


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	21.33	21.33	5.00	5.00	4.00	4.00	5.67	5.67			6.00	6.00		

Narrative
The Trust rolling 3 month position ending April 2017 is 21.33, which is 2.33 worse than the target of 19 however an improvement compared to the position reported in March 2017 and April 2016. .All localities are achieving target with the exception of York and Selby and the comment above relating to complex patient presentation also applies. Of the 21.33 or more readmissions:• 4.99 (25%) were within Durham & Darlington (4.66 AMH and 0.33 MHSOP)• 3.99 (23%) were within Teesside (3.66 AMH and 0.33 MHSOP)• 5.66 (22%) were within North Yorkshire (4.66 AMH and MHSOP 0.99)• 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)



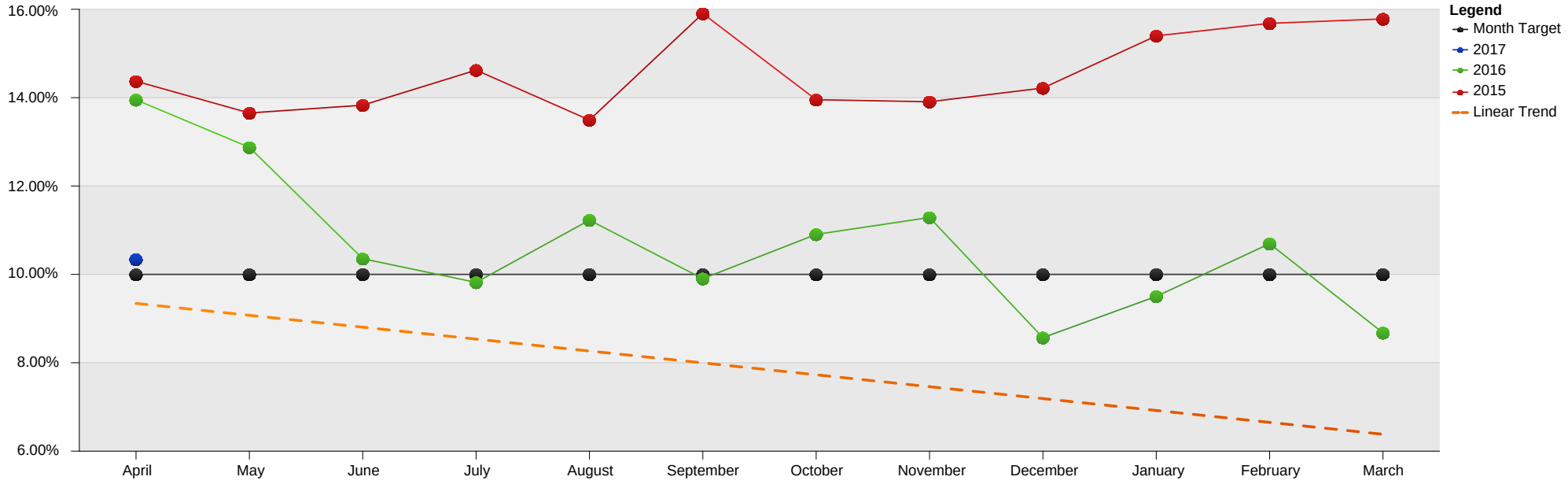
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	89.23%	89.23%	86.44%	86.44%	98.37%	98.37%	80.24%	80.24%	99.14%	99.14%	74.07%	74.07%		

Narrative

The position for April 2017 is 89.23%, relating to 551 patients out of 5116 who waited longer than 4 weeks. This is 0.77% worse than target and an improvement on the March 2017 position. It is also one of the best performance positions seen since the 4 week indicator was introduced.. Please note that within CAHMS services this position now includes telephone assessments stopping the clock in line with the new Single Point of Access service model..Areas of concern:• York & Selby CYP at 59.09% (45 out of 110 patients) this is a 40.1% improvement on the March position. The inclusion of telephone assessments will have contributed to this position, however an action plan continues to be implemented with data quality actions being addressed. Also a capacity and demand mapping exercise and utilisation of partnership working are ongoing. A lack of clinic rooms is also impacting on the timeliness of appointments and options around alternative accommodation are being reviewed.• York and Selby Adults at 64.81% (57 out of 162 patients). This is due to capacity within the service and an action plan is in place to address areas of concern.

Trust Dashboard Graphs for TRUST

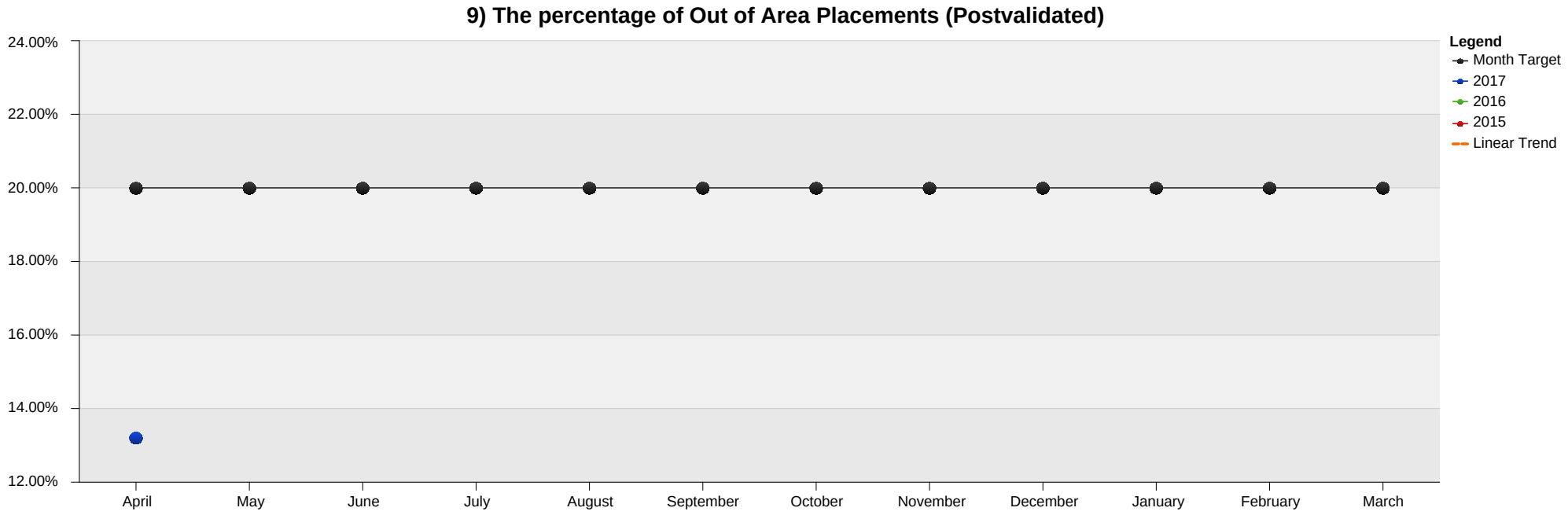
8) Percentage of (Clinic) appointments cancelled by the Trust



	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	10.34%	10.34%	10.94%	10.94%	9.49%	9.49%	12.44%	12.44%			4.78%	4.78%		

Narrative
The Trust position for April 2017 is 10.34%, which relates to 346 of clinic appointments out of 3346 that have been cancelled. This is not meeting the target of 10%, and is a deterioration compared to the position in March 17, however an improvement to the position recorded in April 16.This KPI now relates to clinic appointments only in both the numerator and denominator.Only Teesside and York and Selby are meeting target, North Yorkshire reports the poorest position at 12.44%.

Trust Dashboard Graphs for TRUST

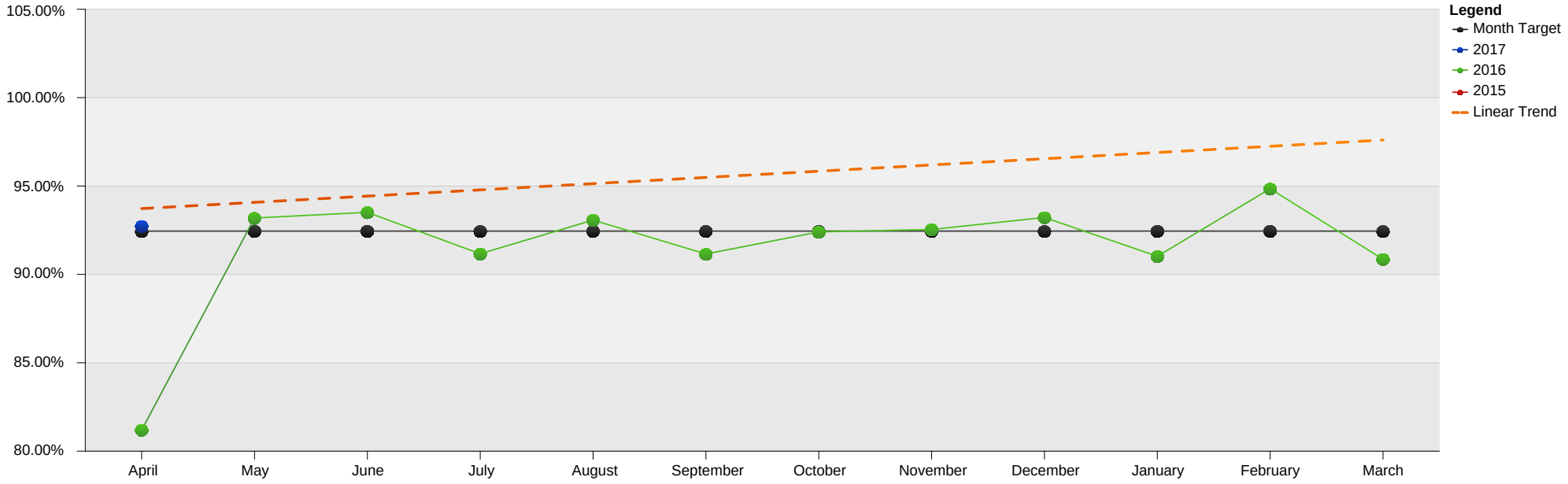


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Area Placements (Postvalidated)	13.21%	13.21%	10.42%	10.42%	2.25%	2.25%	26.09%	26.09%			32.35%	32.35%		

Narrative
The Trust position for April 2017 is 13.21%%, which relates to 70 admissions out of 530 that were admitted out of area. This is meeting 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 is available to compare previous performance.All localities are meeting target with the exception of North Yorkshire and York and Selby. York and Selby report the poorest position at 32.35%. The high level of bed occupancy in North Yorkshire will be impacting on this position, of which delayed transfers of care are a contributing factor.Of the 70 patients (AMH 52, MHSOP 18) 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)

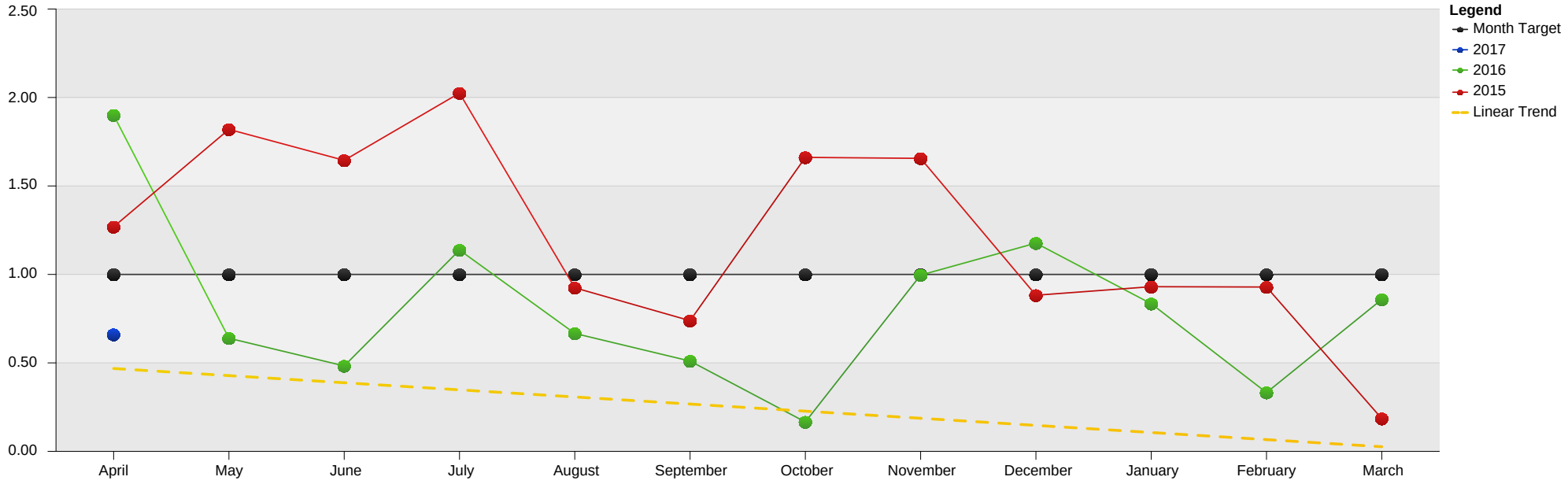


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.73%	92.73%	93.71%	93.71%	94.49%	94.49%	91.18%	91.18%	82.00%	82.00%	94.44%	94.44%		

Narrative
The Trust position reported in April relates to March performance. The Trust position for March 2017 is 92.73% which is meeting the target of 92.45% and an improvement on the position in March 17Only North Yorkshire and Forensic are not meeting target and Forensic services continue to report the poorest performance. 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

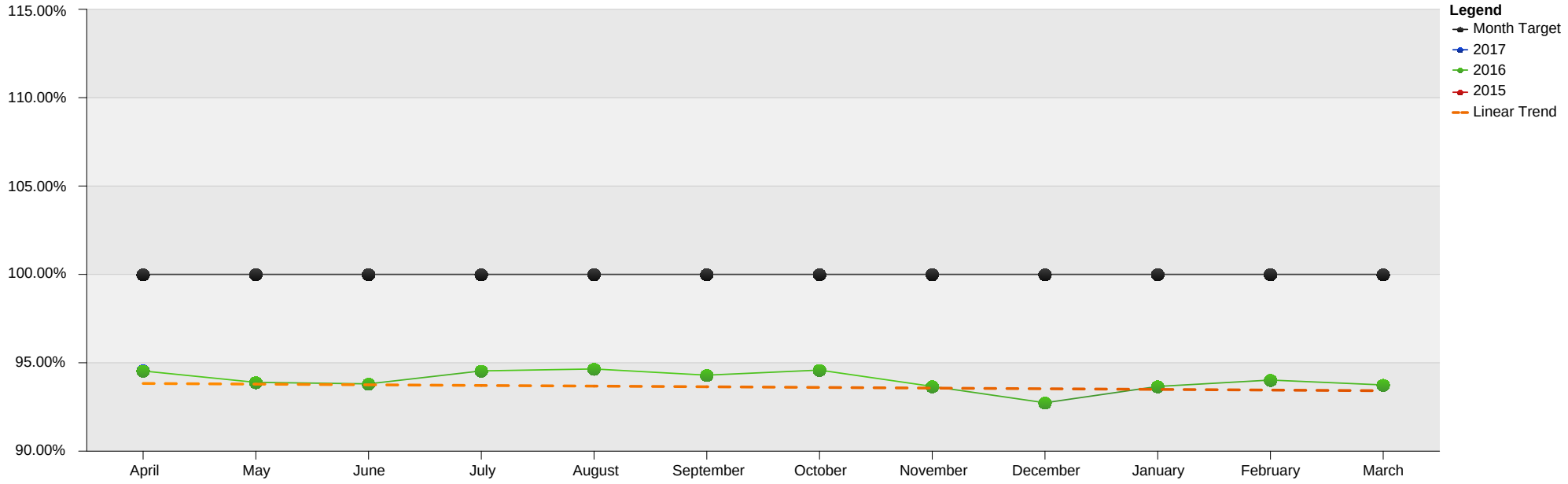


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.66	0.66	0.00	0.00	0.61	0.61	1.78	1.78	0.00	0.00	1.06	1.06		

Narrative
The Trust position for April 2017 is 0.66, which is meeting the target of 1.00. This rate relates to 4 unexpected deaths which occurred in April 17 and this is a reduction on the 5 reported in March 17 and an improvement on the position reported in April 2015 and 2016.The 4 unexpected deaths occurred in the following localities:• 2 were within North Yorkshire, 2 AMH• 1 was within Teesside AMH• 1 was within York and Selby, MHSOP

Trust Dashboard Graphs for TRUST

14) Actual number of workforce in month (Establishment 95%-100%)

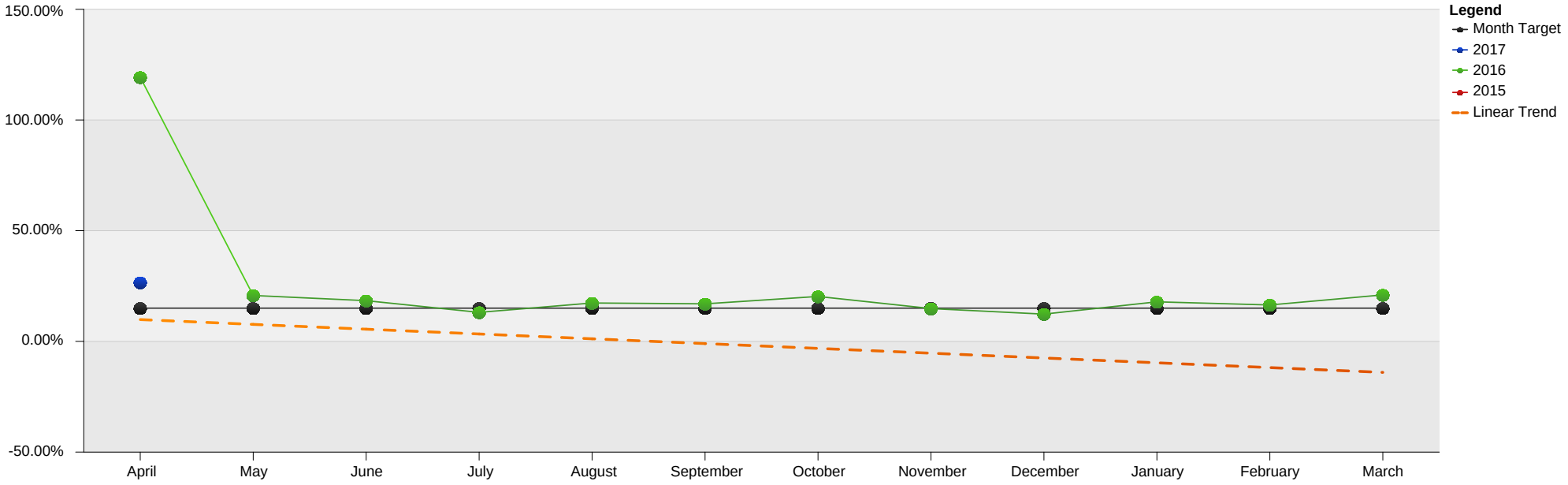


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	94.56%	94.56%	95.66%	95.66%	97.18%	97.18%	94.47%	94.47%	95.88%	95.88%	89.20%	89.20%		

Narrative
The Trust position for 30 April 2017 is 94.56% which is marginally 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



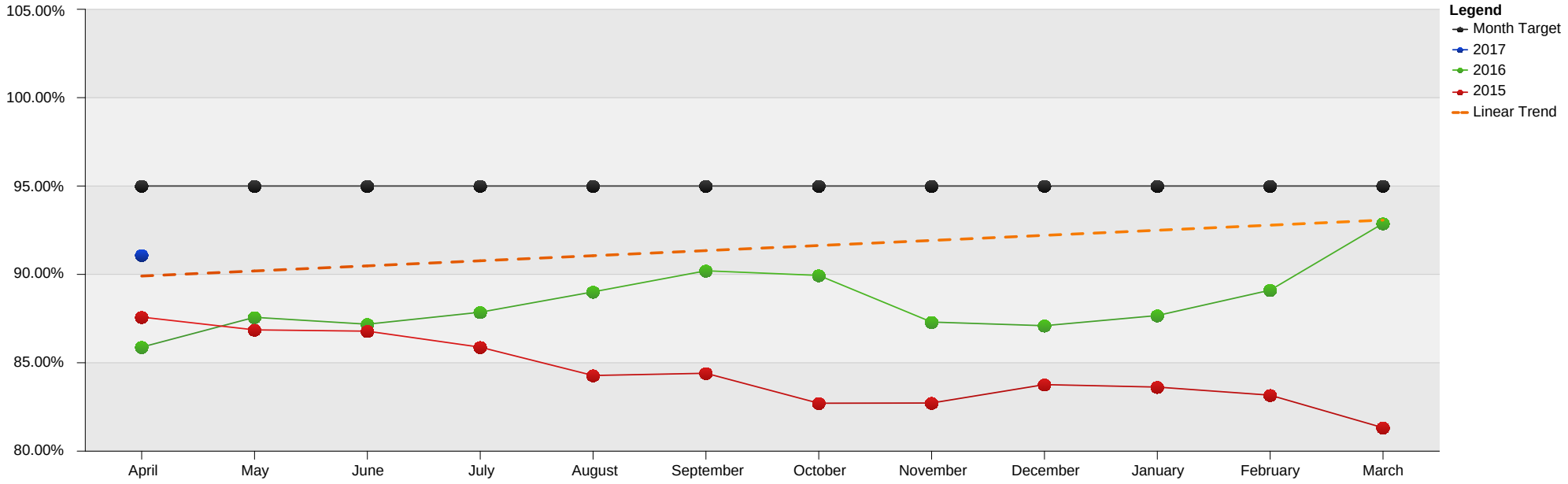
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	26.56%	26.56%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative

The Trust position for April 2017 is 26.56% which is 11.56% over target. This is a deterioration on that reported in March 17 and is the worst position reported from April 2016 to date. There were 17 jobs re-advertised in April out of a total of 63 posts advertised for registered healthcare professional jobs. The majority of the posts were nursing opportunities ranging in band from 5 – 7. The Trust has invested in holding recruitment fayres which have been successful in attracting student nurses from universities. There are in excess of 100 student nurses waiting to commence employment when they qualify in September 2017 and January 2018.Further analysis is required to understand what specific issues are causing this performance position is required; however this work is yet to be allocated due to a lack of current capacity in the HR departmentData 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)

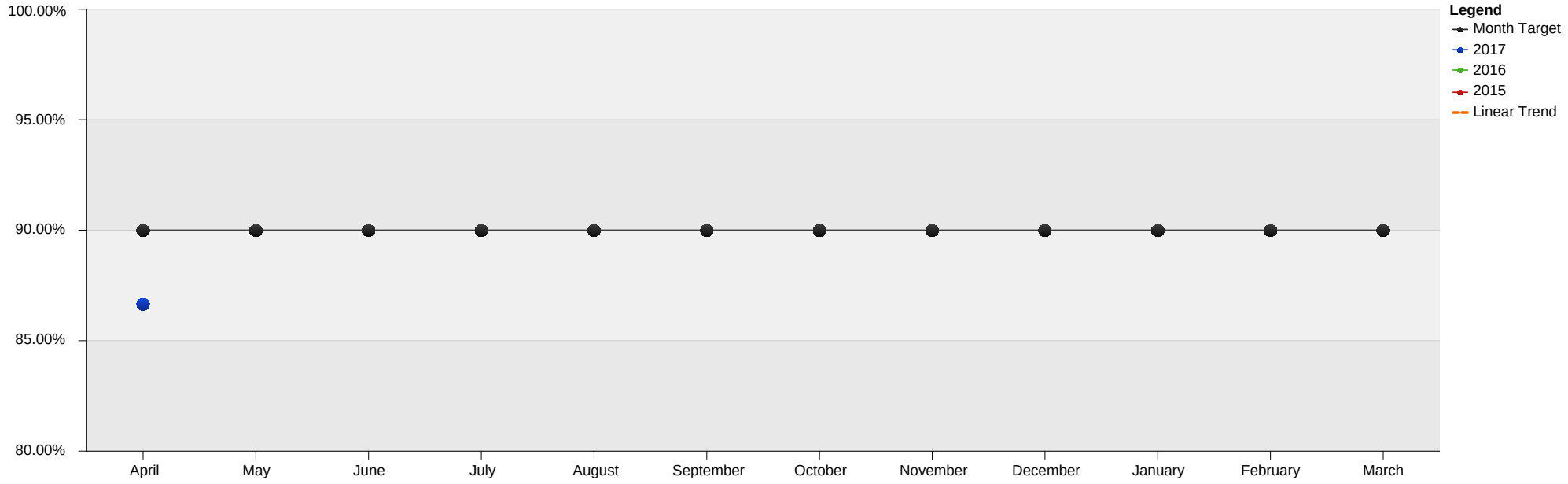


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	91.08%	91.08%	91.02%	91.02%	95.28%	95.28%	88.24%	88.24%	91.08%	91.08%	87.03%	87.03%		

Narrative
The Trust position for April 2017 is 91.08% which relates to 503 members of staff out of 5641 that do not have a current appraisal although this is sis not meeting the target of 95% and is also a slight reduction on the previous month it is still the second best position since 2015/16 to date.Teesside are the only locality that is still meeting target and York and Selby report the poorest performance, however this is a continued improvement when compared to March 17.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

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

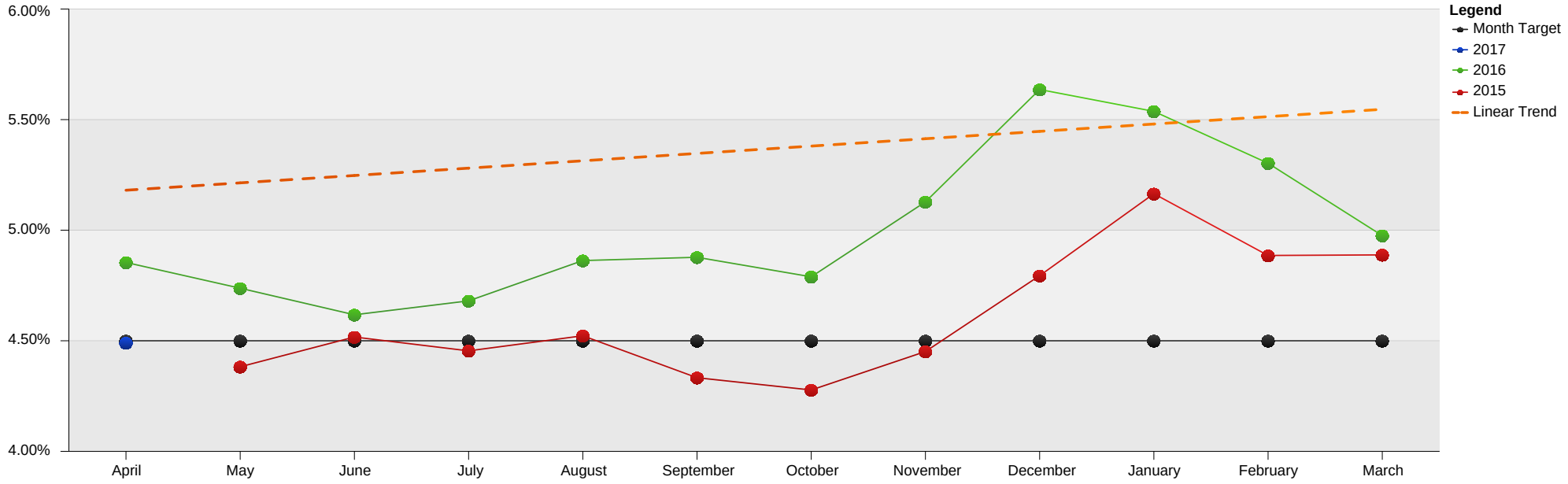


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	86.66%	86.66%	84.27%	84.27%	89.76%	89.76%	85.15%	85.15%	86.16%	86.16%	83.09%	83.09%		

Narrative
The position for April 2017 is 86.66%. This is 3.34% lower than the new target of 90%.All localities are performing below 90%, York and Selby are achieving the lowest level at 83.09%. This indicator now includes all mandatory training and not only the core 7 requirements. Due to this change in the data construction there is no historic data available to compare previous performance. The operational management huddles will re inforce the change to this KPI and drive improvements in performance.

Trust Dashboard Graphs for TRUST

18) Percentage Sickness Absence Rate (month behind)

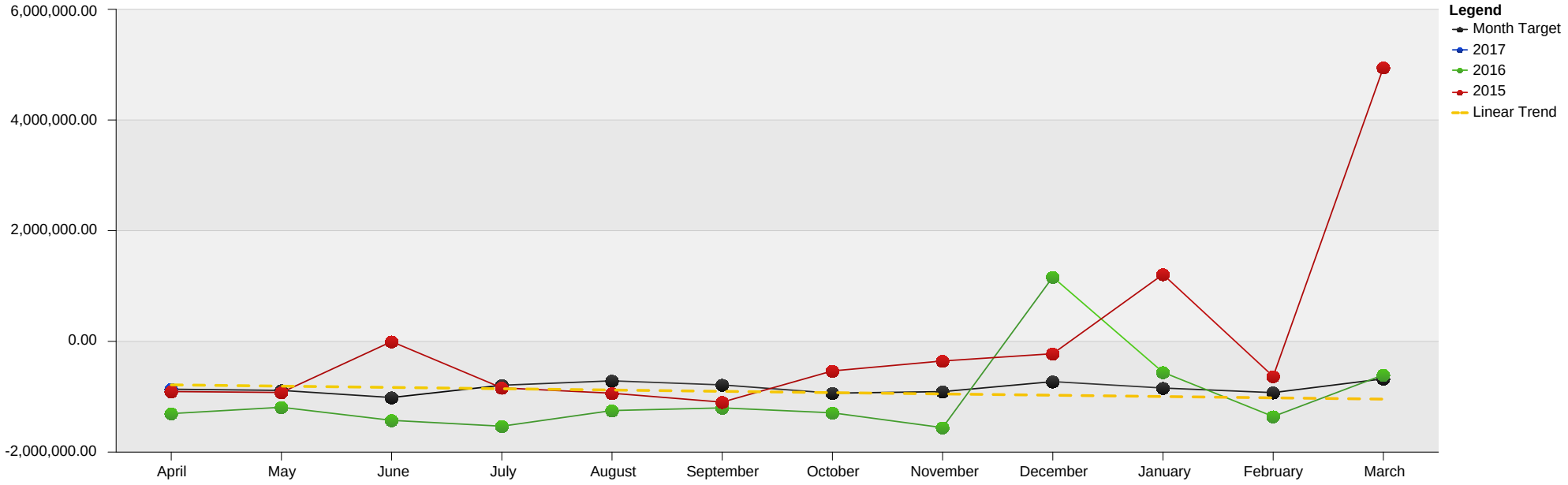


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	4.49%	4.49%	4.37%	4.37%	5.07%	5.07%	3.70%	3.70%	5.36%	5.36%	5.48%	5.48%		

Narrative
The Trust position reported in April relates to the March sickness level. The Trust position reported in April 2017 is 4.49%, which is meeting the target of 4.50% and an improvement on the previous month and is the best performance since November 2015. All localities are meeting target with the exception of Forensics and Teesside. Forensics have poorest performance at 5.36%.The analysis to improve understanding of the noted increase in the number of short term episodes of absence and the decrease in the percentage of staff experiencing no absences is ongoing. A report is due to be presented to the Operational Management Team in May 2017. 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

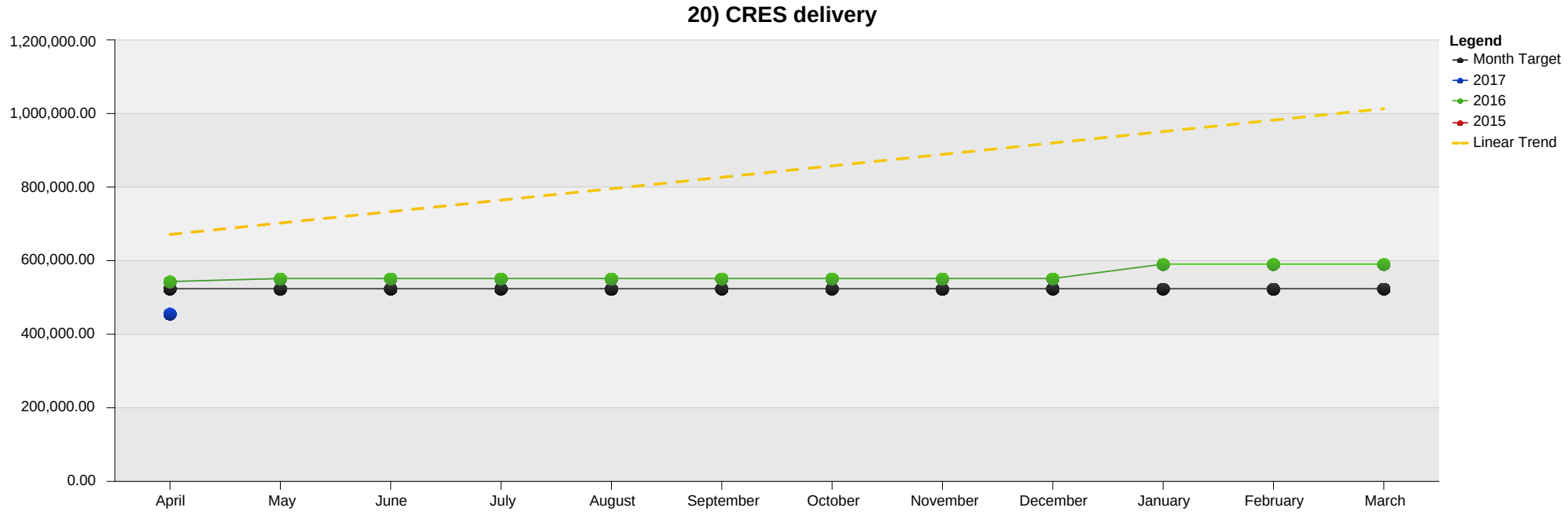
19) Delivery of our financial plan (I and E)



	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
19) Delivery of our financial plan (I and E)	-864,000.00	-864,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The comprehensive income outturn for the period ending 30 April 2017 is a surplus of £864k, representing 3.1% of the Trust's turnover and is in line with plan.

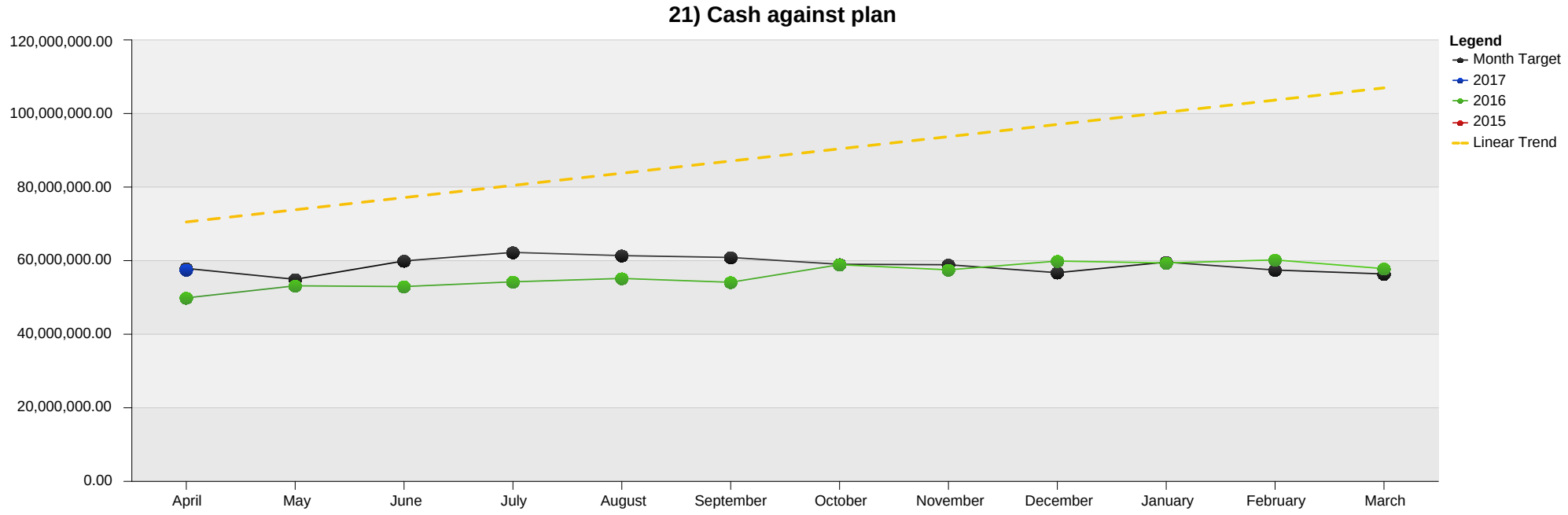
Trust Dashboard Graphs for TRUST



	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	455,573.00	455,573.00	83,500.00	83,500.00	120,500.00	120,500.00	28,500.00	28,500.00	22,083.00	22,083.00				

Narrative
Total CRES delivery by the Trust for 30 April 2017 is £455,573 and is behind plan. The Trust continues to progress schemes to deliver CRES for current and future 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
21) Cash against plan	57,482,000.00	57,482,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 30 April 2017 is £57,482k and is in line with plan.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	April 2017														April 2017 To April 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	7,542.00	7,509.00	1,824.00	1,573.00	1,854.00	2,077.00	1,789.00	1,812.00	567.00	625.00	1,508.00	1,375.00			7,542.00	7,509.00	1,824.00	1,573.00	1,854.00	2,077.00	1,789.00	1,812.00	567.00	625.00	1,508.00	1,375.00		
2) Caseload Turnover	1.99%	0.91%	1.99%	-1.09%	1.99%	2.09%	1.99%	-1.06%	NA	NA	1.99%	5.89%			1.99%	0.91%	1.99%	-1.09%	1.99%	2.09%	1.99%	-1.06%	NA	NA	1.99%	5.89%		
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	87.72%	85.00%	89.80%	85.00%	86.88%	85.00%	91.64%	85.00%	NA	85.00%	79.24%			85.00%	87.72%	85.00%	89.80%	85.00%	86.88%	85.00%	91.64%	85.00%	NA	85.00%	79.24%		
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	77.00	16.00	25.00	11.00	6.00	88.00	96.00			24.00	20.00			75.00	77.00	16.00	25.00	11.00	6.00	88.00	96.00			24.00	20.00		
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	9.18%	10.00%	7.46%	10.00%	10.73%	10.00%	4.67%			10.00%	14.18%	10.00%		10.00%	9.18%	10.00%	7.46%	10.00%	10.73%	10.00%	4.67%			10.00%	14.18%	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	19.00	21.33	5.00	5.00	5.00	4.00	6.00	5.67			2.00	6.00			19.00	21.33	5.00	5.00	5.00	4.00	6.00	5.67			2.00	6.00		

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	April 2017														April 2017 To April 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%	89.23%	90.00%	86.44%	90.00%	98.37%	90.00%	80.24%	90.00%	99.14%	90.00%	74.07%			90.00%	89.23%	90.00%	86.44%	90.00%	98.37%	90.00%	80.24%	90.00%	99.14%	90.00%	74.07%		
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	10.34%	10.00%	10.94%	10.00%	9.49%	10.00%	12.44%	10.00%		10.00%	4.78%			10.00%	10.34%	10.00%	10.94%	10.00%	9.49%	10.00%	12.44%	10.00%		10.00%	4.78%		
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	13.21%	20.00%	10.42%	20.00%	2.25%	20.00%	26.09%			20.00%	32.35%			20.00%	13.21%	20.00%	10.42%	20.00%	2.25%	20.00%	26.09%			20.00%	32.35%		
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	92.73%	92.45%	93.71%	92.45%	94.49%	92.45%	91.18%	92.45%	82.00%	92.45%	94.44%			92.45%	92.73%	92.45%	93.71%	92.45%	94.49%	92.45%	91.18%	92.45%	82.00%	92.45%	94.44%		
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.66	1.00	0.00	1.00	0.61	1.00	1.78	1.00	0.00	1.00	1.06			1.00	0.66	1.00	0.00	1.00	0.61	1.00	1.78	1.00	0.00	1.00	1.06		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	April 2017														April 2017 To April 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%	94.56%	100.00%	95.66%	100.00%	97.18%	100.00%	94.47%	100.00%	95.88%	100.00%	89.20%			100.00%	94.56%	100.00%	95.66%	100.00%	97.18%	100.00%	94.47%	100.00%	95.88%	100.00%	89.20%		
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	26.56%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA			15.00%	26.56%	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%	91.08%	95.00%	91.02%	95.00%	95.28%	95.00%	88.24%	95.00%	91.08%	95.00%	87.03%			95.00%	91.08%	95.00%	91.02%	95.00%	95.28%	95.00%	88.24%	95.00%	91.08%	95.00%	87.03%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	86.66%	90.00%	84.27%	90.00%	89.76%	90.00%	85.15%	90.00%	86.16%	90.00%	83.09%			90.00%	86.66%	90.00%	84.27%	90.00%	89.76%	90.00%	85.15%	90.00%	86.16%	90.00%	83.09%		
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.49%	4.50%	4.37%	4.50%	5.07%	4.50%	3.70%	4.50%	5.36%	4.50%	5.48%			4.50%	4.49%	4.50%	4.37%	4.50%	5.07%	4.50%	3.70%	4.50%	5.36%	4.50%	5.48%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	April 2017														April 2017 To April 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)	-865,000.00	-864,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			-865,000.00	-864,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
20) CRES delivery	523,680.00	455,573.00	111,822.00	83,500.00	114,703.00	120,500.00	66,882.00	28,500.00	61,045.00	22,083.00	59,416.00				523,680.00	455,573.00	111,822.00	83,500.00	114,703.00	120,500.00	66,882.00	28,500.00	61,045.00	22,083.00	59,416.00			
21) Cash against plan	57,887,000.00	57,482,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			59,316,000.00	57,482,000.00	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		1	2		1																**4**
Total	**0**	**1**	**2**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**

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

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

Data Quality Scorecarrd 2016/17 (Reviewed October 2016)

Appendix C

		Data Source					Data Reliability					KPI Construct/Definition									
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Total Score	**Percentage as at April 2016**	**Percentage**	Notes	**Notes**
1	Total number of external referrals into trust services	5					5					5					15	**100%**	**100%**		
2	Caseload Turnover	5					5					5					15		**100%**		
3	Number of patients with a length of stay over 90 days (AMH & MHSOP A&T wards)	5					5					5					15		**100%**		
4	Bed occupancy (AMH & MHSOP A&T wards)	5					5					5					15		**100%**		
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						4				5					14	**93%**	**93%**		York and Selby historic data is not in the system so any admissions prior to 1st April may not be on the system. As a result it may appear that Y&S locality position deteriorates as the year progresses.
6	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	5						4				5					14	**100%**	**93%**		York and Selby historic data is not in the system so any admissions prior to 1st April may not be on the system.
7	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					14	**67%**	**93%**		Data will be directly extracted from Datix into the IIC; however, this process is not fully embedded. IAPT caseload is currently a manual upload. Data reliability has improved following the introduction of the central approval team
8	Percentage of patients who have not waited longer than 4 weeks following an external referral	5						4				5					14	**93%**	**93%**		Data reliability is 4 due to issues over recording of Did not attends which would stop the clock. Although this is improving, York and Selby locality still have data quality issues to amend following transfer onto PARIS.
9	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated		4					4				5					13	**87%**	**87%**		Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches. In addition there is an issue with staff updating a patient's GP but overwriting historical data - work is underway with Civica in order to amend PARIS to prevent this.
10	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					12		**80%**		All questionnaires are paper-based, except for some CAMHS units, where patients use a touch screen facility to record their comments. The manual questionnaires from Trust are sent to CRT and scanned into their system. Raw data files are received from CRT, which are accessed by IPT and uploaded into the IIC. TEWV are changing provider during the year. Procurement is currently underway. Transition from CRT to new system will be planned and closely monitored.
11	Percentage of appointments cancelled by the Trust	5									1				2		8	**87%**	**53%**		Codes have been changes and KPIs updated however this is only for outpatient appointments. Community contacts have not been updated and there is an issue because you cannot future date appointments. The release of staff diary on PARIS should resolve this however this will not be until next financial year.

Data Quality Scorecarrd 2016/17 (Reviewed October 2016)

Appendix B

		Data Source					Data Reliability					KPI Construct/Definition									
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1	Total Score	**Percentage as at April 2016**	**Percentage**	Notes	**Notes**
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined					
14	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	**93%**	**93%**		Issues with appraisal dates being entered to ESR have lessened - there appears to be greater confidence in the data being reported. York and Selby staff were transferred on 1st October and will begin to be reported in November through the IIC. Robust process recently implemented within York and Selby to regularly review appraisal compliance information as part of regular management meeting. Fortnightly reports being produced by Workforce Information team to support monitoring.
15	Percentage compliance with mandatory and statutory training – snapshot	5						4				5					14	**93%**	**93%**		Issues with training dates being entered to ESR have lessened - there appears to be greater confidence in the data being reported. York and Selby staff were transferred on 1st October, training information input ESR. There is an ongoing issue associated with idenitification of training requirements linked to training matrix. There is a piece of work being undertaken associated with this which may provide a resolution.
16	Percentage Sickness Absence Rate (month behind)	5						4				5					14	**87%**	**93%**		Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR and there are examples whereby managers are failing to end sickness in a timely manner or inaccurately recording information onto the system – this is picked up and monitored through sickness absence audits that the Operational HR team undertake. York and Selby services are now in line with the remainder of the Trust using MSS or the rostering system - so actions highlighted above will be replicated.
17	Actual number of workforce in month		4				5					5					14		**93%**		Data extracted elecronically but processed manually
18	Percentage of registered health care professional jobs that are advertised two or more times				2			4				5					11		**73%**		Mostly reliable - the form to capture this information has been amended but is still reliant on recruiting managers completing the section of the form. The recruitment team are more proactive in recording on the tracking spreadsheet where they are aware it is a readvertisement because they know this is being reported through a KPI. The recording of the information is a manual input into a spreadsheet which has the potential for human error.

Data Quality Scorecarrd 2016/17 (Reviewed October 2016)

Appendix B

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at April 2016	Percentage	Notes	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined					
19	Are we delivering our financial plan (I and E)		4				5					5					14	**93%**	**93%**		Mostly reliable - the form to capture this information has been amended but is still reliant on recruiting managers completing the section of the form. The recruitment team are more proactive in recording on the tracking spreadsheet where they are aware it is a readvertisement because they know this is being reported through a KPI. The recording of the information is a manual input into a spreadsheet which has the potential for human error.
20	Delivery of CRES against plan				2		5					5					12		**80%**		Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4				5					5					14		**93%**		An extract is taken from the system then processed manually to obtain actual performance.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd May 2017**
TITLE:	**Strategic Direction Performance Report – Quarter 4 2016-17**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 4 (31st March 2017).

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

This report reflects that three of the Trusts five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. There has been a deterioration in the KPIs relevant to Goal 2; however it is noted that there is an improved position on Business Plan progress and significant positive qualitative intelligence reported. The KPIs relevant to Goal 3 have reported a worse position than in the previous two financial years; however it is noted that all business plan actions have been completed and significant positive qualitative intelligence reported.

Recommendations:

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

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**23rd May 2017**
TITLE:	**Strategic Direction Performance Report – Quarter 4 2016-17**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 4 (31st March 2017).

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The 5 year targets for the Trust Strategic Direction Scorecard were agreed by the Board on the 18th August 2015, with any amendments being approved in subsequent relevant quarterly reports.

3. KEY ISSUES:

3.1 Trust Strategic Direction Scorecard

The Strategic Direction Scorecard is shown under each strategic goal.

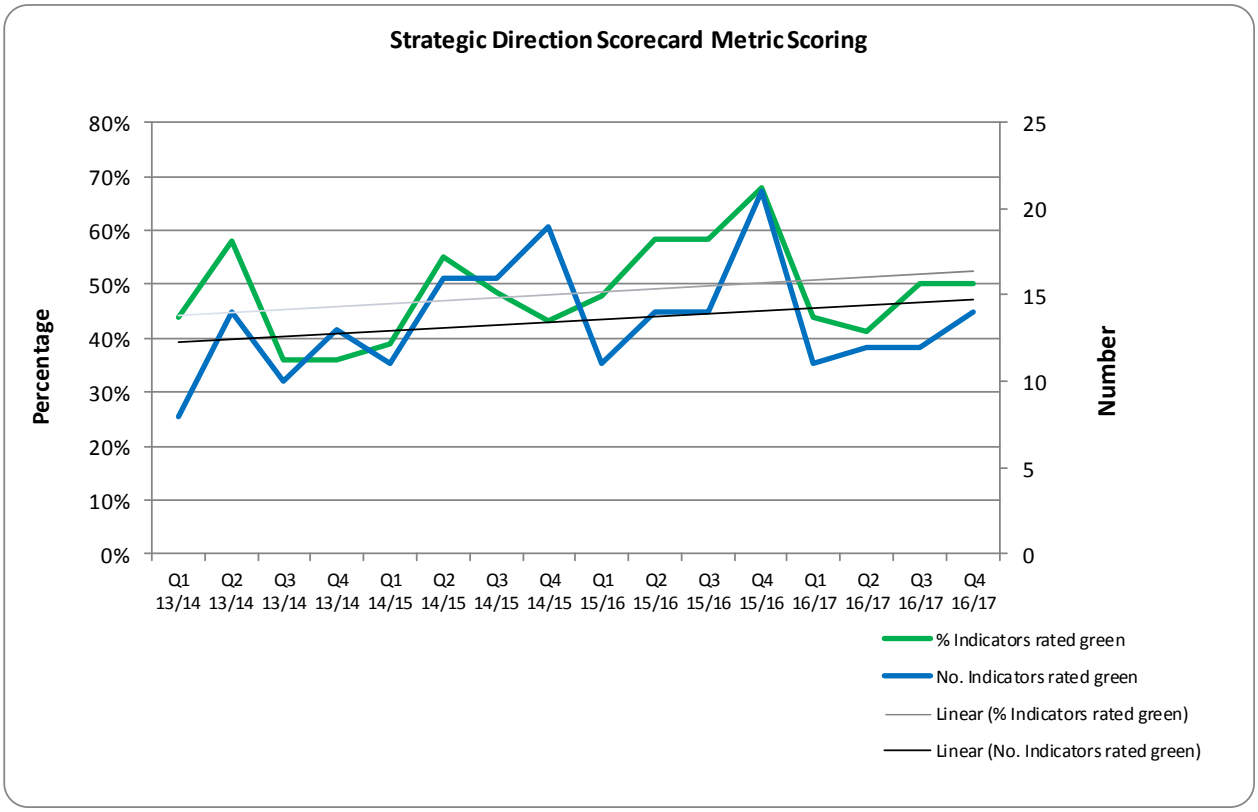
The following table and graph provide a summary of the RAG ratings at quarter 4 compared to the position in the previous quarter and the previous financial years 2014/15 and 2015/16. The number of indicators monitored has reduced compared to the previous two years, as indicators have changed or are no longer appropriate. The Trust has performed worse this year than in 2015/16 with 55% (16) indicators reported green in 2016/17 compared to 68% (21). However, performance has remained positive compared to 2014/15 when 42% (18) reported green.

The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics. The actual number of those rated green has increased since last quarter; however those rated red have also increased, maintaining a 50% balance between those achieving target and those not. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

	FYTD 2014/15		FYTD 2015/16		Q1 2016/17		Q2 2016/17		Q3 2016/17		Q4 2016/17		FYTD 2016/17	
	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	18	42%	21	66%	11	44%	12	41%	12	50%	14	50%	16	55%
Indicators rated red	25	58%	11	34%	14	56%	17	59%	12	50%	14	50%	17	59%
Indicators with no target	2		3		2		2		3		3		2	
Indicators currently under development/being finalised	1		1		0		0		0		0		0	
Indicators where data is not yet available/not applicable in qtr	0		4		12		8		12		6		2	
total indicators on scorecard at reporting period	46		40		39		39		39		37		37	

The percentage is based on the number of indicators that can be RAG rated (28 for quarter 4).

The graph below shows that whilst the percentage of greens is, in general, increasing, there has been a significant downward trend during 2016/17, with quarter 2 reporting the lowest percentage of green indicators since quarter 1 2014/15.



3.2 **Strategic Goal *1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)***

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of 6 as at quarter 4; all are reporting a deterioration on the quarter 3 position.

The end of year position also reports 3 indicators rated red, which is consistent with the previous two years; during 2015/16 the same 3 indicators rated red but 2 out of 3 have improved in 2016/17 compared to 2015/16.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17											
	Indicator	Q4 Target 2016/17	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	2015/16 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)											
1	Percentage of patients surveyed reporting their overall experience as excellent or good	>91.44%	92.59%	92.17%	92.26%	92.86%	⇧	>91.44%	92.48%	91.37%	>18/19 out-turn
2	Percentage of patients who have not waited longer than 4 weeks from "referral " to "assessment" for external and internal referrals	90.00%	81.77%	85.09%	87.12%	85.17%	⇩	90.00%	84.76%	83.17%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	80.00%	84.39%	82.65%	82.22%	⇩	85.00%	82.29%	79.96%	85.00%
4	The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)	Surveys: Top 20% of MH Trusts	Results due in Q2	Results delayed - now due in Q3	Better or About the Same as other Trusts	Assessment completed in Q3	n/a	Surveys: Top 20% of MH Trusts	Better or About the Same as other Trusts	Yes	Surveys: Top 20% of MH Trusts
5	The Trust ranks in the top 10th percentile of all mental health Trusts for the NHS Staff Survey (annual)	Surveys: Top 10% of MH Trusts	Results due in Q4	Results due in Q4	Results due in Q4	Ranked 4th	⇩	Surveys: Top 10% of MH Trusts	Ranked 4th	Yes - top MH//LD trust	Surveys: Top 10% of MH Trusts
6	Percentage of service users with a recovery focussed action plan (Adult Mental Health)	95.00%	93.22%	91.47%	90.88%	89.73%	⇩	95.00%	89.73%	93.00%	95.00%

Indicators of concern are:

- **KPI 2 - Percentage of patients who have not waited longer than 4 weeks from "referral" to "assessment" for external and internal referrals** – The Trust position for quarter 4 is 85.17%, which relates to 3213 patients out of 21660 who had waited longer than 4 weeks for a first appointment. This is 4.83% below the target of 90% and deterioration on the quarter 3 position.

  Only Forensic Services (98.37%) and Teesside (96.42%) are reporting above target for quarter 4, with York & Selby reporting the lowest performance at 69.86%.

  Within North Yorkshire CYP an action plan is in place and work on capacity and demand analysis is taking place with actions to address staff vacancies and sickness. The trajectory for recovery is June 2017.

  The York & Selby action plan continues to be implemented with data quality actions being addressed, analysis of current waiting lists carried out, utilisation of partnership working and a single point of access established.

  These issues are all now monitored via the weekly report out process.

  The Trust position for 2016/17 is 84.76% which is better than the 2015/16 position of 83.17%.

- **KPI 3 – Percentage of patients reporting 'yes always' to the question 'did you feel safe on the ward?'** – The Trust position for quarter 4 is 82.22% which relates to 675 patients out of 821 patient survey responses who confirmed they felt safe on our wards. This is 2.78% below the target of 85% and a slightly worse position than quarter 3 (82.65%). Only Tees are achieving target whilst Durham and Darlington (83.81%), North Yorkshire (84.04%), Forensic Services (66.35%) and York and Selby (78.43%) are

reporting below performance.

The Trust position for 2016/17 is 82.29% which is better than the 2015/16 position of 79.96%.

- **KPI 6 - Percentage of service users with a recovery focused action plan (Adult Mental Health)** – The Trust position for quarter 4 is 89.73% which is 5.27% below the target of 95% and slightly worse than the quarter 3 position.

  All localities are under performing, with Teesside and North Yorkshire slightly below target at 93.62% and 92.07%, respectively. Durham and Darlington are reporting at 87.20%. The following should be noted:

  - There continues to be some staffing issues experienced in some teams within Durham and Darlington locality which has impacted on performance into quarter 4, although staffing levels are improving.

  - Generally, there is an issue which has affected all localities in their Psychosis teams. In the model lines process recovery stars are to be completed within 12 weeks of first appointment, this can result in patients being seen as 'breaches' for some time, if they have been in service for less than this period of time. Board has approved a proposal for Psychosis teams, that the construction of the KPI be changed to include 'Number of service users open to psychosis teams at quarter end, who have been in service for 12 weeks or more' The Assertive Outreach element of the indicator would remain unchanged. This will be actioned for 2017/18.

  The Trust position for 2016/17 is 89.73% which is worse than the 2015/16 position of 93.00%.

Other Points to note:

- **KPI 4 – The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)** - The Community Mental Health Survey 2016 is not directly comparable to previous Community Surveys. The scoring has changed and is now based on each question being 'Better', 'About the Same' or 'Worse' than other Trusts. There is no overall rating given. The Trust is performing 'Better' in 4 questions and 'About the Same' in all others (28). Therefore the scorecard is marked 'Better or About the same as other Trusts'.

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 4 were rated green (89%) but is a reduction on the quarter 3 (91%) position.

There are 14% of the priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

The 14% represents 13 priorities / service developments. Of these:

- 8 require additional time going beyond the current year (to be agreed by Board);
- 2 require further work to be completed early in the next financial year;
- 1 priority / service development requires approval to be excluded from the 2017/18 - 2019/20 business plan (to be agreed by Board);
- 1 priority / service development requires approval for the actions to be replaced by those with the 2017/18 - 2019/20 business plan (to be agreed by Board);
- 1 priority / service development continues to highlight the risks associated with the Paris Programme.

There is 1 priority / service development reporting an overall status of green but requires additional time going beyond the current year to complete an actions (to be agreed by Board).

Where a Board decision is required to change or remove an action, this is contained in Appendix 2 for approval.

3.2.3 Other Qualitative Intelligence

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

- **Northdale Centre**, Ridgeway, Roseberry Park, Middlesbrough, were finalists in the outstanding health services category of The National Autistic Society – Autism Professional Awards 2017.

- **The integrated mental health team and colleagues, HMP Low Newton, Durham** have had their perinatal mental health pathway for female offenders accepted for inclusion in the Positive Practice in Mental Health Collaboration's national online directory of positive practice.

- The final business case for the **Tier 4 New care Models** was agreed by the Board and NHSE in March 2017 to go live on 1 April 2017.

3.2.4 In conclusion it can be seen for this strategic goal that whilst the number of red KPIs on the scorecard remains unchanged, there has been a deterioration in 4 of the 6 KPIs; however 2 of the 3 reds have improved during 2016/17. Despite significant qualitative intelligence in terms of how services are improving, the deterioration in performance and the Business Plan indicates further work is needed to ensure progress against the strategic goal is delivered. This will be supported by further work around waiting times, patient experience and recovery focussed outcome plans.

3.3 Strategic Goal 2 - *To continuously improve the quality and value of what we do*

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing 5 indicators rated red out of 8 as at quarter 4, with one indicator reporting an improvement.

The end of year position reports 7 indicators rated red, which is worse than with the previous two years; 2015/16 reported 2 indicators rated red and 2014/15 reported 4.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17											
	Indicator	Q4 Target 2016/17	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	2015/16 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 2 (To continuously improve the quality and value of what we do)											
7	Number of outstanding action points for **more than 31 days** for Level 5 SIs and action points for safeguarding serious case reviews and domestic homicide reviews	0	17	19	23	23	⇔	0	23	0	0
8	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	11	15	19	24	⇩	0	24	13	0
9	Friends & Family Test - **Patient** Survey Question: "How likely are you to recommend our ward/services to friends and family if they needed similar care or treatment?"	>86.01%	85.96%	86.14%	86.81%	87.40%	⇧	>86.01%	86.56%	86.01%	> previous year out-turn
10	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	37.50%	20.00%	0.00%	20.00%	⇧	50.00%	17.14%	53.57%	>=75%
11	Percentage of staff reporting that they can 'contribute towards improvements at work'*	>2015/16 (79%) and in top 20%ile of MH/LD trusts	Results due in Q4	Results due in Q4	Results due in Q4	76.00%	n/a	>2015/16 (79%) and in top 20%ile of MH/LD trusts	76.00%	79% and in top 20%	> 2018/19 and in top 20%ile for MH/LD Trusts
12	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"	>82.58%	81.04%	80.37%	No Staff FFT in Q3	82.02%	n/a	>82.58%	81.22%	82.58%	> previous year out-turn
13	For Trust hospital sites with over 10 beds, the trust score for each category (Cleanliness, Food, Privacy & Dignity, Condition, Appearance & Maintenance, Dementia Friendly, Learning Disability) > national average PLACE (new PEAT) assessments.	80%	Assessment due in Q2	50.00%	Assessment completed in Q2	Assessment completed in Q2	n/a	80%	50.00%	80.00%	80%
14	Hospitality Assured Accreditation score*	n/a	Assessment due in Q2	81.10%	Assessment completed in Q2	Assessment completed in Q2	n/a	82.00%	81.10%	Assessment now due Q1 16/17 & results in Q2	86.00%

Indicators of concern are:

- **KPI 7 - Number of outstanding action points on action plans for more than 31 days for Level 5 SI's and action points for safeguarding serious case reviews and domestic homicide reviews**– The Trust position for quarter 4 is 23 against a target of zero, which equates to the quarter 3 position. All relate to Level 5 SIs.

  The majority of actions are from old SI reports in which the original action plan/action owner has now moved from the relevant area or retired and therefore the original evidence has not been readily available. Meetings have been held with a number of representatives from the services and work is ongoing to sign all actions off by the end of May 2017.

The Trust position for 2016/17 is 23 which is significantly worse than the 2015/16 position of 0.

- **KPI 8 - Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days** – The Trust position for quarter 4 is 24 against a target of zero, which is a deterioration on the quarter 3 position.

  2 relate to Complaints. For one element, the Head of Service has arranged some urgent work to clarify the item and ensure the action was fully addressed; it was subsequently closed in the same week but this was after the end of March. The Complaints Team have now standardised the action plan tracker in line with Audit recommendations and from 1st April 2017 will follow a more formal process of "chasing" overdue actions and escalation of those.

  22 relate to Clinical Audit and arise from 2 IPC audits, only 1 of which remains outstanding to date. Each specialty has a clinical audit sub group which meets monthly, reviews outstanding actions and provides support to facilitate completion and sign off of the action point. Outstanding actions are monitored each month by the Clinical Effectiveness Group and discussed with the Service Development Managers to facilitate completion. Where appropriate any actions exceeding 90 days are escalated to the Quality Assurance Committee.

  The Trust position for 2016/17 is 24 which is significantly worse than the 2015/16 position of 13.

- **KPI 10 - Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication** – The Trust position for quarter 4 is 20.00% against a target of 50%, which is better than the quarter 3 position.

  There were 5 baseline assessment tools signed off by the Clinical Effectiveness Group (CEG); however only one was within 6 months of publication.

  For many of the NICE guidance, assessment of current levels of implementation can be complex. This is due to the fact that many of the guidance cross multiple specialties and all Localities. It is important to gain a Locality perspective as commissioning arrangements frequently differ and action plans therefore need to reflect all relevant areas of improvement to be targeted. The Clinical Effectiveness Group monitors this KPI. Facilitating sign off of baseline assessments and action plans via Service Development Groups prior to presentation to the Clinical Effectiveness Group can incur delays to the process. Outstanding and overdue BATs are reviewed to identify any further support that can be assigned to assist delivery.

  The Trust position for 2016/17 is 17.14% which is worse than the 2015/16 position of 33.33%.

- **KPI 11 - Percentage of staff reporting that they can 'contribute towards improvements at work'** – The Trust position for quarter 4 is 76.00% against a target of 79%. However, the Trust remains in the top 20th percentile of Mental Health/Learning Disability Trusts; ranking 4th for 2016/17.

  A Trust composite action plan will be produced to respond to the key findings in the staff survey and agreed by Board, which will focus on a number of areas that have reduced in the survey. A similar question is also asked in the Friends & Family Test and this will be addressed with individual teams should they report low figures.

  The Trust position for 2016/17 is 76.00% and ranked 4th, which is worse than the 2015/16 position of 79.00% and rank of 1st.

3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 4 were rated green (97%) which is an improvement on the position as reported in quarter 3 (95%). However, these actions are not expected to impact on the delivery of the overall priority / service development.

3.3.3 Other Qualitative Intelligence

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

- **Memory clinic staff in Hartlepool** were shortlisted to the final three of the Dementia Quality Improvement Awards 2017.

- **Teesside proactive intensive community liaison team**, mental health services for older people (MHSOP), Teesside, won a quality improvement (QI) award at the Northern Lights Dementia Awards. This QI project initiative to raise delirium awareness among care homes in Teesside was completed in collaboration with Tees Dementia Collaborative. The **#icanpreventdelirium** project, which was also initiated by Teesside MHSOP, in partnership with Health Education England North East, was runner up in the same category.

- The CQC undertook a compliance visit to the Trust in November 2016 during which they visited all of the Adult Mental Health wards and psychiatric intensive care units and all of the inpatient wards for older people across the Trust. The outcome of the visit to AMH services was a rating of **good** overall which is the same rating that was given during the visit in January 2015. The outcome of the visit to MHSOP services was an overall rating of **requires improvement** compared to the rating in 2015 was **good**. An action plan has been developed to address all of the issues identified during the inspection and this is currently being progressed.

- The **mental health services for older people suicide prevention training team** have been shortlisted in the Patient Safety Awards in the mental health category.

3.3.4 In conclusion it can be seen for this strategic goal that the number of red KPIs has deteriorated in 2016/17 compared to 2015/16. However, achievement of the majority of Business Plan actions and qualitative intelligence provides an encouraging position that can be improved with further work around the number of outstanding action points for both level 5 SIs and Clinical Audits, and the percentage of NICE guidance baseline assessments signed off within 6 months. The new processes being implemented are expected to support this improvement.

3.4 Strategic Goal 3 - *To recruit, develop and retain a skilled, compassionate and motivated workforce*

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 5 indicators rated red out of 12 as at quarter 4; only one of these indicators is reporting an improvement. Two of those that are red are very close to target.

The end of year position reports 6 indicators rated red, which is worse than with the previous two years; 2015/16 reported 3 indicators rated red and 2014/15 reported 5.

Strategic Goal 3 (To recruit, develop and retain a skillled, compassionate and motivated workforce)													
15	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"	>70.95%	70.68%	68.15%	No Staff FFT in Q3	72.00%	n/a	>70.95%	70.45%	70.95%	n/a	n/a	> previous year out-turn
16	Percentage of medical students and junior doctors reporting satisfaction with their placement	88.00%	95.24%	88.89%	90.48%	87.69%	⇩	88.00%	89.97%	89.09%	87.25%	83.02%	90.00%
17	Percentage of positive nursing placement evaluations received	95.00%	95.59%	96.52%	96.10%	95.19%	⇩	95.00%	95.69%	95.17%	94.93%	95.13%	95.00%
18	Excess cost of employing medical agency versus substantive	£75,000	£228,963	£163,162	£130,794	£174,765	⇩	£150,000	£697,684	£1,150.1k	n/a	n/a	zero
19	NHS Employers Assessment of Wellbeing	100%	100.00%	100.00%	100.00%	100.00%	⇔	100%	100.00%	100.00%	100.00%	92.86%	100%
20	Percentage of Culture Metrics showing improvement at year end*	100%	due in Q2	66.67%	no longer reported	no longer reported	n/a	100%	no longer reported	To be reported at July 16 Trust Board	16.67%	66.67%	100%
21	Percentage of positive staff responses for training/development evaluations received (data is a month behind	75.00%	72.21%	74.47%	74.90%	74.25%	⇩	75.00%	74.18%	75.30%	deferred	Not available	TBC
22	Quality of Appraisals	>3.36	Results due in Q4	Results due in Q4	Results due in Q4	4.00	n/a	>3.36	4.00	3.36	49% but in top 20%	52% & in Top 20%	>= 2018/19 & in top 20%
23	Percentage of medical staff successfully revalidated	100%	100.00%	100.00%	75.00%	N/A	n/a	100%	90.00%	98.15%	100.00%	100%	100%
24	Percentage of indicators in the NHS Staff Survey for which there was no noticeable or sufficient different in responses of those who identified themselves as disabled, compared to those who did not identify themselves as disabled	tbc	Results due in Q4	Results due in Q4	Results due in Q4	93.75%	n/a	0.00%	93.75%	n/a			TBC
25	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	50%	8.70%	18.18%	3.57%	3.85%	⇧	50.00%	8.08%	32.00%	34.02%	Not available	80.00%
26	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	<2015/16 outturn (28%)	Results due in Q4	Results due in Q4	Results due in Q4	33.00%	n/a	<2015/16 outturn (28%)	33.00%	28% and top 20% (best for MH/LD Trusts)	38% but in top 20% (DEC 14)	38% & in Top 20% (DEC 13)	< previous year out-turn

Indicators of concern are:

- **KPI 18 - Excess cost of employing medical agency versus substantive** - the Trust position for quarter 4 is £174,765, which is £99,765 worse than the target of £75,000 and a deterioration on the quarter 3 position.

As at the end of quarter 4, 17 agency staff were required to support vacancies in Durham and Darlington (3 AMH and 1 MHSOP), Forensic (1 FMH), North Yorkshire (2 MHSOP and 2 CYPS), Teesside (3 AMH) and York and Selby (2 CYPS and 3 MHSOP).

A further 4 agency staff were used to cover sickness in Durham and Darlington (1 AMH), North Yorkshire (2 AMH) and York and Selby (1 CYPS).

The Trust position for 2016/17 is £697,684 which is significantly better than the 2015/16 position of £1,150.1k.

- **KPI 25 - Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above** – The Trust position for quarter 4 is 3.85%, which reflects 1 advertised post out of 26 that had at least 2 internal candidates above the line for Band 7 posts and above. This is 46.15% below the target of 50% but a very slight improvement on the quarter 3 position.

  Appointing managers are being contacted to discuss the lack of appointable candidates to Band 7 posts and above to establish why this is the case and what support can be offered to help attract candidates to these posts.

  A Kaizen event took place during March to review the process and function of the Talent Management Conversations. This is now to be embedded within the appraisal process. Consideration of a new role within each locality - Talent Management Champion - was also identified. Further work on this is currently taking place.

  The Trust position for 2016/17 is 8.08% which is significantly worse than the 2015/16 position of 32.00%.

- **KPI 26 - Percentage of staff reporting that they 'suffered work related stress in last 12 months' -** The Trust position for 2016/17 is 33%, which is worse than the 2015/16 position of 28%.

  A process has been developed by the Organisational Development department that aims to provide advice, guidance and tailor made intervention to improve staff engagement for teams identified via the Staff Friends & Family Test. Interventions include working with Team Managers to identify activities such as social safeness and team building days to support team resilience.

Other Points to Note:

- **KPI 23 Percentage of medical staff successfully revalidated** – There have been no revalidations due in quarter 4.

- **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 – The Trust position for 2016/17 is 93.75%. We are unable to provide a target as there is no comparable data following Board's approval to change the construction of the indicator. Board of Directors are asked to approve the suggested target of >93.75% for 2017/18.

3.4.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 4 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.4.3 Other Qualitative Intelligence

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

- The North East NHS Leadership Recognition Awards, celebrates leaders at all levels and across all professions who have ultimately improved people's health, the public's experience of the NHS and those leaders who we are truly proud to work alongside. In January, staff won in three categories: **Thomas Hurst**, Ward Manager – Emerging leader award, **Mani Krishnan**, consultant psychiatrist – Inspirational Leader award and **Lisa Taylor**, Offender Health Head of Service – Inclusive Leader award.

- The **KPO Team** were shortlisted for the Team Outstanding Achievement award within the North East NHS Leadership Recognition Awards.

- **Helen Pearce**, consultant psychiatrist, forensic learning disability services, Roseberry Park, Middlesbrough, has won 'outstanding healthcare professional' at the recent National Autistic Society Autism Professional Awards 2017.

- **Julia Taylor,** community psychiatric nurse, Sovereign House, Hartlepool, has been awarded a bravery award by West Yorkshire Police for saving a member of the public's life while in the course of her daily duty as an admiral nurse.

3.4.4 In conclusion it can be seen for this strategic goal that the number of red KPIs remains unchanged. Whilst only two of the indicators within this goal have improved in 2016/17, achievement of the Business Plan and significant qualitative intelligence in terms of workforce provides an overall encouraging position. The Trust will continue to benefit from an increased focus on talent management.

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

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing no indicators rated red at quarter 4.

The end of year position reports 2 indicators rated red, which is slightly worse than 2015/16 which reported 1 indicator rated red but better than the 4 reported red in 2014/15.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17											
	Indicator	Q4 Target 2016/17	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	2015/16 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 4 (To have effective partnerships with local, national and international organisations for the benefit of the communities we serve)											
27	Attendance rate at H&WB Boards	90%	77.78%	81.82%	90.91%	90.91%	⇔	90%	85.71%	87.50%	90%
28	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	100.00%	100.00%	100.00%	⇔	98%	100.00%	100.00%	98%
29	Proportion of student nursing placements provided as a % of placements requested	90%	100.00%	100.00%	99.04%	101.50%	⇧	90.00%	100.26%	99.12%	90.00%
30	R&D Outcomes - Annual number of recruits to National Institute of Health Research studies supported by TEWV R&D staff	n/a	69	469	204	363	⇧	453	1105	412	10% increase year on year
31	R&D Outcomes - Annual external R&D income (including external grants and commercial income)	£0	£139,955	£161,696	£117,715	£165,849	⇧	£678,014	£585,215	£616,376	10% increase year on year
32	Corporate Governance Statement signed off annually by Board with no conditions* and Monitor Governance Risk Rating maintained at 'GREEN' each quarter	n/a	Signed & Green	n/a	No longer reported	No longer reported	n/a	n/a	No longer reported	Signed & Green	Signed & Green

Other Points to Note:

- **KPI 29 Proportion of student nursing placements provided as a % of placements requested** – Trust services have taken students above the audited numbers due to demand outstripping supply. It is anticipated this will be more frequent in the future.

3.5.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 4 were rated green (89%) but this is a reduction on the quarter 3 (95%) position.

There are 11% of the priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget. This represents 1 priority/service development to develop and deliver the South Durham GP Aligned Professionals transformation plan. There is 1 action within this priority / service development that requires additional time going beyond the current year (to be agreed by Board)

There is 1 priority / service development reporting an overall status of amber / green but requires additional time going beyond the current year to complete 2 actions (to be agreed by Board).

Where a Board decision is required to change or remove an action, this is contained in Appendix 1 for approval.

3.5.3 Other Qualitative Intelligence

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

- **Karen Wells**, Improving Access to Psychological Therapies High Intensity Qualified Worker, Windsor House, Harrogate, was shortlisted in the Midwifery Awards in the 'Slimming World partnership working' category.
- **Parkinson's Advanced Symptoms Unit (PASU) team** won a Parkinson's Event Network Award. The PASU is a community-based collaboration between the Trust and James Cook University Hospital, Middlesbrough (neurology services). The Parkinson's Event Network Awards acknowledge excellence in providing treatment and care for people with complex Parkinson's. The Awards team noted the PASU's 'improved management of mental health symptoms' and the service's work leading to 'a fall in emergency admissions'.

3.5.4 In conclusion taking into account progress against the quantitative KPIs, the Business Plan and the qualitative intelligence the overall position remains extremely positive for this strategic goal.

3.6 **Strategic Goal 5 - *To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve***

3.6.1 Trust Strategic Direction Scorecard

This strategic goal is showing 1 indicator rated red out of 7 as at quarter 4, which is an improvement on the quarter 3 position. That indicator is showing an improvement.

The end of year position reports 2 indicators rated red, which is worse than with the previous two years; both 2015/16 and 2014/15 reported 1 indicator rated red.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17											
	Indicator	Q4 Target 2016/17	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	2015/16 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 5 (To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve)											
33	Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)	37.50%	71.43%	71.43%	71.43%	64.29%	⇧	37.50%	64.29%	57.14%	<=6.25%
34	Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard	75%	87.50%	75.00%	75.00%	87.50%	⇧	75.00%	81.25%	5 yr Strategy & metrics approved EMT March 2016	TBC
35	Percentage change in income for Trust contracted services compared to previous year	<=95	6.72%	6.83%	7.40%	7.42%	⇧	1.10%	7.42%	8.09%	Better than deflator
36	Reference Cost Index score for in-scope PbR Services	<=95	Due in Q2	97	100	Due July	n/a	<=95	100	92	TBC
37	Reference Cost Index score for out of scope PbR Services	<=95	Due in Q2	86	88	Due July	n/a	<=95	88	95	TBC
38	EBITDA **	4.69%	8.62%	8.64%	7.91%	14.08%	⇧	0.00%	0.00%	8.22%	8.00%
39	Good Corporate Citizenship audit scores*	65.00%	Due in Q4	Due in Q4	Due in Q4	66%	n/a	65.00%	66%	66.00%	75.00%

Indicators of concern are:

- **KPI 33 - Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)** – The Trust position for quarter 4 is 64.29%, which is better than the figure reported for quarters 1-3 (71.43%). However, this is 26.79% more than expected and therefore an underperformance.

  Of the 8 metrics, 4 have shown an improvement on quarter 3. Those showing a deterioration are the patients recorded on PARIS for which accommodation status and ethnicity are missing, marital status not recorded and the number of 'system' breaches for crisis gatekeeping. There is a data quality action plan which is underway led by the Information Department with the clinical services to address the data quality issues. This is monitored at Trust Data Quality Group on a monthly basis.

  The Trust position for 2016/17 is 64.29% which is worse than the 2015/16 position of 57.14%.

Other Points to Note:

- **KPI 36 Reference Cost Index Score for in-scope PbR services** and **KPI 37 Reference Cost Index Score for out of scope PbR services** – the position at the 31st March remains the same as reported at quarter 3. The final position will not be reported until July 2017.

3.6.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 4 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.6.3 Other Qualitative Intelligence

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

- The Trust received additional income in quarter 4 of £66k.

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

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no issues of compliance with the CQC fundamental standards.

4.2 **Financial/Value for Money:**
The report highlights that none of the Sustainability metrics are below target.

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

4.4 **Equality and Diversity:**
There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled', reporting 21% of staff considering themselves to have a disability.

4.4 **Other implications:**
There are no other implications associated with this paper.

5. RISKS:

There are no identified risks associated with this paper.

6. CONCLUSIONS:

This is the final Strategic Direction Performance Report for 2016/17 and reports progress against the Strategic Direction Scorecard and the Trust Business Plan whilst also considering other forms of qualitative intelligence.

This report reflects that three of the Trusts five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. There has been a deterioration in the KPIs relevant to Goal 2; however it is noted that there is an improved position on Business Plan progress and significant positive qualitative

intelligence reported. The KPIs relevant to Goal 3 have reported a worse position than in the previous two financial years; however it is noted that all business plan actions have been completed and significant positive qualitative intelligence reported.

Overall the scorecard position has remained consistent with quarter 3; however of the 11 KPIs reporting red at quarter 3, 8 of these have reported a deterioration. In comparison to the end of year position for 2015/16, of those indicators that can be compared the RAG status of 9 has improved, 15 deteriorated and 3 remained the same.

7. RECOMMENDATIONS:

Board of Directors are asked to:

- Approve the changes to the Trust Business Plan detailed in Appendix 1.
- Approve the suggested target in section 3.4.1 (KPI 24).

Sharon Pickering
Director of Planning, Performance & Communications

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Board requests for changes:

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
4.3	Engage in each health and social care system in which we work to contribute to the development and delivery of their transformation plan (including Vanguards) AMH **GP Aligned professionals - South Durham**	Durham and Darlington	AMH	To implement GP aligned professionals within DDES CCG area	Evaluation commenced	16/17 Q4	Jo Dawson		The partnership board and Locality Manager receives information on a monthly basis to review activity, however formal evaluation has not yet commenced and is included in the 17/18 work programme. **Board are requested to extend the timescale for the evaluation to Q2 17/18.**
1.6.029	Deliver agreed service developments - **BME patients accessing services**	Tees		Review the ethnicity of patients accessing services to identify where members of particular ethnicities are under represented	Review complete and action plan developed to address any issues identified		Dominic Gardner		Analysis completed which indicates under representation of South Asian, Gypsy & Travellers and Chinese communities. The paper will be discussed at the next Locality Business Development Group on 9th May where actions will be developed. **Board are therefore requested to extend the timescale for completion to 17/18 Q1.**

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
1.6.041	Deliver agreed service developments - **Equality**	Tees	MHSOP	Development of a number of videos and podcasts to talk about living well with Dementia and how to get support when required	Videos and podcasts produced	16/17 Q4	Alison Cook/ Ruth Harris		Delays in meeting deadline due to priorities in other areas. **Therefore Board are requested to extend the deadline to 17/18 Q2.** Meeting arranged with Sarah Jay first week in April to coordinate.
				Development of a number of videos and podcasts to talk about living well with Dementia and how to get support when required	Videos and podcasts available via Trust social media				
1.6.051	Deliver agreed service developments - **Producing a Sustainability Plan for Medical Staffing**	North Yorkshire	All	If scope approved, produce Business Case	Implement proposals		Neil Mayfield		Discussions have been ongoing in NY with regard agreeing roles of AMH consultants in Scarborough following approval of proposals by EMT, Job description is being drafted for approval, following which recruitment can commence. **Board are therefore asked to approve a change in the timescale to 17/18 Q1**.

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
1.6.044	Deliver agreed service developments - **Relocation of OP Redcar Community Team**	Tees	MHSOP	Team relocated to new base if required due to South Tees FT redevelopment plans for Guisborough Hospital	Relocation complete	~~16/17 Q1~~ 16/17 Q4	Alison Cook		Ongoing discussions regarding the lease between solicitors which has caused further delays to the move is now resolved and lease is signed. Weatherhead's commenced work early March at the Coathham road site; this is scheduled to take 12 weeks minimum without any delays etc. Snagging work is scheduled to be completed by the 15th May meaning a potential move date of the first week in June. **A PM2a was submitted to EMT on the 19 April 2017 requesting an extension to 17/18 Q2 for completion of this project, the request was provisionally agreed subject to Board approval.**

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
1.6.063	Deliver agreed service developments - **Review of Physical Health provision across North Yorkshire**	North Yorkshire	AMH / MHSOP	Review current Physical Healthcare provision in North Yorkshire	Business Case agreed at EMT	16/17 Q2	Naomi Lonergan		Business Case not produced as LMGB agreed that resources for Physical Healthcare would be met from within existing resources. Therefore this, and subsequent actions/metrics have not/will not be delivered. **Board are therefore requested to agree that priority does not need to be included in 2017/18 Business Plan.**
				Implement preferred option as detailed in Business Case	Project Close Down Report agreed at EMT	16/17 Q4			
1.6.088	Deliver agreed service developments - **Rostering**	York and Selby	MHSOP	Implementation of 12 hour rostering system across MHSOP inpatient services	Implementation of roster complete	~~16/17 Q3~~ 16/17 Q4	Brian Coupe		LCC paper produced for April 2017 and roll out of roster to be complete by 17/18 Q2. **Board are requested to extend the deadline to 17/18 Q2.**
1.6.106	Develop and implement plans to deliver significant service changes/developments required for each service - **Retender Domestic services contract**	EFM	NA	Re tender domestic services contract of non-patient facilities	Contract awarded	~~15/16 Q4~~ 16/17 Q4	Caroline Siddall		The York and Selby locality tender outcome had an impact upon this work and as a result the Trust took the decision to delay the process by 12 months. The contract was therefore extended and the subsequent actions by a further year. Due to a delay in the

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
									procurement process, the award of the contract is now planned to be completed by the end of 17/18 Q3. **As a result Board are requested to extend the deadline to 17/18 Q3.**
1.6.073	Deliver agreed service developments - **IAPT Services**	York and Selby	AMH	Achieve Prevalence rates for people accessing IAPT services	Achieve national target prevalence rates for people accessing IAPT services	16/17 Q4	Gill Boycott		The IAPT service received a performance notice in January 2017. Subsequently, on 23rd February, NHS England Intensive Support Team, held a diagnostic review into local IAPT access commissioning, provision and delivery given the historic issues relating to performance and failure to achieve the national metrics. The IAPT service has development an action plan to address those areas that need improvement, in order to meet the national targets, which will be monitored on a monthly basis. **Board are requested to extend the deadline to 17/18 Q4.**
				Achieve Recovery rates for people accessing IAPT services	Achieve recovery national target recovery rates				

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
1.6.115	Develop and implement plans to deliver significant service changes/developments required for each service **- Review of software for EFM (Utility Billing, EFM Helpdesk, Cleanliness Recording) (EFM Software project)**			Project complete	Closure formally approved	~~15/16 Q3~~ ~~16/17 Q3~~ 16/17 Q4	Ray Milliner		EFM has completed the actions of which they are responsible for. However, there is still an outstanding action to be completed regarding utility billing. However, this action is lead by the Finance department and as of yet, it has not been completed. **Board are requested to extend through to Q1 17/18 Q1 for completion of action.**
1.6.112	Deliver agreed service developments - **Virtualising the server and desktop infrastructure to enable the wider use of different technologies (Next Generation Devices Project)**	Information	N/A	Phase 2 - Implement project as per approved project plan	Phase 2 complete	16/17 Q4	Steven Forster		The project transition to current project manager (Steven Forster – Technical Development Manager) is complete. **A PM2a was submitted to EMT on the 19 April 2017 which described proposed changes to the project milestones with a request to extend the project until the end of Q1 17/18, the request was provisionally agreed subject to Board approval.**
				Project complete	Closure formally approved				

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q4 Metric Status	Comment and requests for decisions
4.1	Continue to improve engagement with GPs and GP Practices as partners in care through delivering the agreed project plan and identifying further work for the future	Chief Executive	All	Develop a standard approach for GPs to communicate referrals to the Trust	Report of Pilot discussed by EMT	16/17 Q4	Jane Leigh		Action not achieved, **Board are requested to approve a 3 months extension to Q1 17/18**.
				Implement standardised written commun-ication from the Trust to GPs	Electronic templates implemented across the whole Trust				Action not achieved, **Board are requested to approve a 6 months extension to Q2 17/18**.

BOARD OF DIRECTORS Item No 17
FOR GENERAL RELEASE

DATE:	**23rd May 2017**
TITLE:	**To consider the publication of information on compliance with the public sector duty under the Equality Act**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Decision**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their 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 Trust must publish information to demonstrate its compliance with the general equality duty. The purpose of this report is to seek ratification of this information. Directors are asked to note the differences in outcomes and experiences for service users and staff from protected groups that are reported.
Directors are asked to consider the trust's workforce race equality standard 2017 and accompanying action plan and to note that when this returns to the Board of Directors meeting in July 2017 some reconciliation of figures may have taken place with those provided by NHS England.

Recommendations:

- To ratify the publication of equality data documents and approve their publication on the trust website as required by the Equality Act.
- To approve the changes to the locality equality objectives (at points 3.2.1, 3.2.3 and 3.2.4 in Appendix A).
- To note point 6.4 in the paper on service user equality in relation to the CQC's equality objectives
- To note the differences in outcomes and experiences for staff from protected groups outlined in the paper on staff equality and the proposed actions at 7.2 in Appendix B.
- To comment upon the trust's workforce race equality standard 2017 and accompanying action plan (Appendix C).

MEETING OF:	**Board of Directors**
DATE:	**23 May 2017**
TITLE:	**To consider the publication of information on compliance with the public sector duty under the Equality Act**

1.0 INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek ratification of the information to be published under the Trust's Equality Act duties

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

2.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users and staff who share a relevant protected characteristic who are affected by its policies and practices

3.0 KEY ISSUES:

3.1 The Trust needs to ensure compliance with the Equality Act 2010, by publishing information to demonstrate its compliance with the general equality duty.

3.2 Appendix A includes service user equality data and Appendix B includes staff equality data. These reports describe areas where the outcomes and experience of both service users and staff from particular protected groups are less than service users and staff who do not share those protected characteristics. There is evidence that the greater the proportion of staff from protected groups who report experiencing discrimination at work in the last 12 months the lower the levels of patient satisfaction. It is hoped that some of the interventions to improve outcomes and experience for staff will impact positively on the experience and outcomes of service users.

3.3 The trust is required to publish its Workforce Race Equality Standard (WRES) and associated action plan annually (Appendix C). The proposed action plan and the WRES figures are being presented to BOD at this time for

consultation. The finalised WRES and action plan will come back to the BOD in July 2017 for final sign off prior to publication.

4.0 IMPLICATIONS:

4.1 Compliance with the CQC fundamental Standards:

It is a requirement of the CQC fundamental standards that the Trust meets its obligations under the Equality Act 2010.

4.2 Financial/Value for Money:

Financial penalties can be incurred for non- compliance with the legislative requirements of the Equality Act. This may result in reputation loss for the Trust.

4.3 Legal and Constitutional (including the NHS Constitution).

The Trust is required to publish information demonstrating its compliance with the general public sector duties of the Equality Act 2010. This document will meet that legal requirement and as Equality Act compliance is a pre-requisite of Care Quality Commission registration will maintain Trust registration.

4.4 Equality and Diversity:

The Trust must demonstrate compliance with statutory equality requirements. Failure to do so may result in legal action and subsequent financial penalties and damage to the Trust's reputation.

4.5 Other implications:

None have been identified.

5.0 RISKS:

5.1 The quality of information submitted for publication continues to be subject to improvement and there may be risks related to the data quality

6.0 CONCLUSIONS:

6.1 The Trust needs to publish information demonstrating it is compliant with the general public sector duties of the Equality Act 2010 and the information in the attached document will meet that requirement.

6.2 The Trust needs to understand whether and why particular groups in the community are under or over represented in its service user population and to take action as appropriate. The Trust also needs to ensure that any differences in experience between protected groups and the service user population in general are understood and appropriate action taken to ensure high quality care is delivered for all.

6.3 The trust needs to understand the differences in experience and outcome for its staff and to take action where necessary to lessen the disparities.

6.4 Whilst actions have been undertaken for some time to address the issues described above it must be noted that considerable disparities still exist for

both staff and service users from protected groups and that serious consideration is needed of both the actions needed and the resources available to lessen the differentials in experience and outcomes for these groups.

7.0 RECOMMENDATIONS:

7.1 To ratify the publication of equality data documents.

7.2 To approve the changes to the locality equality objectives (at points 3.2.1, 3.2.3 and 3.2.4 of Appendix A).

7.3 To note the differences in outcomes and experiences for staff from protected groups outlined in the paper on staff equality and the proposed actions at 7.2 in Appendix B.

7.4 To comment upon the content of the workforce race equality standard and associated action plan (Appendix C).

David Levy, Director of Human Resources and Organisational Development
Sarah Jay, Equality, Diversity and Human Rights Lead

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

PUBLICATION OF SERVICE USER EQUALITY DATA

1 APRIL 2016– 31 MARCH 2017

Published 23rd May 2017

making a difference together

If you need this information summarised in another language or format such as Braille, talking tape or DVD please call the number below.

Polish:
Jeżeli potrzebujesz streszczenia tych informacji w innym języku lub formacie, np. w Braille'u lub w formie nagrania dźwiękowego, zadzwoń na poniższy numer.

Arabic:
إذا أردت منا تلخيص هذه المعلومات بلغة أخرى أو بصيغة مختلفة مثل لغة بريل أو شريط صوتي أو قرص DVD
يرجى الاتصال برقم الهاتف التالي.

Bengali:
যদি আপনি অন্য একটি ভাষায় এই তথ্যের সংক্ষিপ্তসার চান অথবা ব্রেইল, কথা বলা টেপ অথবা ডি.ভি.ডি. ফরম্যাট-এ এই তথ্য চান, তাহলে অনুগ্রহ করে নিচের নম্বরে টেলিফোন করুন।

Farsi:
در صورتی که مایلید خلاصه این اطلاعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره زیر تماس بگیرید.

Hindi:
यदि आप इस सूचना का सारांश किसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टाकिंग टेप या DVD में चाहते हों, तो कृपया नीचे दिए गए नंबर पर फोन करें।

Kurdish (Kurmanji):
Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈੱਟ ਜਿਵੇਂ ਬ੍ਰੇਲ, ਟਾਕਿੰਗ ਟੇਪ ਜਾਂ DVD ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:
如果您需要该条信息用其他语言或格式概述，例如盲文，录音磁带或 DVD。请联系以下号码：

Urdu:
اگر آپ کو ان معلومات کے خلاصہ کی کسی دیگر زبان یا شکل مثلاً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو برائے مہربانی درج ذیل نمبر پر کال کریں۔

Telephone 0191 3336267

PUBLICATION OF EQUALITY DATA

1. INTRODUCTION

1.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to :

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

1.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are gender, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

1.3 The Trust has published information to meet its public sector duties for the last six years. During this time the quality of the data has steadily improved however the Trust recognises that there are still qualifications around the quality and validity of the data, particularly as in some areas the numbers are relatively low. The Trust wants to be transparent in demonstrating its compliance with its Equality Act duties and has decided to publish raw data. The information published must therefore be viewed as descriptive and any interpretations of it must be conservative.

1.4 The information in this report includes:

- An analysis of service users who were referred to Trust services between 1st April 2016 and 31st March 2017 by race and ethnicity, gender, disability, religion, sexual orientation, age, marriage and civil partnership. The data is taken from information given by service users who at times refuse to provide information requested, giving incomplete data. In the data a blank is recorded as null, refuse to disclose means that the service user preferred not to give the trust that information and not known means that the clinician has recorded that they do not know that information.
- An analysis of the length of waiting time from referral to first contact by ethnicity and an analysis of length of hospital stay by ethnicity.
- An analysis of the patient friends and family test by race and ethnicity, age, gender, disability and sexual orientation. This is included at Appendix 1.

Where possible the Trust's data has been compared to that of the 2011 Census produced by the Office of National Statistics. Copyright is acknowledged as adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0.

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2. ACCESS TO SERVICES

2.1 The following data is for the year 1st April 2016 to 31st March 2017 and is the information contained on the Trust's electronic clinical record system. Some of the fields are incomplete for some service users and some service users have preferred not to give the Trust certain information. The level of missing values and non-disclosure is indicated in each section.

2.3 Where it is available the makeup of the Trust's service user population has been compared to the information on the general population that was gathered in the 2011 census.

2.4 Summary of Service Users by Ethnic Group Compared to ONS 2011 Census Information

Ethnic Group	Ethnic breakdown of service users in the Trust (number)	Ethnic Breakdown of service users in the Trust (%)	Ethnic Breakdown 2011 Census (number)	Ethnic Breakdown 2011 Census (%)
White; British	168354	85.75	1598854	94.55
White; Irish	482	0.25	5330	0.32
White; Other White includes Eastern European	2143	1.09	26434	1.56
Mixed; White and Black Caribbean	274	0.14	3995	0.24
Mixed; White and Black African	192	0.10	1964	0.12
Mixed; white and Asian	291	0.15	5166	0.31
Mixed; Other Mixed	479	0.24	3299	0.20
Asian or Asian British; Indian	306	0.16	6872	0.41
Asian or Asian British; Pakistani	618	0.31	11953	0.71
Asian or Asian British; Bangladeshi	89	0.05	1721	0.10
Asian or Asian British; Other Asian	452	0.23	7286	0.43
Black or Black British; Caribbean	86	0.04	848	0.05
Black or Black British; African	259	0.13	4526	0.27
Black or Black British; Other Black	156	0.08	1052	0.06
Asian or Asian British Chinese	164	0.08	5664	0.33
Other Ethnic Group		0.42	4400	0.26

includes Iranians and Arabs	832			
Travellers including Gypsy, Roma Traveller/Irish Traveller	165	0.09	1600	0.09
Not stated and declined to disclose	10493	5.35		
NULL	10485	5.34		
Total	196320	100	1690,964	

2.4.1 10485 or 5.34% of service users' race/ ethnicity is not available as it has not been provided. This compares to 5.4 % last year. There are variations from the census norms which the Trust will use to explore access issues.

2.4.4 Length of waiting time from referral to first contact by ethnicity

The Trust has produced its own figures on the length of waiting time from first referral to first contact analysed by ethnicity. There are some differentials in these which will be explored and appropriate action taken. A degree of caution must be applied in interpreting these figures because of the number of service users whose ethnicity is not known or not stated which could significantly affect the figures in each category.

Ethnic Group	No. of patients	Average length of time (days)
White; British	38961	10.39
White; Irish	97	12.40
White; Other White includes Eastern European	465	13.19
Mixed; White and Black Caribbean	54	6.69
Mixed; White and Black African	43	5.67
Mixed; white and Asian	61	8.49
Mixed - Other Mixed	112	6.97
Asian or Asian British; Indian	72	14.25
Asian or Asian British; Pakistani	134	6.86
Asian or Asian British; Bangladeshi	25	10.32
Asian or Asian British; Other	107	8.45

Black or Black British; Caribbean	23	9
Black or Black British; African	47	6.4
Black or Black British; Other Black	38	7.34
Asian/Asian British - Chinese	32	11.47
White - Gypsy	26	8.77
Irish - Traveller	12	4.25
Other Ethnic Group - Arabs	83	7.69
Null	3232	9.32
Not stated	2203	18.72
Decline to disclose	22	8.91
Other Ethnic Group – any other	196	9.47

2.4.5 Length of hospital stays by ethnicity

The Trust has again analysed the length of inpatient stay by ethnicity. Following feedback these figures have been produced for long stay wards, acute wards and short stay respite to provide a more accurate understanding of differences between ethnic groups These figures are for the period 1st April 2016 to 31st March 2017 Some patients were admitted to hospital prior to 1st March 2016 and this is not reflected in these figures. There are some differences in these which will be explored.

Length of hospital stay by Ethnicity 01/04/2016 - 31/03/2017

ACUTE WARDS:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	3149	35.89	0	365
White; Irish	18	44	0	289
White; Other White includes Eastern European	60	31.17	0	140
Mixed; White and Black African	3	22.75	14	440
Mixed White/Black Caribbean	8	47.86	1	250
Mixed; white and Asian	5	37.14	4	199
Mixed; Other Mixed	14	41.72	1	233

Asian/Asian British Bangladesh	1	7	7	7
Asian or Asian British; Indian	13	44	4	181
Asian or Asian British; Pakistani	24	32.93	3	131
Asian or Asian British; Other Asian	12	40.95	5	206
Black or Black British; Caribbean	5	22.71	1	109
Black or Black British; African	7	19.94	1	133
Black or Black British; Other Black	2	29	7	64
Asian / Asian British - Chinese	7	34.36	0	130
Other Ethnic Group Any other	24	35.27	1	233
White Irish	18	44	0	289
Other Ethnic group includes Arabs	5	23.67	6	38
White - Gypsy	2	52	19	146
Null	86	15.23	0	142
Not stated	70	343.01	0	257
Total	3518	35.43	0	365

Long Stay wards:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	597	137.67	0	365
White; Irish	2	357.5	350	365
White; Other White includes Eastern European	8	143.89	6	365
Mixed; White and Black Caribbean	1	81	81	81
White Irish Traveller	1	19	19	19
Mixed White/Black African	1	23	1	45

Mixed; Other Mixed	3	135.25	56	229
Other Ethnic group – any other	8	93.13	9	342
Asian/Asian British Indian	1	262	262	262
Asian or Asian British; Pakistani	6	87.83	10	227
Asian or Asian British; Other Asian	6	203.43	12	365
Black or Black British; African	9	95	1	365
Black or Black British; Other Black	1	118	118	118
Black, Black British Caribbean	1	44.5	12	105
Asian / Asian British - Chinese	2	183	1	365
Other ethnic group - Arab	1	145	90	200
Declined to disclose	1	88	88	88
Not stated	6	35.38	3	120
Null	5	3.8	2	7
Total	661	134.85	0	365

Short stay/respite stay:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	287	3.18	0	54
Mixed white and Asian	1	3	0	7
White; Other White includes Eastern European	2	12.50	6	19
Mixed; Other Mixed				
Asian, Asian British Indian	1	5.86	3	20
Asian or Asian British; Pakistani	6	2.68	1	7
Asian or Asian British; Other Asian				
Asian/Asian British Chinese	1	10	10	10
Black or Black British; African	2	4.89	1	15
Black or Black British; Other	1	13	13	13
Other ethnic group, any other	1	1.67	0	3
Not stated	2	1.43	1	12
Total	310	3.18	0	54

2.5 Summary of Service Users by age compared to the ONS 2011 Census

Age	Breakdown of Service Users in the Trust by age (Number)	Breakdown of Service Users in the Trust by age (%)	ONS Census 2011 Breakdown by age (number)	ONS Census 2011 Breakdown by age (%)
0-18	31857	16.23	346436	20.5
18-29	40532	20.65	250209	14.8
30-44	37231	18.96	311330	18.4
45-64	38634	19.68	470521	27.8
Over 65	48066	24.48	312469	18.5
Total	**196320**	**100.00**	**1,690,965**	

2.5.1 Comparing the age categories of the Trust to those of the ONS 2011 Census the number of service users in the 0 – 18 and 45 - 64 categories are less than the Census figures, which needs to be explored. The number of service users in the over 65 age group is expected due to the increased prevalence of age related mental health problems in this group.
The Trust's data on the age of service users was complete.

2.6 Summary of Service Users by Sexual Orientation

Sexual Orientation	Breakdown of service users by sexual orientation (number)	Breakdown of service users by sexual orientation (%)
Person does not know	263	0.13
Null	129550	65.99
Persons of the opposite sex	63873	32.54
Persons of the Same or opposite sex	1029	0.52
Persons of the Same Sex	1605	0.82
Total	**196320**	**100.00**

2.6.1 In 2005 HM Treasury and the Department of Trade and Industry completed a survey to help the Government analyse the financial implications of the Civil Partnerships Act (such as pensions, inheritance and tax benefits). They concluded that there were 3.6 million gay people in the United Kingdom – around *6% of the total population* or 1 in 16.66 people.

Most of the time, the figure of between 5-7% of the population is used. Stonewall, a National Lesbian, Gay and Bisexual campaigning organisation feel this is a reasonable estimate. However, as this question was not asked in the 2011 UK census there is no way of knowing for sure how many Lesbian, Gay or Bisexual people there are in the UK.

Comparing these estimated figures with the Trust's service users the Trust has an under-representation of those who have declared that they are lesbian, gay or bisexual. This is a particularly sensitive area for many service users and this is possibly reflected in the fact that for 129550 or 65.99% of service user's information about their sexual orientation is not stated, not known or they have preferred not to say. However this is a 23% deterioration on last year's figures.

2.7 Summary of Marital and Civil Partnership Status of Service Users within the Trust compared to the ONS 2011 Census.

Status	Breakdown of service users in the Trust by Marriage Civil Partnership (number)	Breakdown of service users in the Trust by Marriage Civil Partnership (%)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (number)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (%)
Divorced/ Civil Partnership Dissolved	7341	3.74	132910	9.1
Married / Civil Partnership	29845	15.20	720888	49.31
In a relationship	1292	0.66		
Living with a partner	1577	0.80		
Not Disclosed	8684	4.42		
Separated	3509	1.79	34250	2.34
Single	85365	43.48	464109	31.73
Surviving Partner/ Widowed	14905	7.59	109897	7.52
Null	43675	22.25		
Not known	127	0.06		
Total	**196320**	**100.00**	**1,462,054**	

2.7.1 For 43802 or 22.31 % of service users marital and civil partnership status information is not available as service users have refused to give it. This is a 4% deterioration in the data completeness compared to last year. ' In a relationship' and ' living with a partner' were added as additional fields in PARIS in 2016 to better reflect the range of relationships amongst our service users. There are no categories in the 2011 census with which to compare these options.
There is a variation between the Trust's data for marriage and civil partnership and that of the ONS 2011 in the categories of those who are divorced or whose civil partnership has been dissolved, those married or in civil partnerships and those who are single.

2.8 Summary of gender of service users within the Trust compared to the ONS 2011 Census.

Status	Breakdown of service users in the Trust by gender (number)	Breakdown of service users in the Trust by gender (%)	ONS Census 2011 breakdown by gender (number)	ONS Census 2011 breakdown by gender (%)
Male	92590	47.16	828146	48.97
Female	102187	52.05	862814	51.03
Null	1528	0.78		
Not known/not specified	15	0.01		
Total	**196320**	**100.00**	**1,690,960**	

2.8.1 The gender breakdown of the Trust's service users is very similar to that of the ONS data. For 1543 or 0.65 % of service users the data on gender is incomplete. This is a deterioration of 0.14% compared to last year.

2.9 Summary of Service Users by religion compared to the ONS 2011 Census service user Population by religion

Religion	Breakdown of Service Users in the Trust by religion (number)	Breakdown of Service Users in the Trust by religion (%)	ONS 2011 Census Breakdown by religion (number)	ONS 2011 Census Breakdown by religion (%)
Any other	3752	1.91	5124	0.30
Buddhist	332	0.17	3881	0.23
Christian	81134	41.33	1174586	69.46
Hindu	96	0.05	3516	0.21
Jewish	71	0.04	937	0.06
Muslim	1291	0.66	20143	1.19
Sikh	130	0.07	2440	0.14
None	38818	19.77	371479	21.97
Null	19642	10.01		
Not stated	51054	26.01	108854	6.44
Total	**196320**	**100.00**	**1,690,960**	

2.9.1 Data on religion is not available for 19642 or 10.01 % of the Trust's service users as it has not been given. This is almost identical to the level of data completeness last year.

There are differences between the data on the religion of the Trust's service users and the data in the 2011 Census in the categories of any other religion, Christian, Muslim, Hindu, Sikh and none.

2.10 Summary of Servicer Users by Disability

Disability	Breakdown of Service Users in Trust (number)	Breakdown of Service Users in Trust (%)
Hearing Impairment	7041	3.59
Mobility impairment	8670	4.42
Learning Disability	5620	2.86
Multi-sensory impairment	833	0.42
Other Disability	2296	1.17
Physical disability	4893	2.49
Mental Health	15405	7.85
Visual Impairment	11256	5.73
Speech Impairment	1092	0.56
Null	157399	80.17
Total number of unique referrals	196320	100.00

2.10.1 The Trust has been able to report on the numbers of service users with hearing impairment, mobility impairment, multi- sensory impairment, other disability, physical disability, visual impairment or speech impairment. Some service users have more than one disability so may appear in more than one category. Figures from the Royal National Institute of Blind people suggest that 1 in 30 people have sight loss, and figures from Action on Hearing loss state that 1 in 6 people or 16.66 % have some kind of hearing loss. The figures for service users with mental health difficulties or learning disabilities have not been included. Information from the 2011 census states that 38% of the population of the North East and 33% of the population of Yorkshire and Humber report a long standing illness or disability with 20% of the population of the North East and 19% of the population of Yorkshire and Humber reporting a limiting long standing illness or disability

3. Equality Objectives

3.1 Service user and carer involvement is essential to help the Trust deliver and develop services which are service user centred and feedback on services is essential in order to continually improve our services in response to what we are told. The Trust has well-established mechanisms for engaging with its service users and carers in a variety of ways.

3.2 In March 2016 each locality was asked to develop an equality objective for 2016 – 2020, together with an outline of the actions for the first year. There was evidence of good consultation and activities in some localities which have led to the development of the equality objectives. The equality objectives and progress made in the first year are detailed below.

3.2.1 **Durham and Darlington overall objective**: To raise staff awareness of autism and to improve service provision and encourage effective multi agency holistic provision for people with autism of all ages and abilities in Co. Durham and Darlington 2016 – 2020

Progress
This objective was subsumed by the trustwide autism project and has been replaced by a new objective.

Equality Objective 2017 - 2020
To continue to ensure that the principles of Green Light are embedded in services

3.2.2 **York and Selby overall objective**: Working with partners to improve access and experience of mental health services for students and young people (16 – 25) in York and Selby.

Progress: The locality has made good progress with this equality objective, evidence of which was provided to the EDHR steering group, and is to continue work on the objective for the period 2017 – 2020.

3.2.3 **Forensic services objective 1:** Continue the work with LGB and T patients that was commenced after the CQC visit in July 2014.
Objective 2: Review the support for women who are on maternity leave.

Progress: Both these objectives were completed in 2016/17, detailed evidence of which was provided to the EDHR steering group.

Equality Objectives 2017/2020
Objective 1 To improve the support for staff who are on extended forms of planned maternity / paternity / adoption leave.
Objective 2 Consider in line with Service user requests on how to celebrate diversity within the service.
Objective 3 To provide clarity on the role and function of the E & D Champions within the service

3.2.4 **Teesside objective 1** To continue implementation of the Greenlight audit in adult services, building on the work carried out last year and completing the self-assessment. The locality has made good progress with this equality objective, evidence of which was provided to the EDHR steering group, and is to continue work on the objective for the period 2017 – 2020 Progress actions for improved access and service models across urgent and routine care pathways. This will involve further embedding the work begun within the Acute Care Pathway and consideration of further actions to be taken in relation to our routine care

Objective 2 To ensure access to mental health services for refugees and asylum seekers on Teesside particularly in adult services and in children's teams

Progress: Objective 2 was completed in 2016/17, detailed evidence of which was provided to the EDHR steering group. It has been replaced by

Additional Equality Objective 2017 - 2020

Under/ Over - Represented Communities

Based upon the information identified from analysis of our data, we will attempt to explore the reasons for the under/over representation of particular BAME communities within our services. This may involve utilising a Community development approach to review experience of our services for those communities, and identify remedial actions that we may need to take to support access and retention for people to achieve successful outcomes. This will include a review of how well our workforce reflects the ethnic make-up of the communities that we serve. Levels of access to health provision for BAME communities is identified as an area of focus in forthcoming CQC work programmes .Further discussion is required with colleagues in Tees to identify whether this will be addressed Locality-wide

3.5.6 **North Yorkshire objective** To better understand the mental health needs of the farming communities in North Yorkshire and where appropriate take action to improve and increase access to services.
Progress: The locality has made good progress with this equality objective, evidence of which was provided to the EDHR steering group, and is to continue work on the objective for the period 2017 – 2020.

3.5.7 **Trust Wide – Workforce**
Overall objective: To undertake research to better understand the causes of any differences where staff who share similar characteristics report lower levels of satisfaction in either the staff friends and family test or the staff survey and to take steps to reduce or eliminate any lower levels of satisfaction.
Progress
It became apparent that the research required a formal process and the IRAS form was submitted in March 2017. It is hoped that the research and analysis will begin in May/ June 2017 depending on the length of time needed to obtain HRA approval.

4. Analysis of the effects of the Trust's policies and practices

4.1 Equality analyses are carried out on all Trust policies and procedures and these are available on the Trust website.

4.2 Equality analysis is also carried out on service developments and improvements and is an integral part of the Trust's project management processes through which all major service changes are progressed.

5. Equality in Practice

The Trust is committed to ensuring that all people have equal access to its services. Some of the initiatives the Trust has taken to realising this vision are described in the information relating to the Trust's equality objectives in section 3. Others are described below.

5.1 Disability Access Audits

The Trust recognises the importance of ensuring that people with disabilities can access its premises. The Health and Safety team have carried out audits on all inpatient sites.. These audits are to continue as part of the health and safety workbook audit programme and in 17/18 will begin on outpatient areas. It must be acknowledged that .the audit only covers limited areas and do not include clinic rooms, ward and other areas in which patients are seen.

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5.2 Interpreting Services

In order to deliver an equitable service to those whose first language is not English the Trust has recently let a three year contract to an interpreting agency, ensuring quick access to appropriately qualified interpreters. The quality and usage of the service is regularly monitored.

5.3 Dementia

The North East Dementia Alliance commissioned a report on Dementia in minority communities in North East England in August 2012. In response to this the Trust has started to pilot some work with its South Asian communities in Stockton and Middlesbrough. During 16/17 the trust undertook a lot of work with a South Asian community organisation to raise awareness of dementia amongst the community and to seek to increase early referrals into services. This included training community members in dementia awareness and carrying out some consultations to better understand how MHSOP need to be changed to meet the needs of the community. As a result referrals into services have increased, a drop in session has been established at a community venue in Stockton and a video in Urdu is planned to further raise awareness in the community of dementia and the treatments available. This work has now been extended to all services in Stockton and Middlesbrough.

5.4 Data Completeness

Measurement is key to understanding whether there are differences in experience or outcomes for those in protected groups and then acting on these. Crucial to this is achieving a high level of data completeness and accuracy in the demographic data on PARIS. The Equality, Diversity and Human rights team have worked with the PARIS team over the last 18 months and as a result:

- Changes have been made to PARIS to enable LD and CAMHS services (perhaps MHSOP in some cases) to have new options in the sexual orientation field due to the needs of their service users
- Changes have been made to the disability field in order to improve the levels of data completeness.
- ‘Partner’ and ‘ in a relationship’ have been added to marital status.
- Changes have been made in all categories with the removal of the fields ‘not known’ and ‘not stated’ and the addition of ‘declines to disclose’ to ensure consistency and to clearly identify whether the reason for the lack of data is due to service user choice.

6 Conclusions

6.1 The levels of data completeness available to the Trust to measure its performance in its public sector duties have either remained static or slightly deteriorated. Further work is needed to improve rates of completeness in certain categories. Higher levels of data completeness would allow the Trust to have greater confidence in its understanding of the makeup of its service users and their needs.

6.2 Good progress has been made on the Trust's equality objectives and localities have taken ownership of these and are committed to achieving them

6.3 In addition to the work on the equality objectives the Trust has a number of other initiatives (described in 5 above) in which clinical services have recognised a need for focused work with some of its minority communities to ensure that they have equal access to mental health and learning disability services.

6.4 There are differences in the level of satisfaction shown in the patient FFT (see Appendix 1) for Black/ Black British service users, Asian/ Asian British service users, lesbian, gay and bisexual service users and those under 18 using our services. The Board are asked to note this in view of the recently published CQC equality objectives one of which will focus for 2017/18 on how providers ensure person- centred care for lesbian, gay, bisexual and trans people who use adult social care and mental health inpatient services

7. Recommendations

7.1 It is proposed that the information contained in this report is published on the Trust's website as evidence that the Trust is meeting its public sector equality duties.

7.2 The Board are asked to approve the changes to the equality objectives for Forensic services, Durham and Darlington and Teesside at points 3.2.1, 3.2.3 and 3.2.4.

7.3 The Board are asked to note the information at point 6.4.

7.4 It is recommended that further work be undertaken to understand the high level of blanks and not known in most categories on PARIS and to working to support staff to improve the level of data completeness so that we can better understand

APPENDIX 1

RACE AND ETHNICITY

Ethnicity and Year	2013-14	2014-15	2015-16	2016-17	Total Surveys	Overall % 2013-14 to 2016-17
White British - Total % of Excellent and Good Responses	91.7%	91.0%	92.2%	93.1%	34811 (out of 37731)	92.3%
	3740	5981	12130	12960		
White Other - Total % of Excellent and Good Responses	83.7%	97.3%	100.0%	-	74 (out of 82)	90.2%
	36	36	2	0		
Black or Black British - Total % of Excellent and Good Responses	83.3%	68.1%	74.4%	77.4%	279 (out of 369)	75.6%
	20	32	90	137		
Asian or Asian British - Total % of Excellent and Good Responses	87.9%	76.0%	84.7%	86.8%	556 (out of 658)	84.5%
	58	76	211	211		
Mixed Race - Total % of Excellent and Good Responses	89.4%	87.3%	84.6%	89.9%	375 (out of 428)	87.6%
	42	69	121	143		
Other - Total % of Excellent and Good Responses	87.5%	80.4%	80.5%	88.5%	265 (out of 314)	84.4%
	21	37	91	116		
Unknown - Total % of Excellent and Good Responses	83.6%	88.2%	88.3%	90.6%	4068 (out of 4578)	88.9%
	194	945	1419	1510		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	40428 (out of 44160)	

Key:
90% and over
85%-89.9%
Below 85%

GENDER

Gender and Year	2013-14	2014-15	2015-16	2016-17	Total Surveys	Overall % 2013-14 to 2016-17
Male - Total % of Excellent and Good Responses	91.9%	84.6%	92.4%	92.2%	3343 (out of 3654)	91.5%
	237	307	1163	1636		
Female - Total % of Excellent and Good Responses	94.1%	95.2%	96.4%	94.4%	3624 (out of 3807)	95.2%
	269	295	1373	1687		
Other - Total % of Excellent and Good Responses	100.0%	66.7%	66.7%	0.0%	11 (out of 16)	68.8%
	3	4	4	0		
Prefer not to say - Total % of Excellent and Good Responses	83.3%	71.4%	80.0%	50.0%	16 (out of 22)	72.7%
	5	5	4	2		
Unknown - Total % of Excellent and Good Responses	90.8%	90.4%	90.7%	92.3%	33434 (out of 36661)	91.2%
	3597	6565	11520	11752		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	40428 (out of 44160)	

Key:
90% and over
85%-89.9%
Below 85%

AGE GROUP

Age Group and Year	2013-14	2014-15	2015-16	2016-17	Total Surveys	Overall % 2013-14 to 2016-17
Under 18 - Total % of Excellent and Good Responses	100.0%	100.0%	79.7%	70.9%	191 (out of 256)	74.6%
	1	9	59	122		
18-29 - Total % of Excellent and Good Responses	74.4%	76.0%	87.4%	89.5%	769 (out of 892)	86.2%
	58	76	167	468		
30-44 - Total % of Excellent and Good Responses	96.4%	79.1%	84.6%	91.4%	832 (out of 942)	88.3%
	53	87	226	466		
41-50 - Total % of Excellent and Good Responses	93.6%	85.4%	-	-	143 (out of 160)	89.4%
	73	70	0	0		
45-64 - Total % of Excellent and Good Responses	97.0%	91.2%	95.6%	93.8%	1168 (out of 1237)	94.4%
	98	104	390	576		
65 and over - Total % of Excellent and Good Responses	96.1%	98.5%	97.3%	97.2%	3930 (out of 4041)	97.3%
	219	258	1741	1712		
Prefer not to say - Total % of Excellent and Good Responses	100.0%	75.0%	63.6%	25.0%	26 (out of 35)	74.3%
	12	6	7	1		
Unknown - Total % of Excellent and Good Responses	90.8%	90.4%	90.7%	92.2%	33369 (out of 36597)	91.2%
	3597	6566	11474	11732		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	40428 (out of 44160)	

Key:
90% and over


85%-89.9%
Below 85%

DISABILITY

Disability Answer and Year	2013-14	2014-15	2015-16	2016-17	Total Surveys	Overall % 2013-14 to 2016-17
Yes - Total % of Excellent and Good Responses	-	93.7%	94.9%	93.6%	3251 (out of 3455)	94.1%
	0	193	1263	1795		
No - Total % of Excellent and Good Responses	-	92.6%	93.6%	92.5%	2360 (out of 2539)	92.9%
	0	87	991	1282		
Prefer not to say - Total % of Excellent and Good Responses	-	0.0%	59.1%	72.7%	21 (out of 36)	58.3%
	0	0	13	8		
Unknown - Total % of Excellent and Good Responses	91.1%	90.2%	90.9%	92.3%	34796 (out of 38130)	91.3%
	4111	6896	11797	11992		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	40428 (out of 44160)	

Key:
90% and over
85%-89.9%
Below 85%

SEXUAL ORIENTATION

Sexual Orientation and Year	2013-14	2014-15	2015-16	2016-17	Total Surveys	Overall % 2013-14 to 2016-17
Heterosexual - Total % of Excellent and Good Responses	92.3%	91.2%	88.3%	90.9%	12251 (out of 13485)	90.8%
	3319	4327	2420	2185		
Gay - Total % of Excellent and Good Responses	84.5%	80.2%	73.4%	85.0%	227 (out of 281)	80.8%
	60	69	47	51		
Lesbian - Total % of Excellent and Good Responses	74.4%	84.3%	75.0%	81.3%	163 (out of 205)	79.5%
	29	59	36	39		
Bisexual - Total % of Excellent and Good Responses	88.3%	79.5%	80.9%	81.4%	406 (out of 494)	82.2%
	91	105	127	83		
Prefer not to say - Total % of Excellent and Good Responses	86.8%	81.2%	86.1%	82.3%	1642 (out of 1953)	84.1%
	511	474	346	311		
Unknown - Total % of Excellent and Good Responses	87.1%	91.8%	92.6%	93.2%	25739 (out of 27742)	92.8%
	101	2142	11088	12408		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	40428 (out of 44160)	

Key:
90% and over
85%-89.9%
Below 85%

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX B

PUBLICATION OF STAFF EQUALITY DATA

1 APRIL 2016– 31 MARCH 2017

Published 23rd May 2017

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

If you need this information summarised in another language or format such as Braille, talking tape or DVD please call the number below.

Polish:
Jeżeli potrzebujesz streszczenia tych informacji w innym języku lub formacie, np. w Braille'u lub w formie nagrania dźwiękowego, zadzwoń na poniższy numer.

Arabic:
إذا أردت منا تلخيص هذه المعلومات بلغة أخرى أو بصيغة مختلفة مثل لغة بريل أو شريط صوتي أو قرص DVD
يرجى الاتصال برقم الهاتف التالي.

Bengali:
যদি আপনি অন্য একটি ভাষায় এই তথ্যের সংক্ষিপ্তসার চান অথবা ব্রেইল, কথা বলা টেপ অথবা ডি.ভি.ডি. ফরম্যাট-এ এই তথ্য চান, তাহলে অনুগ্রহ করে নিচের নম্বরে টেলিফোন করুন।

Farsi:
در صورتی که مایلید خلاصه این اطلاعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره زیر تماس بگیرید.

Hindi:
यदि आप इस सूचना का सारांश किसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टाकिंग टेप या DVD में चाहते हों, तो कृपया नीचे दिए गए नंबर पर फोन करें।

Kurdish (Kurmanji):
Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈੱਟ ਜਿਵੇਂ ਬ੍ਰੇਲ, ਟਾਕਿੰਗ ਟੇਪ ਜਾਂ DVD ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:
如果您需要该条信息用其他语言或格式概述，例如盲文，录音磁带或 DVD。请联系以下号码：

Urdu:
اگر آپ کو ان معلومات کے خلاصہ کی کسی دیگر زبان یا شکل مثلاً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو برائے مہربانی درج ذیل نمبر پر کال کریں۔

Telephone 0191 3336267

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

PUBLICATION OF EQUALITY DATA

1. INTRODUCTION

1.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to :

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

1.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are gender, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

1.3 The Trust has published information to meet its public sector duties for the last six years.

1.4. The information in this report as far as possible replicates the indicators of the Workforce Race Equality standard (WRES). Additional indicators have been included in the disability section to prepare the trust for the introduction of the Workforce Disability Equality Standard in April 2018. The information relates to staff employed by the trust and contains information from about age, gender, disability, race and sexual orientation for the period 1st April 2016 – 31st March 2017.The information sources are as follows:

- Indicator 1 is data obtained from ESR, the trust's electronic staff rota. VSM in this indicator stands for very senior manager
- Indicator 2 is data pulled from NHS jobs which is the database the trust uses to advertise jobs and to recruit staff
- Indicator 3 has been sourced from detailed records kept throughout the year on disciplinary cases
- Indicator 4, the relative likelihood of staff accessing non mandatory training and CPD has been obtained from responses to a question in the staff friends and family test.
- Indicators 5 – 10 and 5 – 15 in relation to disability come from the national staff survey which this year was sent to all staff.
- Information for the indicator on the make- up of the trust board has been pulled from ESR and shows the percentage difference between the board makeup and that of the trust as a whole by each protected characteristic.

2. AGE:

	Indicator.	Data for reporting year						
	For each of these four workforce indicators, compare the data for Age Groups.							
1.	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)	Band	17-25	26-35	36-45	46-55	56-65	66+
		1-4	6%	18%	20%	34 %	20%	2%
		5-7	6%	25%	25%	31 %	12%	1%
		8 a.b.c.d	0%	13%	36.8 %	42 %	8%	0.2%
		9	0%	0%	0%	67 %	33%	0%
		VSM	0%	0%	12%	76 %	12%	0%
		Medics	0%	17%	36%	37 %	9%	1%
2.	Likelihood of staff being appointed from shortlisting across all posts.	17-24	0.25		45-54	0.22		
		25-34	0.25		55-64	0.21		
		35-44	0.24		65+	0.8		
3.	Likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	17-25	0.0175		46-55	0.0108		
		26-35	0.0139		56-65	0.0140		
		36-45	0.0164		66+	0		
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	It is not possible to provide this information for age.						
	National NHS Staff Survey indicators For each of the four staff survey indicators, compare the outcomes of the responses for each of the age groups.							
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	16-30:31% 31-40: 28% 41-50: 26% 51+: 29%						
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	16-30: 16% 31-40: 15% 41-50: 17% 51+: 19%						
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	16-30: 98% 31-40: 94% 41-50: 94% 51+: 93%						
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	16-30: 6.5% 31-40:3.6% 41-50:4.9% 51+: 5.4%						
9.	KF17. % feeling unwell due to work related stress in the last 12 months.	16-30:27% 31-40:33% 41-50:34%						

		51+:33%
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	16-30:56% 31-40:56% 41-50:59% 51+60%
	Board representation indicator: For this indicator, compare the difference for age groups.	

11. Percentage difference between the organisation's Board voting membership, non-voting membership and NEDs and its overall workforce.

Age	Voting	Non voting	NEDs
17-25	-5%	-5%	-5%
26-35	-20.3%	-20.3%	-20.3%
36-45	-5%	-25%	-25%
46-55	+46%	+16%	-9%
56-65	-15%	+35%	+48%
66+	-0.7%	-0.7%	+11.3%

AGE BREAKDOWN FOR TRUST STAFF

Age Range	17-25	26-35	36-45	46-55	56-65	66+	Grand Total
Number	342	1364	1624	2215	997	47	6589
%	5%	20.3%	25%	34%	15%	0.7%	100

The data on age is complete.

- There are no staff in the 17 – 25 age range in any posts above a band 7.
- Staff aged 36 -45 are over represented in bands 8 and medics.
- Staff aged 46 -55 are over represented in bands 8, 9 and VSMs.

3. **DISABILITY**:

	Indicator.	Data for reporting year		
	For each of these four workforce indicators, compare the data for Disability.			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)	Band	Disabled	Not Disabled
		1-4	9%	91%
		5-7	11%	79%
		8 a.b.c.d	8%	92%
		9	0%	100%
		VSM	0%	100%
		Medics	4%	96%
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	People without a disability are 1.38 times more likely to be appointed from shortlisting compared to those without a disability.		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	Disabled people are 1.17 times more likely to enter the disciplinary process than those without a disability.		
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses to Q4 staff FFT).	Staff who are not disabled are 1.16 times more likely to access non- mandatory training and CPD compared to disabled staff.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for disability/non disability.			
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Disabled: 35% Not disabled:27%		
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	Disabled: 24% Not disabled: 16%		
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	Disabled: 90% Not disabled: 95%		
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	Disabled: 10% Not disabled: 3%		
9.	KF17. % feeling unwell due to work related stress in the last 12 months	Disabled: 49% Not disabled: 29%		
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure e) Have you felt pressure from your manager to come to work?	Disabled: 77% Not disabled: 53% Disabled: 24% Not disabled: 17%		

11	Q5f: How satisfied are you with each of the following aspects of your job: f) the extent to which my organisation values my work	Disabled: 43% Not disabled: 55%
12	Q20f (Appraisal): Were any training, learning or development needs identified	Disabled: 74% Not disabled: 76%
13	Q20g (Appraisal): Did your manager support you to receive this learning and development	Disabled: 57% Not disabled: 64%
14	Q20b Did your appraisal help you improve how you did your job?	Disabled: 23% Not disabled: 36%
15	Q27b (Reasonable adjustment): Has your employer made adequate adjustments to enable you to carry out your work?	Disabled: 84%
	Board representation indicator: For this indicator, compare the difference for disability/non disability.	
16.	Percentage difference between the organisation's Board voting, non- voting and NED membership and its overall workforce.	The percentage difference between the trust board voting, non- voting and NED membership is -8% in all categories

DISABILITY BREAKDOWN FOR TRUST STAFF

Not disabled	Disabled	Grand Total
3888	345	4233
92%	8%	100

2356 staff, 36% have not declared on ESR whether they have a disability or not.

When compared to staff without a disability those who identify as disabled are:

- 1.17 times more likely to enter the disciplinary process than those without a disability
- Experience a higher level of harassment, bullying and abuse from patients, relatives or the public and from staff than those without a disability. They have also experienced more discrimination from managers/team leader or other colleagues.
- Are significantly more likely to have felt unwell due to work related stress in the last 12 months
- Are significantly more likely to have attended work in the last three months despite feeling unwell
- Less satisfied with the the extent to which the organisation values their work
- Felt less supported by their manager to receive training and development identified during appraisal

- Reported significantly less that their appraisal helped them to improve how they did their job.

4. GENDER

	Indicator.	Data for reporting year			
	For each of these four workforce indicators, compare the data for Gender.				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Band	M	F	
		1-4	20%	80%	
		5-7	21%	79%	
		8a.b.c.d	57%	43%	
		9	67%	33%	
		VSM	65%	35%	
		Medics	54%	46%	
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	Men are 1.04 times more likely to be appointed from shortlisting compared to women.			
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	Men are 2.15 times more likely to enter the disciplinary process than woman.			
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses to Q4 staff FFT).	Women are 1.04 times more likely to access non- mandatory training and CPD compared to men.			
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for male/female.				
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Male: 31% Female: 28%			
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	Male: 14% Female: 18%			
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	Male: 90% Female: 95%			
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	Male 5.1% Female 5%			
9.	KF17. % feeling unwell due to work related stress in the last 12 months**.**	Male: 32% Female: 33%			
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	Male 55% Female 60%			
	Board representation indicator: For this indicator, compare the difference for male/female.				
11.	Percentage difference between the organisation's Board voting, non- voting and NED membership and its overall workforce.	Gender	Voting	Non Voting	NEDs
		Male	+57%	+25%	+52%
		Female	-57%	-27%	-52%

GENDER BREAKDOWN FOR TRUST STAFF

Female	Male	Grand Total
5094	1495	6589
77%	23%	100

The data on age is complete.

- Men are overrepresented in bands 8, 9, VSM and medics when compared to the overall staff makeup.
- Men are 2.15 times more likely to enter the disciplinary process than women

5. RACE/ETHNICITY:

	Indicator.	Data for reporting year		
	For each of these four workforce indicators, compare the data for White and BME staff.			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)	Band	White	BAME
		1-4	98%	2%
		5-7	97%	3%
		8 a.b.c.d.	97%	3%
		9	100%	0%
		VSM	100%	0%
		Medics	60%	40%
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.32 times more likely to be appointed from shortlisting compared to BAME staff.		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	BAME people are 2.55 times more likely to enter the disciplinary process than white people.		
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses in Q4 FFT)	White staff are 1.17 times more likely to access non- mandatory training and CPD compared to BAME staff.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.			
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White:28% BAME: 37%		
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White: 17% BAME: 19%		
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	White: 94% BAME: 94%		
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	White: 5% BAME: 3%		
9.	KF17. % feeling unwell due to work related stress in the last 12 months**.**	White: 33% BAME: 26%		
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	White: 60% BAME: 41%		
	Board representation indicator: For this indicator, compare the difference for White and BME staff.			
11.	Percentage difference between the organisation's Board voting, non- voting	Percentage difference between the organisation's Board voting, non-		

	and NED membership and its overall workforce.	voting and NED membership is -4%

RACE/ETHNICITY BREAKDOWN FOR TRUST STAFF

White (including Medics)	BAME (including Medics)	White (excluding Medics)	BAME (excluding Medics)	Grand Total
6269	272	6107	165	6585
96%	4%	98%	2%	100

The data for 44 people, 0.7%, is not available.

- BAME staff are underrepresented in bands 1-4 and 5- 7 when compared to the percentage of BAME staff in the overall workforce.
- BAME staff are significantly overrepresented in the medical staff.
- BAME staff are 2.55 times more likely to enter the disciplinary process than white staff
- More BAME staff than white staff have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- Less BAME staff than white staff have felt unwell due to work related stress in the last 12 months.
- Less BAME staff than white staff have attended work in the last 3 months despite feeling unwell.
- Apart from Medical staff there are low numbers of BAME staff employed by the trust.

A number of actions have already begun to address some of the issues highlighted by this data. These include:

- A review of recruitment decisions where shortlisted BAME job applicants were not appointed to posts during the last 12 months.
- A review of disciplinary cases involving BAME staff during the last twelve.
- The development of a TEWV BAME leadership and management programme for bands 5-7.Work is being carried out to support senior TEWV doctors to prepare for potential board level positions in the future,
- To develop a TEWV Bullying and Harassment Reporting and Resolution Procedure

6. SEXUAL ORIENTATION:

	Indicator.	Data for reporting year		
	For each of these four workforce indicators, compare the data for Heterosexual/Lesbian/gay/bisexual			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members).	Band	Heterosexual	LGB
		1-4	98%	2%
		5-7	97%	3%
		8 a.b.c.d.	98%	2%
		9	100%	0%
		VSM	92%	8%
		Medics	97%	3%
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	LGB people are 1.04 times more likely to be appointed from shortlisting compared to heterosexual people		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	LGB people are 5.62 times more likely to enter the disciplinary process than heterosexual people. It should be noted that fewer than 5 of the total number of people in the disciplinary process identified as LGB and for 16% of staff data on sexual orientation is not available so great caution must be applied to this data.		
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses to Q4 staff FFT).	Heterosexual staff are 1.11 times more likely to access non- mandatory training and CPD compared to LGB staff.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for each of heterosexual/lesbian/gay/bisexual.			
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Heterosexual: 28% Lesbian, Gay and Bisexual: 32%		
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	Heterosexual: 17% Lesbian, Gay and Bisexual: 20%		
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	Heterosexual: 94% Lesbian, Gay and Bisexual: 90%		
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	Heterosexual: 5% Lesbian, Gay and Bisexual: 3%		
9.	KF17. % feeling unwell due to work related stress in the last 12 months.	Heterosexual: 31% Lesbian, Gay and Bisexual 46%		
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	Heterosexual: 64% Lesbian, Gay and Bisexual 69%		
	Board representation indicator: For this indicator, compare the difference for			

	heterosexual/lesbian/gay/bisexual.	
11.	Percentage difference between the organisations' Board voting membership and its overall workforce.	Percentage difference between the organisations' Board voting membership and its overall workforce is -2%

SEXUAL ORIENTATION BREAKDOWN FOR TRUST STAFF

Heterosexual	LGB	Grand Total
5360	142	6587
98%	2%	100%

The data on sexual orientation for 1085 staff, 16% is not available.

When compared to heterosexual staff, LGB staff are

- 5.62 times more likely to enter the disciplinary process, however it should be noted that under 5 of the total number of people in the disciplinary process identified as LGB and for 16% of staff data on sexual orientation is not available so great caution must be applied to this data.
- More likely to feel unwell due to work related stress in the last 12 months.

7. CONCLUSIONS

7.1 There are clear differences in some of the metrics for staff from protected groups.

7.2 Research is to be undertaken in the trust amongst BAME, disabled and LGB staff to understand, from their perspective the causes behind some of the differences in the national staff survey results and some of the other metrics in this report. Following the analysis of this research an action plan is to be drafted to go to BOD in November 2017.

7.3 Amongst the benefits of addressing these are:

- Organisations that treat their staff fairly, listen to them and develop their talent to the full, are ones that provide better care for all patients.
- Developing a more inclusive workplace can produce considerable benefits for all staff, for organisational finances and productivity,

7.4 The Audit Commission report ' The Journey to Race Equality', the principles of which can be applied to all protected groups, emphasised the importance of leadership at all levels of the organisation, especially at trust board level, in prioritising equality, setting the culture, raising expectations, increasing accountability and following through with action.

8. RECOMMENDATIONS

8.1 It is proposed that the information contained in this report is published on the Trust's website as evidence that the Trust is meeting its public sector equality duties.

8.2 The Board is asked to note the differences in experience and outcome for staff from protected groups and to support the actions outlined in 7.2 and to support the development of further actions.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX C

WORKFORCE RACE EQUALITY STANDARD

2016/2017

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

1. Background narrative

a. Any issues of completeness of data

In relation to Indicator 4 the relative likelihood of BAME staff accessing non- mandatory training and CPD compared to White staff. The Trust does not have a process for monitoring requests or approvals for non- mandatory training and holds no data on this. The trust has included a specific question within its staff friends and family test Staff were asked 'I am able to access job relevant non- mandatory training and /or continuing professional development opportunities.' The calculation in this document has been based on the number of positive responses to this question in q4 16/17. In total 2667 white staff replied to this question and 93 BAME staff.

b. Any matters relating to reliability of comparisons with previous years

The national staff survey was sent to all staff this year. 101 of those completing it identified as BAME which gives the trust much greater confidence in the results compared to last year when there were very few BAME staff included in the survey sample.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

6585

	b. Proportion of BME staff employed within this organisation at the date of the report	
	4%	

	3. Self-reporting a. The proportion of total staff who have self-reported their ethnicity	
	99.3%	
	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity	
	No	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity	
	The level of self – reporting is very high.	
	4. Workforce data	

a. What period does the organisation's workforce data refer to?	
1st April 2016 to 31st March 2017	

5. Are there any other factors or data which should be taken into consideration in assessing progress?	
6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

WORCEFORCE RACE EQUALITY STANDARD

	Indicator.	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff.				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Detailed staff breakdown Race2.do	1.69% of non-clinical and 4.77% of clinical BAME staff in bands 8-9 & VSM posts compared to overall workforce of 3.91%	The percentage of BAME in the trust is affected by the large numbers of medical staff who are from BAME backgrounds. Very few BAME staff are in bands 8b and above for both clinical and non-clinical staff. For non- clinical staff there are no BAME staff in bands 6 and 7	1. The development of a trust BAME leadership and development programme for bands 5-7. This will be ready to roll out in October 2017 2. See work to be done on improving likelihood of recruitment.
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.32 times more likely to be appointed from shortlisting compared to BAME staff.	White staff are 1.43 more likely to be appointed from shortlisting compared to BAME staff.	There has been a slight improvement in this indicator however more work is needed.	1. A review of recruitment decisions where shortlisted BAME job applicants were not appointed to posts during the last 12 months. This will be completed by end May 2017. 2. The development of an action plan based on the

					findings of the review. This will be completed by end of September 2017 and presented to BOD in November 2017. .
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from ta two year rolling average of the current year and the previous year.	BAME staff are 2.55 times more likely to enter the disciplinary process than white staff	BAME staff are 2.03 times more Likely of entering the formal disciplinary process compared to White staff	BAME staff are more likely to enter the disciplinary process than white staff. The reasons for this are unclear and work is needed to understand the causes.	1. Undertake root cause analysis of reasons BAME staff have entered formal disciplinary process, identifying any hot spots. This will be completed by end of May 2017 2. Undertake research with BAME staff to seek their views for increased likelihood of them entering disciplinary process. This will be completed by September 2017. 3. Develop action plan to address this. This will be completed by end of September 2017 and presented to BOD in November 2017. .
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	The likelihood of white staff accessing non-mandatory training and CPD is 0.34 compared to 0.29 for BAME staff. The relative likelihood of	The likelihood of White staff accessing CPD and non- mandatory training is 0.86 compared to 1 for BAME staff. are 0.86 times compared to 1 for	This year information for this indicator has been pulled from a response to a question in the staff FFT as the trust has no other way of recording this	1.Research is being undertaken with BAME staff which will seek their views on the likelihood of them accessing non-mandatory training and

		white staff accessing non- mandatory training and CPD compared to BAME staff is 1.17 so they are more likely to access non- mandatory training and CPD compared to BAME staff.	The relative likelihood of white staff accessing non- mandatory training and CPD compared to BAME staff is 0.86 so white staff are less likely to access non-mandatory training and CPD compared to BAME staff.	information at present.	CPD. This will be completed by September 2017. 2. Develop action plan to address this. This will be completed by end of September 2017 and presented to BOD in November 2017 3.The development of a trust BAME leadership and development programme for bands 5-7. This will be ready to roll out in October 2017.
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White:28% BAME: 37%	White: 20.88% BAME: 27.27%	The difference between the experience of white and BAME staff has remained static. This difference is mirrored in incidents recorded on DATIX. The trust is concerned at the high levels of all staff who experience harassment, bullying or abuse from patients, relatives or the public	1. A review of the publicity around the trust's zero tolerance towards racial abuse will be undertaken to ensure that all units display the relevant signage. This will be completed by September 2017 and reported to BOD in November 2017.
6.	KF 26. Percentage of staff	White: 17%	White: 13.64%	The gap between BAME	Although the difference

	experiencing harassment, bullying or abuse from staff in the last 12 months.	BAME: 19%	BAME: 36.36%	and white staff's experience of bullying, harassment and abuse has greatly decreased since last year. The number of staff completing the staff survey who identify as BAME has increased from 11 to 101.	between BAME and white staff's experience of staff on staff bullying has greatly decreased the trust are still concerned at the level of bullying within the trust and has decided to develop a TEWV Bullying and Harassment Reporting and Resolution Procedure Sept 2017
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	White: 94% BAME: 94%	White: 93.26% BAME: no data	There is no difference in the reported experience of BAME and white staff	No action to be taken in relation to this indicator at present.
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	White: 5% BAME: 3%	White: 5.03% BAME: 0.00%	White staff are more likely to have experienced discrimination at work from manager/ team leader or other colleagues.	No action to be taken in relation to this indicator at present.
	Board representation indicator: For this indicator, compare the difference for White and BME staff.				
9.	Percentage difference between the organisations' Board voting membership and its overall workforce.	Percentage difference between the organisations' BAME Board voting membership, non- voting membership and NEDs and its overall BAME workforce is -4.0%	Percentage difference between the organisations' BAME Board voting membership and its overall BAME workforce is -4.0%	There are no BAME members of the trust board and this has not changed since last year.	The TEWV talent management action plan is to be further amended to incorporate actions to address this issue. It will be presented to the next talent management board in October 2017

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd May 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:	**23rd May 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
300	28.4.17	Agreement in relation to the Roseberry Park PFI scheme	Brent Kilmurray, Chief Operating Officer 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 (October 2015)
Seals Register

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23 May 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:

1 policy that has undergone full review and been rewritten as a policy with supporting procedure:

- CLIN-0029-v4 Management of Substance Misuse on Trust Premises Policy
- CLIN-0029-001-v1 Management of Substance Misuse on Trust Premises Procedure

1 policy that has undergone full review:

- CLIN-0084-v2 Physical Healthcare and Wellbeing Policy (Inpatients and Community)

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 03 May 2017

DATE:	**23 May 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 has undergone full review and require ratification:

CLIN-0029-v4 Management of Substance Misuse on Trust Premises Policy
CLIN-0029-001-v1 Management of Substance Misuse on Trust Premises Procedure

Version 3 of this policy has undergone full review and separated into an overarching policy with separate procedure. The policy discusses the Trust approach to managing substance misuse, identifying the legislation and national guidance. The procedure provides step-by-step provides guidance for managing intoxicated patients/visitors on Trust premises and managing illegal drug use and alcohol use on Trust premises.

CLIN-0084-v2 Physical Healthcare and Wellbeing Policy (Inpatients and Community)

The Physical Healthcare Policy (Inpatients) CLIN-0084-v1 was ratified in September 2015. The primary focus for the Physical Healthcare Project in its first phase was inpatient services, therefore it was agreed that the policy would be reviewed and updated to include the standards for physical healthcare on referral and ongoing monitoring within community services following engagement with community managers and teams.

Updates to the policy include:

- Incorporation of the Physical Healthcare Assessment of Patients Procedure (CLIN-0052-v4) to facilitate easy access for clinicians.
- Completion of a physical health examination has been amended in line with the standard set by the Royal College of Psychiatrists.
- Recovery and Wellbeing section. Experts by Experience were engaged to inform the review and it was identified that the policy could be further developed to include a recovery and wellbeing section to reflect the CHIME recovery principles, linking to the five actions that are important for health and wellbeing. This led to the title change, Physical Health and Wellbeing Policy.
- Compliance to the Mental Health Act Code of Practice 2015.

The Physical Health and Wellbeing Group, including nursing, medical staff and allied healthcare professionals have been consulted with as part of the review.

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 03 May 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.

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