AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 30TH JANUARY 2018 VENUE: THE DURHAM CENTRE, BELMONT INDUSTRIAL ESTATE, DURHAM, DH1 1TN AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meetings of the Board of Directors held on **28th November** and **19th December 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 receive a briefing on key issues in the County Durham and Darlington Locality.	**Patrick Scott to attend**	**Presentation**
Item 7	To receive and note the quarterly report of the Guardian of Safe Working.	**Dr. Julian Whaley to attend**	**Attached**
Item 8	To consider the six monthly "Hard Truths" Nurse Staffing Report.	**EM**	**Attached**
Item 9	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 10	To consider a report on Equality and Diversity including: (a) Progress against the Workforce Race Equality Standard (WRES) Action Plan (b) The revised Equality Delivery System 2 (c) The revised Equality, Diversity and Human Rights Policy	**DL**	**Attached**

Item 11	To consider a report on the Trust's position, including trends for each CCG area, and action being taken to improve performance on the IAPT recovery indicator.	**DB**	**Attached**

Performance (11.30 am)

Item 12	To consider the summary Finance Report as at 31st December 2017.	**DK**	**Attached**
Item 13	To consider the Trust Performance Dashboard as at 31st December 2017.	**SP**	**Attached**

Governance (11.40 am)

Item 14	To consider a report on the Single Oversight Framework.	**PB**	**Attached**
Item 15	To approve the revised Organisational Risk Management Policy.	**PB**	**Attached**

Items for Information (12.00 noon)

Item 16	To receive and note a report on the use of the Trust's seal.	**CM**	**Attached**

Item 17 To note that the next meeting of the Board of Directors will be held on Tuesday **27th February 2018** in the Board Room, West Park Hospital Darlington at 9.30 am.

Confidential Motion (12.05 pm)

Item 19 **The Chairman to move:**

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

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

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

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

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
24th January 2018

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 28TH NOVEMBER 2017 IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. B. Kilmurray, Chief Operating Officer and Deputy Chief Executive
Mr. D. Kendall, Interim Director of Finance and Information
Dr. N. Land, Medical Director
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mrs. M. Booth, Public Governor for Middlesbrough
Mrs. D. Cannings QPM, Public Governor for Hambleton and Richmondshire
Prof. J. Reilly, Clinical Director for Research and Development (minute 17/295 refers)
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Mrs. F. Bainbridge, Involvement and Engagement Officer

Mr. R. Samuels, member of the public

17/289 APOLOGIES FOR ABSENCE

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

17/290 MINUTES

Agreed *– that the public minutes of the last meeting held on 31st October 2017 be approved as a correct record and signed by the Chairman.*

17/291 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

It was noted that:
(1) The consideration of the development of a tool to cover all concerns raised by staff, in accordance with minute 17/62 (28/3/17), had been deferred to April 2018 in view of an improvement event on this matter being held early in the New Year.

(2) It was planned to include comparative information on the levels of bullying, harassment, etc. of BAME staff (minute 17/199 – 20/7/17 refers) in the report to be presented to the Board meeting on 30th January 2018 on the Workforce Race Equality Standard Action Plan.

(3) Further to minute 17/229 (26/9/17), the appointment of Dr. Griffiths as the Deputy Chairman of the Trust was due to be considered by the Council of Governors at its meeting to be held on 30th November 2017.

(4) Mr. Kilmurray had circulated a report to Board Members on the Trust's taxi contracts; however, information on the specific incidents reported by the Guardian of Safe Working to the Board meeting on 31st October 2017 (minute 17/264 refers) remained outstanding.

17/292 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/293 CHAIRMAN'S REPORT

The Chairman reported on the following matters:

(1) Her participation in the recent "Investors in People" assessment.

Mr. Levy reported that:

(a) Staff involvement in the assessment had been greater than expected.
(b) Positive feedback on the organisation of the assessment had been received from the assessor.
(c) The outcome of the assessment was expected to be received in December 2017.

(2) Her attendance at the recent conference for new consultants.

Mrs. Bessant advised that:

(a) In addition to new medical consultants, attendance at the conference had been expanded, this year, to include consultant psychologists and nurse consultants.
(b) The attendees had been very positive about the Trust.

17/294 GOVERNOR ISSUES

No issues were raised.

17/295 RESEARCH AND DEVELOPMENT ANNUAL REPORT 2017

The Board received and noted the Research and Development Annual Report.

Board Members:

(1) Sought clarity on the changes, both locally and nationally, arising from research e.g. the COBRA and REQUOL studies.

Prof. Reilly advised that:

(a) The findings from research fed into NICE guidelines; however, the period between the completion of studies and their impact on clinical practice could be quite lengthy.

(b) The implementation of results locally could be undertaken more quickly but clarity was required on the approach to achieve this.

Mrs. Pickering suggested that it would be useful for the Trustwide IAPT group to have an initial discussion on the implementation of the findings of the COBRA study.

This was supported by the Board.

At the request of the Board, Prof. Reilly also undertook to reflect the implementation and impact of evidence arising from studies in future reports.

(2) Highlighted the benefits of the Annual Report being provided earlier in the year, for example, to support the preparation of the Quality Account.

It was noted that the Annual Report was traditionally presented to the Board's meeting in November but there were no obstacles to providing it earlier in the year.

It was agreed that the business cycle should be changed to bring the report forward to the Board's meeting in May.

Action: Mr. Bellas

(3) Questioned whether there would be opportunities, through the collaboration with the University of York, to undertake research into clinical decision support.

Prof. Reilly advised that a senior lecturer at the University, who had been involved in a number of shared decision programmes, was, at present, in discussions with colleagues in learning disability services on the development of a potential research project in that area.

(4) Sought clarity on the restrictions placed on commercial studies.

In response it was noted that:

(a) There were national governance processes and agreements in place for commercial studies and all research was required to be registered on a national database.

(b) The Trust did not gain financially from undertaking commercial research but, as it was critical for the licensing of drugs, the companies involved tended to resource the trials appropriately. The costs of the trials were, therefore, fully met with a significant contribution to overheads.

(c) It was vital for the companies involved in commercial research to adhere to ethical standards and this was supported by very stringent internal monitoring.

Prof. Reilly undertook to provide Board Members with a paper describing the controls covering commercial studies.

Action: Prof. Reilly

(5) Sought clarity on the ethical implications of undertaking trials involving people who lacked capacity.

Prof. Reilly explained that:

(a) There were stringent rules in the Mental Capacity Act and worldwide standards in relation to this matter.

(b) In general, the involvement of a patient who lacked capacity in research would only be considered where it provided potential benefits for them and would not be countenanced if there were risks of harm.

(c) There were risks that this approach limited research opportunities in areas where a significant number of patients lacked capacity. In these circumstances an assessment would be undertaken on whether there was likely to be a wider benefit from the study and whether the patient would want to help people. These cases were very carefully thought through and robustly scrutinised through internal governance arrangements.

Mr. Murphy reported that the World Mental Health Day event, held by the University of York in partnership with TEWV, on 10th October 2017, had been very exciting particularly the potential application of broader research (e.g. the application of video game technology) to mental health. He considered that the approach the University was taking in drawing together different strands of research was very impressive and that the Trust, as a partner, had helped accelerate this process.

Dr. Land advised that the event had been very well received and, as the partnership with the University was Trustwide, discussions were being held on replicating it elsewhere through roadshows.

The Chairman, on behalf of the Board, thanked Prof. Reilly for his report.

17/296 REPORT OF THE QUALITY ASSURANCE COMMITTEE

Consideration was given to the report of the Quality Assurance Committee (QuAC) including:

(1) The confirmed minutes of its meeting held on 5th October 2017 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 2nd November 2017.

Dr. Griffiths, the Chairman of the Committee, advised that, whilst there had been no specific issues for escalation to the Board, there were continuing concerns about staffing levels in all Localities.

Board Members raised the following matters:

(1) Whether the pressure on the CAMH services at West Lane Hospital was easing.

In response it was noted that:

(a) An influx of recently qualified nurses onto the wards had reduced staffing pressures. There had been some concerns about whether these staff would be overwhelmed but they had swiftly integrated into the teams. The situation would, however, continue to be monitored.

(b) The New Care Model for Tier 4 CAMHS had enabled greater investment in crisis and home treatment services which had led to improvements.

(c) In the business case for the New Care Model it had been recognised that there would be a greater proportion of young people with higher levels of acuity admitted to the wards and the need for additional investment in the services had been anticipated.

(2) Whether the Trust's response to the issue of bullying and harassment of staff, highlighted by the staff survey (minute 17/130 – 23/5/17 refers), would include the concerns identified in the report of the Equality, Diversity and Human Rights Steering Group on the number of incidents where patients had expressed hostile views towards Muslims and that some staff had been repeatedly targeted.

In response:

(a) Mr. Levy assured the Board that the Trust recognised the bullying and harassment of BAME staff and the hostility towards Muslims would not be treated separately to this; however, it was a complex issue.

(b) Mr. Kilmurray considered that a zero tolerance approach should be taken by the Trust and highlighted the importance, in order to raise awareness and improve reporting, of the Trust's security services being involved in the work.

(3) The increase in offender health suicides and the reasons why the police, and not the prison or probation services, had been invited to participate in a Trustwide event on this matter.

Dr. Land explained that:

(a) The increase related to suicides of people charged with child pornography offences.

(b) Those charged might or might not have a mental illness and, in the latter case, there were limits on the actions available to the Trust.

(c) Offender health services were undertaking significant work, together with the Police, to seek to reduce the number of incidents.

(d) Discussions were also being held with the University of York on undertaking research into this matter.

The Board noted that, whilst a national phenomenon, the Trust was one of the few trusts engaging in work in this area and the increase in suicides would be reflected in the number of reportable serious incidents.

The Non-Executive Directors also highlighted the detrimental impact of these incidents on Trust staff even though they were only likely to have been in contact with the people for a short period.

In addition, Mrs. Pickering advised that the Quarter 2, 2017/18, Quality Account Update Report, presented to the meeting of the Committee on 2nd November 2017, had been circulated to stakeholders and the Trust had been invited to attend meetings of a number of Health Overview and Scrutiny Committees to discuss its contents.

17/297 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

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

Arising from the report:

(1) Clarity was sought on whether, in view of the growth in the number of exceptions listed in section 3.4 of the report, there was more of a sense of causal links between safe staffing levels and the quality metrics.

In response it was noted that:

(a) Whilst recognising the list of exceptions had grown, it had still not been possible to identify causal links.

(b) Issues had been identified in some areas and action was being taken to address them.

(c) The increase was also attributed to improvements in the identification of issues and, in some cases, individual patients were responsible for a number of the reported exceptions.

(2) Further information was sought on the difficulties being experienced with the new agency provider.

Mr. Levy advised that:

(a) Problems experienced included the pace of response to requests from wards, with a consequential impact on fill rates, and late payments to the staff which created risks that they might not be willing to work for the Trust in the future.

(b) In response, an improvement plan had been agreed with the provider and the company had been informed that action would be taken under the contract if it failed to resolve the issues.

The Non-Executive Directors asked for an update on this matter to be provided to the Board meeting to be held on 30th January 2018.

Action: Mr. Levy

(3) In response to a question it was noted that staff breaks during shifts were those taken in accordance with the Working Time Directive and were unpaid.

(4) The Non-Executive Directors asked for information on those wards which were not regularly meeting their fill rates to be highlighted in the report on the establishment review which was due to be presented to the Board meeting to be held on 19th December 2017.

Action: Mrs. Moody

17/298 LEARNING FROM DEATHS REPORT

The Board received and noted the Learning from Deaths Report.

The Board noted that:
(1) The report was presented in accordance with the 'Learning from Deaths Framework' published by the National Quality Board in 2017.
(2) As the first report on this matter, it provided details of the approach being taken on the identification, categorisation and investigation of deaths together with an initial draft of a mortality dashboard (Appendix 1 to the covering report).

The Chairman and Mrs. Richardson, who had both contributed to the development of the Trust's approach to reporting, advised that:
(1) The report provided assurance that deaths were being reviewed; reporting on them was being developed; and learning was taking place.
(2) Reporting was difficult due to the vague nature of the national guidance; however, through working with eight other mental health trusts in the North of England, there was some confidence that the approach being taken was appropriate.
(3) The preparation of the report had highlighted issues with the timeliness of notifications about the deaths of service users cared for in the community where the Trust often had minimal contact with them.
(4) Although the number of deaths was gradually increasing (albeit that the number of deaths within the scope of the policy was small) there was now greater confidence in the data.
(5) A significant issue identified was that the national learning disabilities mortality review process, through the LeDer programme, was not working effectively with long delays and a lack of information when reviews had been completed. It was considered that the implications of this for learning from deaths needed to be raised nationally.
(6) As the first iteration of the report it was recognised that there were gaps and areas for development. Comments were being sought at this stage to support the further refinement of reporting prior to the presentation of the next report to the Board at its meeting to be held on 27th February 2018.

Board Members:
(1) Whilst recognising the challenges arising from the data, welcomed the report.
(2) Asked for the age profile of those people who had died to be included in future reports.

Action: Mrs. Moody

(3) Discussed the difficulties in understanding and gaining assurance from the data included in the dashboard (e.g. the relationship between those deaths identified as being in the scope of the policy and the number of deaths reviewed).

The Board noted that the difficulties in interpreting the data arose from:

(a) The lack of specificity in the national guidance. This had led to the Trust developing its own scope (i.e. those service users on the CPA); however it was recognised that this would be refined over time.

(b) Not all deaths within the scope of the policy requiring a formal review.

It was suggested that, to aid transparency, it would be helpful to consider including the following matters in future reports:

(a) A "question and answer" section (possibly as an appendix to the report) to support understanding of the scope of those deaths within policy and the triggers for the different types of review.

(b) A formal statement on the scope of the policy and to provide assurance that all relevant deaths had been reviewed.

Action: Mrs. Moody

(4) Expressed their frustrations with the LeDer programme as the present arrangements undermined learning from deaths; the point of the national guidance.

It was considered that the issues being experienced should be reported to the National Quality Board.

Action: Mrs. Moody

The Chairman also observed that it was difficult to understand why the NHS was not routinely informed of deaths in the same way as other statutory agencies.

17/299 MENTAL HEALTH LEGISLATION COMMITTEE

Further to minute 17/269 (31/10/17) the Board received and noted the report of the Mental Health Legislation Committee including:

(1) The confirmed minutes of its meeting held on 13th July 2017 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 19th October 2017.

Mr. Simpson, the Chairman of the Committee, highlighted the following matters:

(1) That a report on the impact of changes to section 136 of the MHA, under the Police and Crime Act 2017, was due to be presented to the Committee at its meeting to be held on 18th January 2018.

(2) The concerns about the interpretation and application of Deprivation of Liberty Safeguards (DOLS) by local authorities which had been escalated to the Board at its meeting held on 31st October 2017 (minute 17/269 refers).

Mr. Martin confirmed that he had personally dealt with this matter.

(3) The discussions on the revised Human Rights, Equality and Diversity Policy.

The Board noted that issues with the governance arrangements for oversight of the associated action plan had been referred to the Equality, Diversity and Human Rights Steering Group.

(4) The workshop on the future operational arrangements of the Committee, with the aim of improving the assurances it was able to provide to the Board, which had been very positive.

It was noted that the outcomes of the workshop would be included in the present review of the operational arrangements of the Board's Committees.

Action: Mr. Bellas

(5) The introduction of patient case studies in relation to seclusion, at the suggestion of the Non-Executive Directors, which had been welcomed.

17/300 COMPOSITE STAFF ACTION PLAN

Further to minute 17/130 (23/5/17) the Board received and noted a progress report on the Composite Staff Action Plan.

Mr. Levy paid tribute to the support provided by the IIP leads during the recent Investors in People assessment and for promoting action planning in their localities.

Board Members:

(1) Asked for the Local Action Plans to be amended to identify the relevant Locality as it would be useful and interesting for them to be aware of the themes when undertaking Directors' visits.

Action: Mr. Levy

(2) Considered that the frequency of the national staff surveys limited the Trust's ability to undertake its own research, due to risks of survey fatigue, and asked Mr. Levy to make representations to NHS England on this matter.

Action: Mr. Levy

Agreed – *that a report be presented to the Board meeting to be held in May 2018 in relation to the progress made with the completion of the 2017/18 action plan and to consider a proposed 2018/19 action plan.*

Action: Mr. Levy

17/301 RECRUITMENT AND RETENTION ACTION PLAN

Further to minute 17/128 (23/5/17) the Board received and noted a progress report on the Recruitment and Retention Action Plan.

Arising from the report, the Board:

(1) Supported the proposal to focus more on staff retention, in future, as it was recognised that there were limits to the actions available to the Trust on recruitment.

In response to questions on this matter, Mr. Levy advised that:

(a) The variations between Localities on staff retention were not as expected e.g. the Tees Locality had a high staff turnover rate.

(b) The staff turnover rate did not include internal transfers.

(c) One area being examined was a staff transfer scheme to seek to provide a more proportionate process for staff moving to other positions within the Trust on the same pay band.

(2) Sought clarity on the number of staff on temporary contracts in view of the previous decision that only permanent appointments should be made.

It was noted that the number of staff on temporary contracts had reduced from 5%-6% to approximately 1%-2%.

The Chairman asked for a report to be provided to the Board on the fixed term contracts presently in place including how they were being used and for which staff groups.

Action: Mr. Levy

(3) Questioned whether the issues with exit interviews (as discussed under minute 17/128) had been addressed.

Mr. Levy confirmed that improvements had been made to the process for undertaking exit interviews with nurses but that further work was still required for other staff groups. Whilst recognising the importance of this issue, he advised that the pace of improvement would depend on capacity.

At the suggestion of the Non-Executive Directors, Mr. Levy considered that the use of appreciative inquiry to seek to understand the reasons for staff remaining with the Trust would be useful but taking this matter forward would again depend on capacity.

(4) Sought clarity on the trends in relation to the Trust's employment of nationals of other EU states.

The Board noted that approximately 100 staff, who were nationals of other EU states, were employed by the Trust including approximately 10% of the Trust's consultants. Evidence to date was that the number employed had remained relatively consistent since the EU referendum; however, feedback had been received that the number of Trust grade doctors might reduce in the future and that present staff might be considering leaving the UK.

It was noted that:

(a) There was evidence of an increase in negative behaviour towards the staff from patients and members of the public.
(b) The Trust had distributed a note to the staff, asking them to stay, following the EU referendum which had been positively received by them.
(c) Consideration would be given to whether to circulate a further communication to the staff following the publication of the workforce strategy by the Department of Health as it was hoped that the document would include positive statements of support for the continuing employment of EU nationals in the NHS.

Action: Mr. Martin

Agreed *– that a further progress report on the implementation of the Recruitment and Retention Action Plan be presented to the Board at its meeting to be held in May 2018.*

Action: Mr. Levy

17/302 EARLSTON HOUSE

Further to minute 16/C/271 (25/10/17) consideration was given to a proposal to permanently close Earlston House, Darlington.

The Board noted that the outcome of the engagement process with stakeholders, as detailed in the report, was that both the Darlington and County Durham Health Overview and Scrutiny Committees (OSCs) had not raised any issues or concerns with the proposal and the Commissioners had provided their formal support to the closure of the facility.

At the suggestion of the Non-Executive Directors the recommendations contained in the report were amended to also include the disposal of the property.

The Non-Executive Directors, noting the issues raised by the service in the evaluation report (Appendix 1 to the covering report) in relation to a small number of complex high risk individuals who remained on Willow Ward but did not meet the rehab profile, sought clarity on the timescale for resolving their ongoing care needs as this could take some time and impact on the operation of the rehabilitation model.

Mr. Kilmurray responded that it was not possible to provide timescales but, whilst recognising that the availability of the beds would help the operation of the model, it had been 18 months since the temporary closure of Earlston House and the service was managing demand within the 15 beds on Willow Ward.

Agreed *–*

(1) that Earlston House, Darlington be permanently closed; and

Action: Mr. Brown

(2) that the disposal of the property be approved.

Action: Mr. Kendall

17/303 DIGITAL TRANSFORMATION STRATEGY

On the recommendation of the Resources Committee, consideration was given to the approval of the Digital Transformation Strategy.

Agreed – *that the Digital Transformation Strategy (April 2017 – March 2020) be approved.*

Action: Mr. Kendall

17/304 FINANCE REPORT AS AT 31ST OCTOBER 2017

The Board received and noted the Finance Report as at 31st October 2017.

The Board's discussions focussed on the delivery of CRES taking into account the position as at 30th September 2017 and the plans to seek to ensure the delivery of the Trust's financial plan for 2017/18 as discussed at its meeting held on 31st October 2017 (minute 17/C/284 refers).

Mr. Martin advised that:

(1) The difficulties being experienced in delivering CRES had been highlighted at the October Business Planning event and further discussions on these matters would be held during the Board session in January 2018 and through the budget setting process.
(2) He was concerned about the Trust's forecast shortfall on CRES of £3m for the current financial year (compared to £2m in the preceding year).
(3) The Trust had developed a mitigation plan for 2017/18 but there was significant work to be undertaken.
(4) In delivering the mitigation plan and developing its CRES plans for future years the Trust was not prepared to compromise on the quality impact of schemes.
(5) It was clear that, taking into account the recent Budget announcement, the Trust was facing the most challenging financial picture in its history.

The Chairman considered that, in the circumstances, it was imperative for the Board to continue its oversight of the Trust's financial position both at the Board's Business Planning event in January and, if necessary, at a Board seminar.

Action: Mr. Martin

17/305 PERFORMANCE DASHBOARD REPORT AS AT OCTOBER 2017

The Board received and noted the Performance Dashboard Report as at 31st October 2017.

Mrs. Pickering reported that following a review by the Executive Management Team, in accordance with minute 17/227 (26/9/17), it was proposed that no changes should be made to the dashboard targets and, furthermore, no further reviews of the targets should be undertaken during 2017/18 unless there were good reasons to do so (e.g. new indicators or issues with the baselines).

This was agreed.

Arising from the report Board Members discussed:

(1) The position on KPI 6 ("Number of instances of patients who have had 3 or more admissions in a year")

It was noted that:

(a) Performance against the KPI had improved for the first time since the beginning of the year in October 2017; however, it continued to be worse than target and there was no assurance, at this time, that the improvement would be sustained.

(b) Feedback had been received from services that it was clinically appropriate for many of the patients to have been admitted three or more times due to their complexity.
(c) A report on the position in the County Durham and Darlington Directorate was due to be presented to the Board at its meeting on 30th January 2018 in accordance with minute 17/271 (31/10/17).

(2) The implications of the significant increase in referrals, particularly in CAMHS, resulting in the highest number received in a month in the past three years.

Mrs. Pickering advised that:
(a) The increase in referrals could impact on waiting times and, depending on the conversion rate, treatment times.
(b) Further work was needed to understand whether the increase reflected a blip or some more underlying issues.
(c) Only the York and Selby Locality had not seen an increase in referrals.

It was noted that an update report on waiting times in CAMHS was due to be presented to the Board meeting on 19th December 2017.

(3) The outcome of the event in November 2017 in relation to sickness absence and whether further action could be taken to support the health and well-being of staff.

Mr. Levy reported that the meeting, which had been held to inform an event planned for the New Year, had provided greater understanding of the experiences of services.

He advised that a briefing would be provided to the Board on this matter at a future meeting.

Action: Mr. Levy

(4) The position on the take up of flu vaccinations by staff.

In response to questions Mr. Levy advised that:
(a) The present position, at 55% of staff, represented an increase of 6% on the same period in 2016/17; however, the Trust was in the bottom quartile for trusts in the North of England.
(b) The provision of vaccinations would continue, albeit at a lower rate than previously, as there was evidence that there was still demand from staff.
(c) The number of Trust locations, together with “hearts and minds” issues, appeared to have had an impact on the take up rate.
(d) Staff were being asked to confirm whether or not they had received a flu vaccination (e.g. from their GP) and this information would be used to improve take up.
(e) The Trust had looked into the provision of flu vaccinations by pharmacists. This had not been taken forward due to technical issues but would be reconsidered in the future.

(f) The benefits of having a flu vaccination in the context of patient safety had been emphasised in communications.

Board Members considered that it was unacceptable for staff not to receive a flu vaccination and discussed the options available, including in relation to terms and conditions of employment, to improve take up rates.

17/306 PERFORMANCE DASHBOARD FOR 2018/19

Further to discussions at the Board Business Planning Event in October 2017, consideration was given to the key performance indicators to feature in the Performance Dashboard for 2018/19 as set out in Appendix A to the covering report.

In response to questions, Mrs. Pickering:

(1) Confirmed that the development of proposed KPIs 6 and 7 (outcome measures) was linked to clusters and not necessarily to payment mechanisms.

(2) Advised that the proposal to remove the KPI "Percentage of clinic appointments cancelled by the Trust" from the Dashboard was due to difficulties in collecting data and it being limited, at present, to appointments in clinics.

It was noted that the Board might wish to consider reinstating the indicator in 2019/20 following the roll out of electronic staff diaries in the preceding year.

Agreed – *that the KPIs recommended for inclusion in the Trust Performance Dashboard for 2018/19 (as set out in Appendix A to the report) be approved.*

Action: Mrs. Pickering

17/307 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report for Quarter 2, 2017/18 including proposals to approve changes to the Trust Business Plan (as set out in Appendix 1 to the covering report).

Further to the publication of the report, it was noted that the 13 action points on action plans outstanding for more than 31 days (KPI 7) had now been addressed.

Board Members:

(1) Considered that the positive qualitative intelligence contained in the report balanced the mixed picture provided by the performance metrics.

(2) Questioned whether the graph "Strategic Direction Scorecard Metric Scoring" demonstrated a "general improving trend in the percentage of greens since 2013/14" as stated in the report.

Mrs. Pickering undertook to review this matter.

Action: Mrs. Pickering

(3) Considered that, at some future point, it would be useful to receive assurance that the action points from action plans under KPI 7 had been acted upon and changes had been implemented.

The Board noted that improvements had been made to the oversight of the implementation of action plans and it was hoped that the position against the indicator would improve in the future.

(4) Questioned whether there was a correlation between the position on KPI 3 ("Percentage of patients reporting 'yes always' to the question 'did you feel safe on the ward?'") and staffing issues.

The Chairman asked for a report to be presented to the Board on the thematic review on this matter being undertaken by the patient safety team.

Action: Mrs. Moody

Agreed – *that the changes to the Trust Business Plan (as set out in Appendix 1 to the report) be approved.*

Action: Mrs. Pickering

17/308 USE OF THE TRUST SEAL

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

17/309 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.

It was noted, contrary to the statement in the report, that the Executive Management Team had not approved a Printing Policy.

17/310 DATE OF NEXT MEETING

It was noted that a special meeting of the Board of Directors was due to be held (in conjunction with a seminar) at 9.30 am on Tuesday 19th December 2017 in the Board Room, West Park Hospital, Darlington.

17/311 CONFIDENTIAL MOTION

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

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 12.55 pm.

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 19TH DECEMBER 2017 IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. B. Kilmurray, Deputy Chief Executive
Dr. N. Land, Medical Director
Mrs. E. Moody, Director of Nursing and Governance
Mr. D. Brown, Acting Chief Operating Officer (non-voting)
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mr. P. Bellas, Trust Secretary

17/323 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. D. Jennings, Non-Executive Director, Mr. R. Simpson, Non-Executive Director and Mr. D. Kendall, Interim Director of Finance and Information.

17/324 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/325 CHAIRMAN'S REPORT

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

(1) Presenting a "Living the Values" award to the CAMHS crisis and home treatment team in Harrogate.

Mrs. Bessant reported on the improvements in the morale of the team since her last visit and the pride of team members in their work.

(2) Participating in the appointment of the Trust's new Medical Director.

The Board noted that Dr. Ahmad Khouja had been appointed and was due to take up the position in April 2018 following the retirement of Dr. Land.

(3) Attending a recent meeting of the Chairmen of NHS Foundation Trusts in the North East region.

Mrs. Bessant reported on the discussions at the meeting concerning the process for the appointment of the Chairman and Chief Executive of the STP and deficiencies in communications within the group.

17/326 GOVERNOR ISSUES

No issues were raised.

17/327 SAFE STAFFING ESTABLISHMENT REVIEW

The Board received and noted a report on the progress of the inpatient establishment review which had commenced in early 2017 in line with National Quality Board (NQB) Safe Staffing Guidance (2016).

The report, which described the work on the initial establishment reviews, also suggested that the Trust would benefit from further assessment and analysis to manage and address ward based establishments based on the phased approach set out in the section 5 of the report. This matter was due to be further considered by the Executive Management Team (EMT) in January 2018 with the outcome of the discussions reported to the Board in either February or March 2018. Once agreed, it was envisaged that oversight of the approach would be provided by the Safe Staffing Programme Board.

The Board discussed the following matters:

(1) The methodology underpinning the establishment reviews.

The Non-Executive Directors, noting the caveats on the use of the Hurst Tool, welcomed the greater objectivity provided to the establishment reviews through the professional judgement approach and benchmarking with peers via the Care Hours Per Patient Day (CHPPD) data analysis. However, it was considered that there would be benefits, in subsequent phases, from taking a broader perspective focussing on multidisciplinary working.

Mrs. Moody advised that:

(a) No tool, at present, provided a quantitative assessment of multidisciplinary working.
(b) The Trust had sought to include the contribution of AHPs in the review through the CHPPD data analysis but this was limited to those staff included on the ward rosters and excluded “pooled” staffing resources.
(c) The impact of multi-disciplinary working would, therefore, also be considered through the professional judgement discussions.

It was also noted that the findings of the review had been fed back, nationally, so that they could be taken into account in the next iteration of the Hurst Tool.

(2) The extent to which the findings of the establishment reviews validated the safe staffing data.

Mrs. Moody considered that the safe staffing data provided assurance that the Trust's staffing levels were safe; however, the findings of the establishment reviews highlighted areas for potential improvements to quality.

(3) The staffing levels in forensic services where the ratio of registered nurses to HCAs was 33%:67% against that of 58%:42% recommended by Hurst.

It was considered that the staffing levels in the services should be reviewed and validated through the model wards programme.

(4) The purchase of "Safecare", an additional software module to the Health Roster system, which provided daily assessments of staffing levels and requirements using the Hurst Tool.

Mrs. Moody advised that:

(a) The Trust would be visiting Sheffield Health and Social Care NHS Foundation Trust, who used the module, as part of the assessment of the software.

(b) The module had the potential to support the validation of safe staffing data; improve data collection; and, on a day to day basis, provide greater analysis and overview of staffing.

(5) The investments (i.e. the duty nurse system and increased provision to meet identified need in the PICUs) in response to the establishment reviews.

The Non-Executive Directors considered that the assurances provided by the investments in staffing were useful.

(6) The variations in patient care between wards having similar staffing levels.

Dr. Land considered that variations in patient care between wards providing the same services and with similar staffing levels needed to be examined. From his visits to services, it was apparent that the differences between wards could be partly explained by the provision of occupational therapists (OTs). He, therefore, believed that investment in these staff should be considered as part of the review.

In response Mrs. Moody drew attention to:

(a) The common themes arising from the professional judgement discussions, as summarised in Appendix 2 to the report, which highlighted the benefits of increasing OT and administrative support in some services.

(b) The next phase of the review, summarised in section 5 to the report, which would focus on the levelling out of staffing resources taking into account the broader range of roles required to deliver the clinical pathways.

Dr. Land suggested that it would be beneficial, as part of this work, to consider how to make any investment in staffing resources dynamic in order to make the greatest improvements to quality.

(7) The feedback from the professional judgement discussions on the 12 hour shift system.

The Chairman asked for a report to be provided on the outcome of the review of this matter.

Action: Mr. Levy

Agreed – *that the phased approach to the implementation of the establishment reviews, the proposed timelines for the phases and the further actions set out in section 5 of the report, be approved.*

Action: Mrs. Moody

17/328 REPORT OF THE QUALITY ASSURANCE COMMITTEE

Dr. Griffiths, the Chairman of the Quality Assurance Committee, highlighted the following matters which had been escalated to the Board from the meeting of the Committee held on 7th December 2017:

(1) The re-audit of emergency response bags.

The Board noted that:

(a) The re-audit of emergency response bags had been undertaken following concerns arising from an audit in February 2017.
(b) The findings of the re-audit had been disappointing; however, it had been undertaken in a more rigorous way.
(c) A further audit had been undertaken of those wards found not to be compliant from the re-audit and all now met the required standards.
(d) In view of the findings of the re-audit, a further review of 50% of those wards confirmed as compliant would be undertaken in January 2018 and the results of this exercise would be used to determine the programme of monthly monitoring going forward.
(e) A report on the outcome of the review was due to be provided to the Quality Assurance Committee at its meeting to be held on 8th February 2018.

(2) Concerns about core trainee recruitment.

Dr. Land reported that:

(a) In the present round only 20% of vacancies for core trainees had been recruited to nationally.
(b) There had been 30 vacancies, including maternity leave, within the Trust's core trainee schemes; however, following action to fill the gaps, it was now believed that the number had reduced to 15 (which compared to 10 vacancies in each of the preceding three years).
(c) York and Selby Locality provided the greatest concerns as there were 11 vacancies.

(d) One of the reasons for the present position was the success of the Trust in supporting the core trainees with 13 of them now having passed their examinations and moved onto the higher training scheme.

17/329 CAMHS WAITING TIMES

Further to minute 17/193 (20/7/17), the Board received and noted an update report on waiting times within Child and Adolescent Mental Health Services (CAMHS).

The improvements in performance were recognised with (for October/November 2017) initial assessments being provided within 4 weeks of referral for 99% of young people in the County Durham and Darlington and Tees Localities; 95% in the North Yorkshire Locality; and 93% in the York and Selby Locality.

The Board's discussions focussed on the long waiting times for Autism Spectrum Disorder (ASD) assessments noting the significant increases in referrals; the lack of resources; and the complexity of the pathways involving multi-agency and multi-professional approaches.

Questions were raised about the extent to which the CCGs, who were ultimately responsible for the services, were aware of the issues.

Based on his conversations with the Chief Officers of each of the CCGs, Mr. Martin considered that there was a general tendency for commissioners, erroneously, to view the provision of ASD assessments as being solely the responsibility of the Trust.

It was also noted that waiting times for assessments were being increasingly raised in complaints with local MPs and in the national media.

In view of the significant reputational risks for the Trust, the Chairman considered that it would be beneficial for a briefing document to be produced for MPs and partners in order to improve understanding and awareness of the issues; to galvanise action; and to support them influence national policy.

Board Members supported this approach but highlighted that:

(1) Information on activity levels and resourcing in CAMHS, generally, should be included in the document to counter the potential misunderstanding that ASD waiting times could be addressed through shifting resources.

(2) The Trust needed to be careful that, in producing the document, it did not reinforce the often misheld view that it was fully accountable for the provision of the assessments and obscure the responsibilities of other organisations and the impact of service reductions made by them.

It was suggested that a flowchart could be used to highlight the responsibilities of each organisation.

(3) It might be useful for the document to raise awareness of the collateral impact on families and the future prospects for children if mental health issues were not treated early.

Whilst recognising the importance of this matter, the Chairman considered that the Trust needed to be careful not to dilute the core messages of the document in relation to ASD services.

In addition, the Board recognised the hard work of staff in CAMHS and asked for its appreciation to be passed on to them.

Action: Mr. Brown

Agreed *– that, taking into account the above matters, a briefing document be produced to raise understanding and awareness of the issues impacting on ASD waiting times.*

Action: Mr. Brown

17/330 STANDING FINANCIAL INSTRUCTIONS

On the recommendation of the Audit Committee, consideration was given to the approval of the revised Standing Financial Instructions (SFIs).

The Board noted that the revised SFIs reflected comments made by the Audit Committee (as summarised in paragraph 3.5 of the covering report) at its meeting held on 14th December 2017.

Members of the Audit Committee:

(1) Advised that through the revisions to the SFIs the Board was also undertaking the annual review of the financial scheme of delegation.

It was noted that the Committee, arising from its discussions, had asked to be provided with clarity on the scope and operation of the scheme of delegation in the Trust.

(2) Drew attention to the proposal to remove the provisions relating to standing lists of approved tenders and to replace them with the formal competitive tendering process, including the use of national and local frameworks, as set out in revised SFI 10.2.

The Board considered that the proposed amendments were appropriate so long as there was assurance that appropriate due diligence was undertaken on firms and individuals entering into the framework agreements.

Agreed *– that the revised Standing Financial Instructions, including the related changes to the Trust's financial scheme of delegation, be approved subject to:*

(1) the Chief Executive being satisfied with the due diligence processes undertaken on firms and individuals entering into local and national framework agreements; and

(2) the completion of equality analysis screening.

Action: Mr. Kendall

17/331 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors was due to be held at 9.30 am on Tuesday 30th January 2018 in The Durham Centre, Belmont Industrial Estate, Durham, DH1 1TN.

17/332 CONFIDENTIAL MOTION

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

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

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

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.

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

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

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

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

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th January 2018**
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

	Minute No.	Action	Owner(s)	Timescale	Status
29/11/2016	16/289	Team based culture metrics reports to be introduced	DL	~~Jan-18~~ Feb-18	
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	Apr-18	
23/05/2017	17/137	Time to be set aside at a Board meeting or Seminar for a full discussion on the equality data	DL/PB	Dec-17	Completed (Seminar held 19/12/17)
20/07/2017	17/194	A full report (and recommendations) on the values, behaviours and staff compact consultation events to be provided to the Board	DL	~~Jan-18~~ Feb-18	
20/07/2017	17/199	Comparative information to be provided to Board Members on the levels of bullying, harassment, etc of BAME staff	DL	Jan-18	Completed
26/09/2017	17/228	Consideration to be given to reviewing the targets in the Strategic Direction Performance Report for 2018/19	SP	Apr-18	
26/09/2017	17/230	Reviews of the operational arrangements of the Quality Assurance, Resources and MHL Committees to be undertaken	PB	~~Dec-17~~ Feb-18	

	Minute No.	Action	Owner(s)	Timescale	Status
31/10/2017	17/264	A report to be provided on the Trust's taxi contracts including the incidence of alleged inappropriate behaviour by taxi drivers and the measures in place to protect vulnerable people.	DB	Feb-18	Information on the Trust's taxi contracts provided to Board Members on 23/11/17; however, under minute 17/291 (28/11/17) it was noted that information on the specific issues raised in the report of the Guardian of Safe Working was outstanding
31/10/2017	17/268	An update report on the Temporary Staffing Service to be presented to the Board	DL	Apr-18	
31/10/2017	17/269	A further report to be provided to the Board on the interpretation and application of the MHA and DOLS once the local authorities have responded to the solicitors' letter	EM	-	A timescale cannot be set for this action as it is dependent on the response from the local authorities
31/10/2017	17/271	The position on Performance Dashboard KPI 6 ("Number of instances of patients who have 3 or more admissions in a year") in County Durham and Darlington to be reviewed	DB	~~Dec-17~~ Feb-18	
31/10/2017	17/271	A report to be presented to the Board on the Trust's position, including trends, for each CCG area, and action being taken to improve performance, on the IAPT recovery indicator	DB/SP	Jan-18	See agenda item 11
28/11/2017	17/295	The Business Cycle to be amended to bring the Annual Report on Research and Development forward to the Board's May meeting	PB	-	Completed
28/11/2017	17/295	A paper be provided to Board Members describing the controls covering commercial studies	Prof. JR	May-18	

	Minute No.	Action	Owner(s)	Timescale	Status
28/11/2017	17/297	An update on the performance of the nurse agency provider to be provided to the Board	DL	~~Jan-18~~ Feb-18	Change of date due to the timing of meetings with the agency provider
28/11/2017	17/297	Information on wards not regularly meeting their fill rates to be included in the reports on the Establishment Review	EM	~~Dec-17~~ Mar-18	
28/11/2017	17/298	The age profile of people who had died to be included in future "learning from deaths" reports	EM	Feb-18	
28/11/2017	17/298	To aid transparency consideration to be given to including the following matters in future "learning from deaths" reports: - A “question and answer” section (possibly as an appendix to the report) to support understanding of the scope of those deaths within policy and the triggers for the different types of review - A formal statement on the scope of the policy and to provide assurance that all relevant deaths have been reviewed	EM	Feb-18	
28/11/2017	17/298	The issues being experienced with the LeDer programme to be brought to the attention of the National Quality Board	EM	Mar-18	
28/11/2017	17/299	The outcome of the workshop held by the MHLC to be included in the review of the operational arrangements of the Board's committees	PB	Feb-18	(See also minute 17/230)
28/11/2017	17/300	The locality staff action plans to be amended to identify the relevant Locality	DL	Jan-18	
28/11/2017	17/300	Representations be made to NHS England about the frequency of the annual staff survey as it is impacting on the Trust's ability to undertake its own research	DL	-	Completed
28/11/2017	17/300	A report to be presented to the Board to provide an update on progress towards the completion of the 2017/18 composite staff action plan and to enable consideration of a proposed 2018/19 action plan	DL	May-18	

	Minute No.	Action	Owner(s)	Timescale	Status
28/11/2017	17/301	A report to be provided to the Board on the use of fixed term contracts in the Trust including how they are being used and for which staff groups	DL	Feb-18	
28/11/2017	17/301	Consideration to be given to whether to circulate a further communication to staff from other EU states following the publication of the NHS workforce strategy	CM	Feb-18	
28/11/2017	17/301	A further progress report on the implementation of the Recruitment and Retention Action Plan to be presented to the Board	DL	May-18	
28/11/2017	17/302	Approval of the closure of Earlston House	DB	-	Approved
28/11/2017	17/302	Approval of the disposal of Earlston House	DK	-	Approved
28/11/2017	17/303	Approval of the Digital Transformation Strategy 2017 - 2020	DK	-	Approved
28/11/2017	17/305	To note the importance of the Board maintaining oversight of the Trust's financial position both at the Board planning event in January 2018 and, if necessary, at a Board Seminar	CM	-	To note
28/11/2017	17/305	A briefing to be provided to the Board on the event in 2018 in relation to sickness absence and whether further action can be taken to support the health and wellbeing of staff	DL	Apr-18	
28/11/2017	17/306	Approval of the Trust Performance Dashboard KPIs for 2018/19	SP	-	Approved
28/11/2017	17/307	A review of whether the graph "Strategic Direction Scorecard Metric Scoring" demonstrated a "general improving trend in the percentage of greens since 2013/14" as stated in the Q2 Strategic Direction Performance Report	SP	-	Completed (Assurance was provided that the statement in the report was correct)
28/11/2017	17/307	A report to be presented to the Board on the outcome of the thematic review of whether patients feel safe and staffing issues being undertaken by the patient safety team	EM	Apr-18	
28/11/2017	17/307	Approval of recommended changes to the Business Plan	SP	-	Approved

	Minute No.	Action	Owner(s)	Timescale	Status
19/12/2017	17/327	A report to be presented to the Board on the outcome of the review of the 12 hour shift system	DL	Jan-19	
19/12/2017	17/327	Approval of the recommended phased approach to the implementation of the staffing establishment reviews	EM	-	Approved
19/12/2017	17/329	The Board's appreciation of the hard work being undertaken by staff in CAMHS to be passed on to them	DB	-	Completed
19/12/2017	17/329	A briefing document to be produced to raise understanding and awareness of the issues impacting on ASD waiting times	DB	Mar-18	
19/12/2017	17/330	To note approval of the revised standing financial instructions (including changes to the Trust's financial scheme of delegation) subject to: - The Chief Executive being satisfied with the due diligence processes undertaken on firms and individuals entering into local and national framework agreements - The completion of equality analysis screening	DK	-	To note

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Durham and Darlington Locality:
That Difficult Second Season

Patrick Scott

Director of Operations

making a difference together

Key Themes – PPCS…..But Don't take your eye off the ball!!

- Changing commissioner landscape
- ACP
- External world
- Redefining the team…….again!
- Leadership team
- Workforce

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

- Involvement……but not as we know it
- Lassoing the whirlwind – CAMHS
  - Individual packages
  - New models of delivery
  - Strategic commissioning
- IAPT and Primary Care
- Urgent Care
- The bigger picture!.....RP/Friarage/

To continuously improve the quality and value of our work

- PPCS
  - The right thing to do…….but the ask is getting tougher
- QIS
  - Daily Lean Management - constantly evolving….the Truth Is Out There

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

- Challenges and opportunities
  - Significant change in senior leadership team……new team starting to take shape
  - All groups all grades!
  - Move away from discussing profession specific competencies
  - Recruit, retain, develop
  - Talent management – embedding within locality

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

- Local
  - Urgent Care Vanguard / Crisis Care Concordat
  - Local Authorities
  - System leadership – Clinical, Operational and Strategic
  - HWB's and Integration Boards
- National
  - Input into NICE Guidelines and other national work, e.g. IAPT Trailblazer pilot
  - Member of National Collaborative for Positive Practice in Mental Health
  - Parent rep's C&YPS presented to House of Lords on impact of self harm and experiences with CAMHS
  - National conferences
- International
  - Virginia Mason

To be recognised as an excellent and well governed Foundation Trust that makes best use of it's resources for the benefit of our communities

- Financial Issues
  - Tough year
  - Flexible staffing
  - CRES
  - Continue work to tidy up budgets
  - Note – able successes (Street triage, Core 24, community rehab, CAMHS ED, 24/7 Liaison and CAMHS Crisis, EIP, LD)
- LMGB
  - Review and PDSA of Governance structures – Season 2

And finally….


IF "Plan A"
Didn't Work.
The alphabet has
25 more letters!
Stay Cool.

ITEM NO. 7

Trust Board of Directors

DATE:	**January 2018**
TITLE:	**Guardian of Safe Working Quarterly Report**
REPORT OF:	**Julian Whaley, Guardian of Safe Working**
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:

It is the responsibility of the Guardian of Safe Working to provide a quarterly report to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.
The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017. Mandated monitoring processes for the quarter up to December have not identified any breaches to terms and conditions of service requiring the levy of a fine.
The Trust Exception Reports reflect relatively small, mainly non-resident rotas. Processes are in place for ongoing scrutiny and review of work schedules to provide assurance of safe working environments and consideration of training and service needs. This is especially important given recruitment concerns and service reconfigurations.

Recommendations:

The Board are asked to read and note this Quarterly report from the Guardian of Safe Working.

MEETING OF:	**Trust Board**
DATE:	**January 2018**
TITLE:	**Quarterly Report by Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

The Board receive a quarterly report from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for Junior Doctors. This includes aggregated data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern. This will provide assurance to the Board and if needed ask for approval for action to rectify a safety concern.

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours and during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.
The Guardian role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The guardian is required to levy a fine against a department(s) if a doctor works on average over 48 hours/week, works over 72 hours in 7 days or misses more than 25% of required rest breaks. The work of the guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

3. KEY ISSUES:

- A detailed breakdown of Junior Doctor numbers, status, exception reporting and locum usage is contained in Appendices 1&2 with a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendix is shared with the corresponding Health Education England body.
- I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified timeframes. The medical staffing department have supported doctors' supervisors to action these appropriately and maintain a log that enables trends to be spotted and reports submitted to locality forums.
- Almost all exception reports have been placed for additional hours of work. High levels of exception reports relate to the high degree of variation in out of hours non-resident on call rota work. There are isolated instances only of junior doctors reporting work beyond their scheduled finish time or missing breaks. I am satisfied that doctors are paid for work they are undertaking. There has been no justification to levy a fine on any department within the organisation. The Trust continues to provide compensatory rest arrangements that exceed the requirements set out in the contract.
- Junior Doctors can find the DRS reporting system cumbersome and a proposal has been shared to use a monitoring sheet for non-resident on-call work thereby

requiring the doctor to place only one exception report per rota cycle for this nature of exception; this is currently under consultation.

- The organisation has made extensive efforts to ensure good fill of junior doctor posts from February and the predicted vacancies highlighted in the last report are now not expected.
- Vacant posts in some rotas have had an impact on junior doctors. In South Durham, at least one doctor has described missed educational opportunity due to a need to cover other in-patient areas. A similar picture is described in Northallerton. In York there has been considerable difficulty filling night shifts, leading to junior doctors' concern that shifts would be imposed.
- Junior Doctors have raised concern that the difficulties in filling essential shifts is compounded by the organisation offering a lower hourly rate than neighbouring organisations. The Medical Director is attending the next Junior Doctor Forum to forward debate on financial support to the junior doctor workforce within current financial constraints.
- The impact of service change on Junior Doctors continues to be considered. The Tees rota schedule has been redesigned, following junior doctor consultation, with an increased resident doctor presence to ameliorate the risk secondary to ward movement to Sandwell Park.
- The Junior Doctor Forum continues to be well attended and a proposal has been made to have a pre-meeting for Junior Doctors only, to further enhance its value.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour. This report evidences maintenance of these standards

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board understands that extra costs will be incurred for additional anti-social hours work and breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to junior doctors is necessary and appropriate.

4.3 Legal and Constitutional (including the NHS Constitution):

The Learning and Development Agreement signed by the Trust with Health Education England clearly sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow junior doctors to fulfil their curriculum needs within a sound learning environment.

4.4 Equality and Diversity:

The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity has therefore been co-opted to the quarterly trustwide Junior Doctor Forum. An Equality Impact Assesment has been completed and is updated within the forum. The Champion of Flexible Working when appointed will be a key position also in this regard.

4.5 **Other implications:**
It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.

5. RISKS:

Failure to proactively fill anticipated shift vacancies will have a significant impact on Junior Doctor morale.
Junior Doctor Locality Forums are running in each area, including operational and educational leaders as well as the guardian, in order to find systemic soutions. These inform the quarterly Junior Doctor forum, chaired by the guardian who also attends LNC & MEQAS meetings. These systems should provide assurance of interventions to mitigate some of the potential risks highlighted.

6. CONCLUSIONS:

The organisation continues to fulfil requirements of the new 2016 Junior Doctor Contract and junior doctors are appropriately submitting exception reports which are being handled appropriately. I am satisfied that processes are in place to identify and rectify issues of safety.
The ongoing need for whole system engagement with these issues cannot be underestimated.

7. RECOMMENDATIONS:

The Board are asked to read and note this Quarterly report from the Guardian of Safe Working.

Author: Dr Julian Whaley
Title: Guardian of Safe Working for Junior Doctors

Background Papers: Appendices 1 & 2: detailed information on numbers, exception reports and locum usage; contained with this report.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	74
Number of doctors / dentists in training on 2016 TCS (total):	52
Number of clinical supervisors	72
Amount of time available in job plan for guardian to do the role:	2 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors: trainee	0.125 PA per

Exception reports (with regard to working hours) from 1st October 2017 up to 31st December 2017

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	N/A	N/A	N/A	N/A
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	0	0	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	1	1	0
CT1-2 Teesside & Forensic Services Juniors	0	10	10	0
CT1-2 –North Durham	0	10	10	0
CT1-2 – South Durham	0	23	23	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	2	2	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Total	**0**	**46**	**46**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	10	10	0
Teesside & Forensic Senior Registrars	0	2	2	0
North Durham Juniors	0	10	10	0
South Durham Juniors	0	24	24	0
South Durham Senior Registrars	0	0	0	0
Total	**0**	**46**	**46**	**0**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Locality	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
Teesside & Forensic Juniors	CT/GP	43:50	N/A	1B	Yes
Teesside & Forensic Senior Registrars	ST6	41	N/A	1C	Yes
Teesside CAMHS	N/A	N/A	N/A	N/A	N/A
Durham & Darlington CAMHS	Not undertaken within this timeframe.				
South Durham Juniors	F2, CT1-3 & GP Reg	N/A	N/A	1C	Yes
South Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				
North Durham Juniors	F2, CT1-3 & GP Reg	N/A	N/A	1C	Yes
North Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Teesside & Forensic Services	F2	New	Unknown	38	38	0	38	1GP & 1F2
	CT1	New	Yes					
	CT1	New	Yes					
	GP	New	Yes					
	CT2	Old	Yes					
	Trust Doctor	New	Unknown					
	GP	Old	Yes					
	Specialty Doctor	N/A	Yes					
	CT3	Old	Yes					

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
North Durham	Trust Doctor	New	No	11	11	0	11	0
	CT1 – 3	Old	No					
	Specialty Doctor	SAS doctor	No					
	F2	New	Unknown					
	Trust Doctor	New	Unknown					
South Durham	Specialty Doctor	SAS doctor	No	13	13	0	13	0
	CT1 – 3	Old	Yes					
	Specialty Doctor	SAS doctor	Unknown					
	CT 1 – 3	Old	Unknown					
	Specialty Doctor	SAS doctor	No					
Total				**62**	**62**	**0**	**62**	**2**

Narrative around Exception Reporting

Durham & Darlington

There were 34 exception reports raised during that period for the Durham & Darlington locality. This includes data from 2 rotas – South Durham junior doctors and North Durham junior doctors. There were no exception reports raised from the North and South Durham Senior Registrars over the reported period. All the exception reports were in relation to additional plain and enhanced time worked whilst on-call.

Teesside & Forensics

There were several locums that required covering due to a GP and F2 vacancy that were already factored into the rota before discovering they were vacant. The DMD made the decision to keep the vacancies in due to the closeness of the rotation commencing and doctor's already booking annual leave and clinics. Resident shifts have been extremely hard to cover, therefore the default position of the non-resident doctor moving to the resident rota and the non-resident shift becoming the locum has been applied several times. The non-resident locum shifts were then taken up within minutes of being circulated.

The exception reports that were received were for enhanced hours when on non-resident rota (as no time is included in the schedule). The senior registrar reports were for 136 assessments during enhanced time.

The 2002 doctors were monitored earlier in the year but there was only 1 doctor who completed the diary card therefore it doesn't give monitored hours. However, there were no issues highlighted.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	52
Number of doctors / dentists in training on 2016 TCS (total):	45
Number of clinical supervisors	44
Amount of time available in job plan for guardian to do the role:	2 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors:	0.125 PA per trainee

Exception reports (with regard to working hours) Up to from 1st October 2017 up to 31st December 2017

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - Northallerton	No F2 Doctors in North Yorkshire			
F2 - Harrogate				
F2 - Scarborough				
F2 - York	0	0	0	0
CT1-2 - Northallerton	0	0	0	0
CT1-2 - Harrogate	0	14	14	0
CT1-2 - Scarborough	0	17	17	0
CT1-2 - York	0	0	0	0
CT3/ST4-6 – Northallerton	0	10	10	0
CT3/ST4-6 – Harrogate	0	4	4	0
CT3/ST4-6 – Scarborough	0	0	0	0
CT3/ST4-6 – York	0	2	2	0
Trust Doctors - Northallerton	0	7	7	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	8	8	0
Trust Doctors - York	0	0	0	0
Total	**0**	**62**	**62**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	17	17	0
Harrogate	0	18	18	0
Scarborough	0	25	25	0
York	0	3	2	0
Total	**0**	**63**	**63**	**0**

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Northallerton	Specialty Dr	NA	No	40	40	0	40	Long term sickness (x2) Vacancy (x2)
	Specialty Dr	NA	Yes					
	CT3	Old	Yes					
	CT3	New	No					
	CT2	Old	Not known					
	CT1	New	Yes					
	CT3	Old	Yes					
Harrogate	Specialty Dr	NA	Yes	10	10	0	10	Pregnant Dr unable to do out of hours work following risk assessment (x1)
	CT1	Yes	No					
	CT1	Yes	No					
	CT1	Yes	No					
Scarborough	Trust Dr	Yes	No	3	3	0	3	0.2 wte on call from 0.8wte LTFT doctor
	CT1	Yes	No					
York & Selby	Specialty Dr	NA	Yes	45	45	4	41	Maternity leave (x5) Pregnant Dr unable to do out of hours work following risk assessment (x1)
	F2	Yes	Not known					
	Trust Dr	Yes	No					
	ST6	Yes	Yes					
	CT2	Old	Not known					
	CT1	Yes	No					
	F2	Yes	Not known					
	CT1	Yes	Yes					
	Agency Dr	NA	NA					
Total				**98**	**98**	**4**	**94**	**11.2**

Narrative around Exception Reporting

Harrogate:
Non-resident rota - Doctors receive payment for 4 additional hours at plain rate and 1 additional hour at enhanced rate in their work schedule. The majority of exceptions were due to doctors working more hours than in their work schedules however on 2 occasions the exception was due to late finish to the normal working day. There were 2 occasions when it was not possible for the doctor to have a lunch break.

Scarborough:
Non-resident rota - Doctors receive payment for 2 additional hours at plain rate in their work schedule. All exceptions, except 3, related to working more hours than in their work schedule. The remaining 3 exceptions were due to late finish on a normal working day.

Northallerton:
Non-resident rota - Doctors receive payment for 2 additional hours at plain rate in their work schedule. The majority of exceptions related to working more hours than in their work schedule. However 1 exception was due to a late finish to the normal working day.

York:
Resident rota - Only 3 exceptions reported – this is a resident rota. 1 was due to a late finish to the normal working day, 1 was due to having no break and the other was due to the night shift doctor having to work an additional hour to cover the rota. The locum shifts are a mixture of cover from 5pm - 9pm and normal out of hours. The majority of locum cover has been needed due to maternity leave and doctors not being able to work out of hours following Occupational Health advice/risk assessment.

ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th January 2018**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing 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 the report is to advise the Board of a 6 monthly review (1st June 2017 to 31st November 2017) of in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) and in line with the NQB Guidance.

The 'Right Staffing' (previously known as 'Safe Staffing') programme board 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 capacity and capability to provide high quality care to patients. Right Staffing is one of the strategic business priorities for the trust board and a Right Staffing programme manager has now been appointed to manage this strand of work, and has been in post from August 2017.

In conclusion, the following is of relevance:

- The Trust is progressing with the implementation of in-patient establishment reviews using the Hurst Tool, mental health multiplier and professional judgement approach. All of the data collection has concluded and an interim report was presented to the trust board in December to outline the methodology and approach taken and to agree the next steps.
- Changes to numbers of staff in post can be observed as follows:
  - Durham & Darlington – an overall increase of registered nurses and a reduction of unregistered nurses is evident. Additional registered nurses can be observed within Cedar and Holly. Whilst the reduction of unregistered is across the service.
  - An increase of registered nurses and a reduction of unregistered nurses can be observed within Forensic Services. The reduction of unregistered nurses is attributable to the closure of Fulmar in line with the transforming care agenda.
  - North Yorkshire – an increase in both registered and unregistered nurses can be observed. The registered nurse increase is across the locality whilst the increase in unregistered is largely attributable to Ward 15 and Cedar (NY).

  - Within Teesside a reduction of registered and un-registered nurses has been observed across the locality for both staff groups.
  - A reduction of both registered and unregistered nurses can be observed within York and Selby.
- In line with 'NQB guidance for Right Skills', the paper sets out a number of development programmes in place to enhance the skills of our workforce.

- Regarding staffing activity, the 6 month average shows:
  - The actual hours worked exceeding the planned hours across all months. All metrics are reporting above the 89.9% tolerance.
  - Thistle Ward as having the lowest fill rate for registered nurses on days of 61.2% and relates to the service carrying a number of vacancies over a period of time.
  - Talbot Direct Care was cited as having the second lowest fill rate for registered nurses on days of 63.8%. The shortfall of which is being provided by Holly. Training will be given to the roster administrator to ensure appropriate recording of hours worked.
  - Sickness is the biggest factor impacting on staffing with 44 wards (this is the same amount of wards when compared to the previous 6 month report). Maternity Leave (11 wards) and agency usage (11 wards) were cited as the second and third highest.
  - 10,185 additional duties were created with a reason of 'enhanced observations'. This is an increase of 1,458 duties when compared to the previous 6 month report. The 10,185 additional duties created equate to 105,641 hours and increase of 11,386 hours when compared to the previous 6 month period.
  - Westerdale South was cited as the highest users of additional duties with a reason of 'enhanced observations'.
  - Bank usage greater than 25% equating to 10 wards in 3 separate localities. Cedar Ward (D&D) is the highest user with a bank fill rate of 37.8%.
  - Agency usage related to 11 wards in 4 separate localities. Acomb Garth had the highest with an agency usage rate of 28.9%.
  - All wards are using overtime to fill shifts however, those in excess of 4% equates to 41 wards. Teesside are using the most overtime whilst York and Selby are using the least.
  - There are 40 wards from all localities that have utilised bank, agency and overtime within the reporting period.

- Triangulation of quality data over the 6 month average:
  - 111 incidents were raised during the reporting period citing concerns with staffing levels. This is an increase of 37 when compared to the previous 6 month report (74 incidents raised).
  - Incident raised whereby there was no registered nurse on duty was highlighted on the 5th August 2017 in relation to Harland, which has undergone investigation.
  - Triangulation of SIs, level 4 incidents, level 3 self-harm, complaints and incidents control and restraint with bank usage and the fill rates did not highlight any correlations between these strands of data.
  - Triangulation of falls that have resulted in significant harm, pressure ulcers, medication errors, breaks not taken, with that of bank usage and the fill rate indicators. From this it is not possible to draw any meaningful conclusions from this data for the period of this report.
  - In terms of patient, staff and carer feedback an analysis of the data from complaints, friends and family test and compliments has been undertaken but there were no specific issues raised with regards to staffing levels.

- The Right Staffing programme will develop a ward dashboard of quality nursing indicators. An interim approach being utilised within the trust is the use of 9 quality nursing indicators and the performance report out at EMT.
- Care hours per patient day will become a requirement from 1st April 2018 and will extend to nursing staff only. Following a recent pilot this does not present any concerns from a reporting perspective. The Right Staffing programme will explore what 'good' looks like to the Trust once reporting commences.

Recommendations:

That the Board of Directors are asked to note the outputs of the report and the issues raised for further investigation and development

MEETING OF:	**Board of Directors**
DATE:	**30th January 2018**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of a 6 monthly review (1st June 2017 to 31st November 2017) in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) following the format of the new NQB 2016 Guidance.

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. It is well accepted that safe and sustainable staffing is fundamental to good quality care however this includes many variables beyond numbers of staff.

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing/Nurse-staffing). The full monthly data set of day by day staffing for each of the 69 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

2.3 The 'Right Staffing' programme board has been established that will consider the broader multidisciplinary workforce whilst continuing 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 supported by the programme manager in adopting the new Trust programme approach.

2.4 The Right Staffing programme continues to utilise a work stream approach, and will report to EMT and the Strategic Change Oversight Board. The workstreams have been restructured and consider developmental approaches alongside the task based aspects, and are:

- National Guidelines Compliance
- Staffing Establishments
- Temporary Staffing
- Recruitment
- Staff Retention
- Workforce Roles
- Training and Development

2.5 There is a national work stream looking at service specific guidance, recently this has included the draft publication of Learning Disability and Mental Health specific guidance.

The guidance has been considered within the trust Right Staffing programme work streams as part of the professional judgement approach in relation to the establishment reviews.

2.6 Right Staffing is one of the strategic business priorities for the Trust Board, accordingly the Executive Management Team have approved the Right Staffing Programme that will manage the implementation of the NQB guidance in addition to the broader aspects of the workforce identified in 2.4 of this report. A programme manager has been appointed and a programme plan is being finalised.

3.0 TRIANGULATED APPROACH TO STAFFING DECISIONS:

3.1 Right Staff

3.1.1 The NQB guidance places an expectation that Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings. In addition Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence based tools, professional judgement and comparison with peers), this should take account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

3.1.2 The Trust is progressing with the implementation of the Hurst Tool and the mental health multiplier in order to review the current staffing establishments within inpatient areas (excluding Learning Disabilities – awaiting final guidance). All of the data collection has concluded and has been progressed through the Hurst Tool. In addition professional judgement meetings have taken place. A staffing establishment report following the introduction of the Hurst Tool was presented to trust board in December 2017 to agree the next steps where a phased approach was suggested in the programme plan. This included visit other Trusts to further explore the benefits and operation for TEWV in considering the potential for using Allocate Safecare.

3.1.3 As an interim approach the budgeted staffing establishments as at 1st June 2017 and the 30th November 2017 have been obtained from HealthRoster and have been used to compare the actual establishments in post. Attached at appendix 2 of this report is the full breakdown by ward and locality. The key points are as follows:

- Durham & Darlington – registered nurses in post has increased by 10.50 WTE and a reduction of 1.10 WTE unregistered nurses. An increase of registered nurses can be observed within Cedar Ward and Holly Unit. The reduction in unregistered nurses is across the service.
- Forensic Services – registered nurses in post has increased by 1.10 WTE and a reduction of 11.90 WTE for unregistered nurses. The reduction of unregistered nurses can largely be attributable to the closure of Fulmar Ward. The reduction of staffing within the Forensic Services are in line with the transforming care agenda and planned changes.
- North Yorkshire – registered nurses in post has increased by 2.60 WTE and an increase of 3.90 WTE unregistered nurses. The increase of registered nurses is split across all

wards within the locality. The increase of unregistered nurses can be observed from Ward 15 and Cedar (NY).

- Teesside – registered nurses in post has reduced by 24.8 WTE and 10.90 WTE less unregistered nurses. The closure of Lincoln Ward has accounted for an element of the reduction of staff in post. A reduction of 3.2 WTE registered nurses and a 2.7 WTE unregistered nurses can be observed at Wingfield. The rest of the reduction is spread across the service.
- York and Selby – registered nurses in post have decreased by 3.30 WTE and a reduction of 5.30 WTE unregistered nurses is also visible across the service. The reduction of staffing is across all wards for both staff groups.
- Across all inpatient areas, this has resulted in an increase of approximately 35 registered nurses and a reduction of 3.5 WTE unregistered nurses.

3.2 Right Skills

3.2.1 The NQB guidance states that Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multi-professional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services. In addition clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.

3.2.2 All new starters to the Trust attend an offsite induction followed by a local induction into their service. The Trusts central bank service also have clear requirements in place for their bank workers that ensures that all mandatory training is in place for this group of staff prior to commencement of any work.

3.2.3 There are 2 wards within the Trust who in November 2017 are reporting less than 75% compliance for mandatory training at the time of writing the report, as follows:

WARD	November 2017
Rowan Lea	71.80%
Maple Ward	73.19%

3.2.4 There has been considerable change in the world of nurse education and professional nursing roles in recent times, some of which has yet to fully work its way through. This section outlines some of the approaches the Trust either has taken or is developing in response to this emerging picture, while a longer term strategy is developed and the external national guidance continues to refine. The Trust also operates a number of development programmes to enhance the skills of our workforce. A key focus within our approach is to enhance the relationships with the local Higher Education Institutes, and diversify the range of training options at a time when external interest in registered nurse training appears to be declining and there are recruitment difficulties. The Trust is investing directly in both the development of new roles and maintenance of existing programmes. We are also seeking to provide greater support to our existing workforce to recognise the apparent increasing ratio of less experienced nurses within our in-patient establishments, which is under review, and to help to retain existing colleagues within the Trust. Some examples of the range of approaches are set out below:

- **Framework for inpatient HealthCare Assistants** - All new starters from April 2012 have been recruited utilising the HCA Framework and options were presented to existing staff. A database of all Trainee HCA's and the existing HCA workforce is held by the Workforce Department and collates all of the training activity. This approach is a key ingredient in preparing potential candidates for further professional training in line with some of the initiatives below, in addition to its own intrinsic value in staff development and patient care.

- **Nursing Associate Band 4 roles** - These new roles will in future be regulated by the Nursing and Midwifery council, as a new member of the nursing family. The Trust is currently part of a consortium of north east health care organisations which are piloting the role, as part of a national "fast-followers" approach. The organisation agreed to enable ten staff to take up these roles, (there are 92 places across the North-East locality). Minimal costs relating to training are being met by Heath Education England. The academic component of the training is at foundation degree level and delivered by Teesside University. The Trust has made a financial commitment of £186,000 to meet the associated backfill costs in delivering this programme. Nursing Associates will be expected to work alongside care assistants and registered nurses to deliver hands-on care, focusing on ensuring patients continue to get the compassionate care they deserve. Its introduction has the potential to transform the nursing and care workforce - with clear entry and career progression points and we will need to develop a workforce plan to reflect where the new colleagues sit within future service development and indeed the Right Staffing returns. The nursing associates were appointed in TEWV following a rigorous application and interview process. The trainees started a two week induction at Teesside University on 24th April along with the trainees from all service providers across the North East. The programme will be forty five weeks per year for two years. Trainee Nursing Associates will be employed in one of three health and/or care settings – defined as; in hospital, Close to home, and at home. The Trust has recently committed to recruiting to a second regional cohort which could link to apprenticeship levy. The trainees need to be recruited for an induction day to be held by March 29th 2018.

- **Apprenticeship Pre-Registration Training** - The apprenticeship route into nurse training is now approved nationally at level 6. Locally we are engaging with Sunderland University, who are a relatively new entrant into the pre-registration field for us and are the approved local pilot provider of nursing apprenticeships. This forms part of our approach to diversify the range of training providers to attract the widest range of candidates of different backgrounds, and in particular to increase the number of our existing care staff who we can develop into registered nurses. It is likely the other local Universities will develop their own apprenticeship approaches shortly. This will bring opportunities to 'grow our own' workforce and potentially to recoup some of the apprenticeship levy.

- **Diversifying the range of training providers** - As noted above, we are actively seeking to extend our partnerships with local Higher Education Institutes, this includes:

Sunderland on new apprenticeship approaches to nurse training. Sunderland is also introducing a new pre-registration course in partnership with the trust and NTW NHS Trust which is due to commence in 2018. The Trust is to receive 30 new registered mental health nurses and 10 learning disability nurses per year. This introduces a new participant into the arena and can potentially lead to placement pressures which will require careful management, but is seen to be especially positive in the northern part of the Trust.

The Open University, or directly on to the OU pre-registration training programme- this enables colleagues to remain in work while studying as a distance learning model (and demonstrates a high degree of commitment in doing so). This brings some financial benefits to the Trust as well as allowing a more flexible approach to training which suits some colleague's circumstances.

Coventry University, who are currently developing an adult nursing branch at their new campus in Scarborough, and are interested in potentially extending this into a mental health cohort from 2018. Dialogue continues after their successful implementation of the adult branch following NMC approval. The Trust will provide short term support placements for the adult branch to improve joint working and health promotion while we work on a Mental Health specific programme.

- **Out of Hours nursing support – the Duty Nurse Co-ordinator** – 13 additional band 6 posts have been approved and funded by the trust to commence the roll out of the Duty Nurse Coordinator which will provide enhanced support and professional nursing advice out of hours, nights and weekends. This was a key element of phase one of the phased approach recommended in the evidence based establishment report presented to the board in December 2018.

- **Support for Learning Disability Nurse training** - We are aware that both of the two main Higher Education Institutes in the area, Teesside University and York University, are receiving very low numbers of student nurse applications for Learning Disability training, which is threatening the viability of the training courses in both cases. It is likely that the Universities will struggle to run their next cohorts, and this will have implications for future years as education infrastructure could be diverted elsewhere. The Trust remains a major employer of learning disability nurses despite the service re-modelling underway. It is possible that changes to the funding of nurse training (the introduction of student loans) and the current reviews of the future learning disability model nationally may have impacted disproportionately on this specific group of trainees, who have tended to be a small cohort of more mature students, often with existing loans from a first degree. A proposal was approved by EMT to directly support a small cohort of ten suitable internal candidates to take up Learning Disability Nurse training at the local HEI's. The ten applicants took up their places in January 2018 with secondment agreements in place at a fixed mid-point Band 3. There is continued dialogue within the regional group, and we are participating in a national task group that has been set up regarding recruitment. This will enable the local courses to be

maintained while a strategic approach based around developing shorter approved courses is pursued.

- **Preceptorship** - Preceptor preparation workshops are delivered across the Trust to support preceptors in this role. Each preceptee has a specific work based developmental programme that follows a continuum of the four key task areas from the pre-registration programme. It is likely these requirements will change with new NMC standards being consulted on. We also participate in a working group at local universities regarding new curriculums. The retention of newly qualified staff is of growing importance within the organisation as there is a reportedly a less experienced body of nurses within inpatient services overall due to recruitment patterns and opportunities for promotion within community services and a national issue of retention.

- **Band 7/Ward Manager Development days** - Bi-monthly development days have continued to ensure that the Ward Managers are receiving appropriate development, networking and information sharing from the Board and other external bodies. These meetings are led by the Director of Nursing and Governance and provide peer support and reflective practice space for learning from each other's incidents and good practice. The development days are attended by Heads of Nursing and this is combined with the bi-monthly Modern Matron forum on a 6 monthly basis.

- **Nursing Conference** – This year's nursing conference was held on September 18th 2017, and featured our shared and co-produced approach to Patient Safety as its key theme. A workshop on Right Staffing was included within this event.

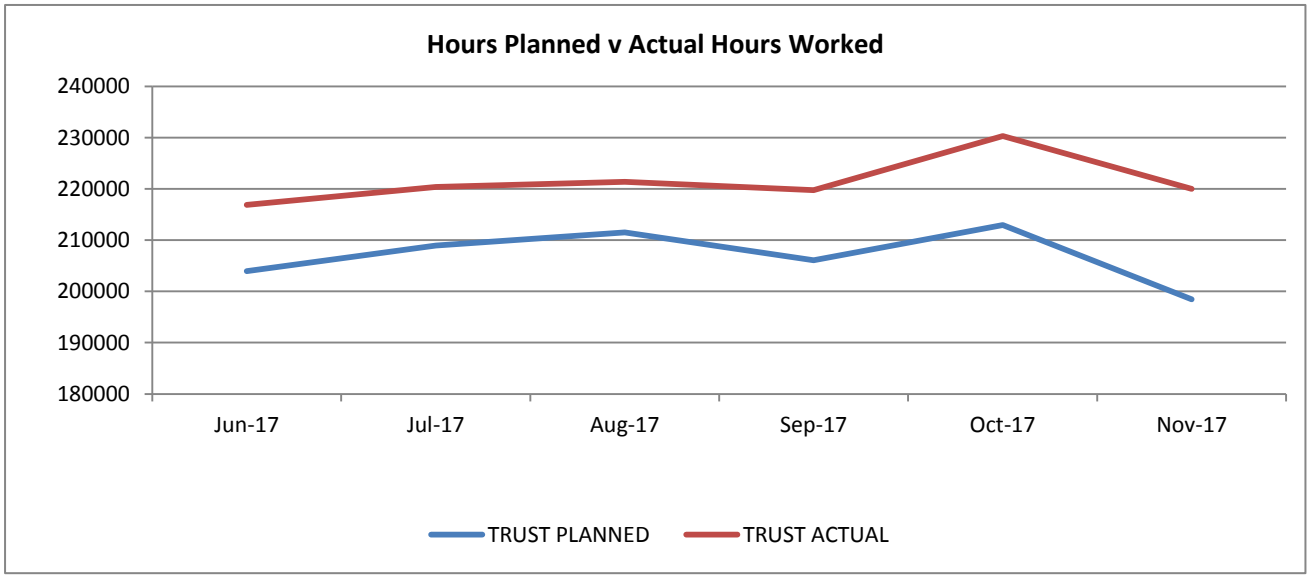
3.2.5 In general, the previous workstream approach had focussed more on inpatient nursing staff numbers, but within the Right Staffing programme this will now extend into community and multi-disciplinary working. It will adopt a broader role that provides increased emphasis on the workforce captured in the restructured workstreams. The recent Learning Disability and Mental Health Service Specific guidance includes more detail on requirements of this approach which we will take into account. We have also used the content of this guidance to inform our current establishment review work, particularly by providing a framework for the professional judgement discussions.

3.2.6 The trust has a long established approach to continuous improvement and the Right Staffing programme identifies key interdependencies with Purposeful Productive Community Service (PPCS), Model Wards, Recovery and Digital Transformation programmes in addition to Human Resources, Organisational Development, Workforce Development and Medical Development, The programme reports into the Strategic Change Oversight Board, and undergoes Deep Dive exercises that provides increased scrutiny and monitoring. It also reports into a weekly programme office which allows communication and liaison with the other strategic programmes and business planning to discuss synergies and coordination of programme plans. The Deputy Director of Nursing is leading a sub-regional 'safe staffing' group looking at trying to standardise approaches and reporting thresholds, including content of monthly and six monthly reports, and agreeing priorities collectively.

3.3 Right place and right time

3.3.1 The NQB guidance states that Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

3.3.2 Moving on to look at the actual hours worked versus the planned staffing within the reporting period. The table below shows a line graph to articulate the Trust position across the reporting period:



3.3.3 It is important to highlight that at no point during the 6 month review did the actual hours match the planned, and that the actual hours were always in excess of planned hours rather than in deficit. The establishment reviews will consider this gap between actual and planned hours in conjunction with the utilisation of temporary staffing. The programme will address this and will be further informed by new NHSI guidance for making effective use of staff banks.

3.3.4 Appendix 3 of the report shows the average fill rate (1st June to 30th November 2017) for both days and nights for both registered and non-registered staff. The 6 monthly position shows that there were 36 wards (over 50%) of wards who had fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts. In terms of unregistered nurses this equated to 6 wards on days that had a fill rate below 89.9%. This shows that although the trust usually meets its planned staffing numbers there is often a deficit of the planned skill mix from registered to non-registered. This presents risks in terms of CQC compliance and limits the quality and safety of interventions that can be offered from a registered nursing perspective.

3.3.5 In terms of the night time shifts the 6 monthly position shows that there were 5 wards who had fill rates of less than 89.9% (shown as red) for registered nurses and health care assistants there was only 1 ward who had a fill rate below 89.9%.

3.3.6 The month on month trend covering the reporting period is outlined below:

Month	Actual Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Jun-17	91.30	↓	114.20	↓	98.60	↓	117.00	↑
Jul-17	84.60	↓	115.50	↑	98.70	↑	119.60	↑
Aug-17	87.40	↑	112.40	↓	97.70	↓	117.80	↓
Sep-17	91.30	↑	113.10	↑	99.40	↑	118.80	↑
Oct-17	90.30	↓	116.40	↑	100.20	↑	121.70	↑
Nov-17	96.00	↑	117.20	↑	105.40	↑	122.60	↑

From the table it is important to highlight the following:

- All fill rate indicators are within the 89.9% tolerance.
- The average fill rate for registered nurses on day shifts has improved from 91.30% in June 2017 when compared to 96.00% in November 2017 (4.7% increase).
- The average fill rate for health care assistants on day shifts has increased from 114.20% in June 2017 to 117.20% in November 2017 (3.0% increase).
- The average fill rate for registered nurses on night shifts has increased from 98.60% in June 2017 when compared to 105.40% in November 2017 (6.8% increase).

.

3.3.7 The overall total red rated occurrences utilising the average fill rate (i.e. less than 89.9%) was 48 occurrences. The table below shows the breakdown by locality:

Locality	Total Number of Red Occurrences	Trend on previous 6 months
Durham & Darlington	7	↑ (2)
Teesside	13	↑ (12)
North Yorkshire	7	↓ (10)
Forensic Services	17	↓ (18)
York and Selby	4	↓ (6)

- Forensic Services have the highest number of red occurrences across the reporting period.

3.3.8 The 6 month average highlights Thistle Ward (Forensic LD) as having the lowest fill rate of 61.2% for registered nurses on days. The low fill rate is as a result of carrying nurse vacancies over a number of months. There are also occasions whereby the second registered nurse would be moved to another ward where the acuity was greater.

3.3.9 The second lowest fill rate utilising the 6 month average highlights Talbot Direct Care (Durham and Darlington, CYPS) with a fill rate of 63.8% for registered nurses on Days. The shortfall is being provided for by either the Holly Unit, the ward manager or community. Training will be given to the roster administrator that ensures those staff working outside of their immediate area is allocated to the appropriate roster to ensure accurate recording in future rosters.

3.3.10 it is important to consider the workforce variances when looking at hours worked. Within the reporting period there were:

- 44 wards who had sickness absence rates greater than 5% loss of actual hours
- 11 wards who had maternity absence greater than 5% loss of the actual hours
- 11 wards who had agency usage greater than 4% of actual hours worked
- 10 wards who had bank usage greater than 25% of actual hours worked
- 6 wards who had vacancies greater than 10% loss of actual hours

3.3.11 This illustrates some of the factors cited as impacting on staffing availability with sickness and maternity highlighted as having the biggest impact. The full ward breakdown is outlined in full in appendix 4 of this report.

3.3.12 In addition there were a number of duties created which were over and above the standard rosters (or budgeted establishment) with a reason of 'enhanced observations' which will have required the use of bank and or agency to backfill these:

Month	Number of duties	Number of Hours
June	1,352	13,804
July	1,713	17,584
Aug	1,530	15,702
Sep	1,669	17,002
Oct	1,961	20,676
Nov	1,960	20,873
TOTAL	**10,185**	**105,641**

- This table highlights a month on month increase in the number of additional duties being created within the trust.

- 10,185 additional duties were created within the reporting period this is an increase of 1,458 duties when compared to the previous 6 month period.

- The 10,185 additional duties created equates to 105,641 hours within the reporting period this is an increase of 11,386 hours when compared to the previous 6 month period. This equates to an average shift length of 10.4 hours per additional duty created (a reduction of 0.4 hours when compared to the previous 6 month period).

3.3.13 the highest creators of additional duties with a reason of 'enhanced observations' were in the following areas:

Locality	Ward / Team	Number of Duties	Number or Hours
Teesside	Westerdale South	1067	10268.88
Forensics	Merlin Ward	854	9251.58
Teesside	Westwood Centre	636	6768.95
Forensics	Fulmar Ward	473	5110.28
Forensics	Mandarin	479	5041.00
Durham & Darlington	Hamsterley Ward	441	4648.95
Forensics	Sandpiper Ward	416	4449.08
Teesside	The Evergreen Centre	407	4254.92
York & Selby	Acomb Garth	371	4007.00
Teesside	Bedale Ward	344	3860.62
	TOTAL	**5488**	**57661.00**

3.3.14 Further analysis of the usage of 'enhanced observations' in relation to budgeted establishments is required to fully understand the level of clinical need and practices at ward level and to seek an effective solution to bank usage. This will form a key part of the proposed work plan for right staffing programme. NHSI have recently announced a mental health observation and engagement collaborative and the right staffing programme will seek to learn from this and link in to Model Ward methodology.

3.3.15 Appendix 4 highlights the use of bank staffing as a proportion of actual hours worked averaged over the 6 month period. These are 'RAG' rated independently of the overall fill rate. Those wards using greater than 25% bank staffing to deliver their fill rates are identified below:

Locality	Ward	Total Hours	Bank Usage %
Durham & Darlington	Cedar Ward	10318.1	37.8%
Teesside	Westerdale South	10334.0	34.4%
Forensics	Merlin	9968.3	33.3%
Forensics	Northdale Centre	9024.9	31.2%
Forensics	Clover/Ivy	7620.3	29.2%
Forensics	Fulmar Ward.	5245.3	26.7%
Teesside	Bedale Ward	6140.4	26.5%
Teesside	Bransdale Ward	4814.5	25.5%
Forensics	Mandarin	5308.7	25.4%
Durham & Darlington	Elm Ward	4560.0	25.1%

- This equates to 10 wards in 3 separate localities.

3.3.16 As noted in previous reports there are risks in high use of bank staffing, these are mitigated by the use of regular bank staff who know the clinical areas, through previous regular bank work, being permanent staff working extra hours or previously employed staff/students.

3.3.17 In terms of Agency usage as a proportion of actual hours worked averaged over the 6 month period 'RAG' rated independently of the overall fill rate. Those wards using greater than 4% agency usage to deliver their fill rates are identified below:

Locality	Ward	Total Hours	Agency Usage %
York and Selby	Acomb Garth	7272.50	28.9%
North Yorkshire	Cedar Ward (NY)	4420.50	21.7%
North Yorkshire	Rowan Ward	3889.00	19.6%
York and Selby	Cherry Tree House	2704.00	14.0%
North Yorkshire	Springwood	1786.30	9.7%
York and Selby	Meadowfields	1560.30	8.9%
York and Selby	Oak Rise	1932.20	8.7%
Teesside	Westerdale South	1646.02	5.5%
York and Selby	Minster Ward	778.50	5.0%
Durham & Darlington	Hamsterley Ward	1064.80	4.7%
York and Selby	Ebor Ward	701.00	4.4%

- This equates to 11 wards in 4 separate localities.

3.3.18 It is important that overtime is also considered when reviewing right staffing indicators. Appendix 4 highlights the hours classified as 'overtime' as a percentage of total hours worked and are 'RAG' rated independently of the overall fill rate. The wards using in excess of 4% overtime are highlighted as follows:

Locality	Ward	Total Hours	Overtime Usage %
Durham & Darlington	Bek-Ramsey Ward	2761.58	10.7%
Teesside	Westwood Centre	3267.04	10.0%
Teesside	Bankfields Court Unit 3	1310.28	9.6%
Teesside	Bankfields Court Unit 2	1331.87	8.6%
York and Selby	Minster Ward	1288.81	8.3%
North Yorkshire	The Orchards (NY)	1102.51	8.2%
Teesside	Baysdale	1190.03	8.0%
Forensics	Mandarin	1513.40	7.2%
North Yorkshire	Ward 14	1100.00	7.2%
Teesside	Bankfields Court Unit 4	868.18	7.0%
North Yorkshire	Ayckbourn Unit Danby Ward	1013.00	6.8%
Forensics	Swift Ward	1216.73	6.7%
Forensics	Nightingale Ward	1047.10	6.7%
Durham & Darlington	Hamsterley Ward	1466.76	6.5%
Forensics	Oakwood	772.84	6.5%

Forensics	Lark	1006.46	6.4%
Forensics	Clover/Ivy	1647.98	6.3%
Durham & Darlington	Holly Unit	413.16	6.3%
Teesside	Bankfields Court Flats	710.67	6.1%
Forensics	Newtondale Ward	1381.12	6.1%
Teesside	Newberry Centre	1446.93	5.9%
Teesside	Bilsdale Ward	994.87	5.9%
Forensics	Harrier/Hawk	1253.06	5.6%
Teesside	Bedale Ward	1271.37	5.5%
Forensics	Northdale Centre	1549.58	5.4%
Durham & Darlington	Birch Ward	1083.27	5.3%
North Yorkshire	Rowan Lea	1128.41	5.1%
Forensics	Thistle	844.42	4.9%
York and Selby	Cherry Tree House	953.55	4.9%
Forensics	Jay Ward	795.40	4.9%
Teesside	Aysgarth	644.75	4.8%
Forensics	Merlin	1379.24	4.6%
Teesside	The Evergreen Centre	1548.18	4.6%
Forensics	Linnet Ward	851.89	4.5%
Durham & Darlington	Tunstall Ward	758.19	4.5%
North Yorkshire	Springwood	824.59	4.5%
Teesside	Stockdale Ward	753.90	4.3%
Durham & Darlington	Maple Ward	685.23	4.1%
Teesside	Westerdale North	691.43	4.1%
Forensics	Sandpiper Ward	1088.94	4.1%
Durham & Darlington	Elm Ward	739.09	4.1%

- All wards across the trust are using overtime.
- Teesside are using the most overtime (20,290.51) whilst York & Selby are using the least (3,551.28).
- There are 40 wards who have utilised bank, agency and overtime within the reporting period as outlined below:

Locality	Ward	Overtime Usage Vs Actual Hours	Agency Usage Vs Actual Hours	Bank Usage Vs Actual Hours
Durham & Darlington	Birch Ward	5.3%	0.9%	24.7%
Durham & Darlington	Elm Ward	4.1%	0.4%	25.1%
Durham & Darlington	Maple Ward	4.1%	1.6%	21.1%
Durham & Darlington	Primrose Lodge	3.9%	0.1%	11.8%
Durham & Darlington	Tunstall Ward	4.5%	0.1%	1.7%
Durham & Darlington	Willow Ward	3.2%	0.1%	7.1%
Durham & Darlington	Bek-Ramsey Ward	10.7%	0.6%	7.8%
Durham & Darlington	Ceddesfeld Ward	2.4%	0.2%	5.9%
Durham & Darlington	Hamsterley Ward	6.5%	4.7%	21.5%
Forensics	Clover/Ivy	6.3%	0.4%	29.2%

Forensics	Eagle/Osprey	3.5%	1.0%	13.5%
Forensics	Harrier/Hawk	5.6%	0.1%	15.0%
Forensics	Kestrel/Kite.	3.8%	0.3%	18.3%
Forensics	Langley Ward	2.8%	0.2%	13.8%
Forensics	Northdale Centre	5.4%	2.7%	31.2%
Forensics	Thistle	4.9%	0.1%	10.7%
North Yorkshire	Danby Ward	6.8%	2.4%	11.5%
North Yorkshire	Cedar Ward (NY)	2.3%	21.7%	8.9%
North Yorkshire	Ward 15 Friarage	3.4%	2.0%	20.7%
North Yorkshire	Rowan Lea	5.1%	1.2%	9.0%
North Yorkshire	Rowan Ward	2.0%	19.6%	10.8%
North Yorkshire	Springwood	4.5%	9.7%	15.6%
North Yorkshire	Ward 14	7.2%	0.3%	2.0%
Teesside	Bedale Ward	5.5%	0.8%	26.5%
Teesside	Bilsdale Ward	5.9%	0.3%	14.2%
Teesside	Bransdale Ward	3.6%	0.2%	25.5%
Teesside	Kirkdale Ward	3.2%	0.4%	15.7%
Teesside	Overdale Ward	3.1%	0.1%	15.3%
Teesside	Stockdale Ward	4.3%	0.5%	17.9%
Teesside	Newberry Centre	5.9%	0.3%	9.6%
Teesside	The Evergreen Centre	4.6%	2.0%	12.2%
Teesside	Westerdale North	4.1%	1.8%	4.8%
Teesside	Westerdale South	2.8%	5.5%	34.4%
Teesside	Wingfield Ward	3.4%	0.9%	21.1%
York and Selby	Ebor Ward	2.8%	4.4%	7.3%
York and Selby	Minster Ward	8.3%	5.0%	10.8%
York and Selby	Oak Rise	2.3%	8.7%	5.2%
York and Selby	Acomb Garth	0.8%	28.9%	6.5%
York and Selby	Cherry Tree House	4.9%	14.0%	5.5%
York and Selby	Meadowfields	0.7%	8.9%	14.9%

3.4 Patient outcomes, people productivity and financial sustainability

3.4.1 The NQB guidance states that boards will need to collaborate across their local health and care system, with commissioners and other providers, to ensure delivery of the best possible care and value for patients and the public. This may require NHS provider boards to make difficult decisions about resourcing as local Sustainability and Transformation Plans are developed and agreed. It is critical that boards review workforce metrics, indicators of quality and outcomes, and measures of productivity on a monthly basis – as a whole and not in isolation from each other – and that there is evidence of continuous improvements across all of these areas.

3.4.2 In turning to the triangulation of staffing data with other safety indicators. Appendix 5 provides an overview of all quality indicators for all inpatient wards. Firstly there were 8 SUI's that occurred in in-patient areas within the 6 month period.

These are summarised below utilising the bank fill rate and staffing fill rates as comparative data:

No. of SUIs	Ward	Bank Usage	Staffing Fill Rate			
			RN Days	RN Nights	HCA Days	HCA Nights
2	Cedar Ward	37.8%	121.0%	136.8%	125.4%	117.8%
1	Farnham Ward	9.3%	106.7%	101.3%	103.9%	100.8%
1	Lustrum Vale	22.7%	77.6%	104.2%	127.9%	107.4%
1	Tunstall Ward	1.7%	109.9%	109.8%	102.7%	100.3%
1	Hamsterley Ward	21.5%	95.8%	102.8%	146.3%	153.9%
1	Roseberry Wards	12.3%	100.3%	101.1%	102.0%	102.2%
1	Rowan Ward	10.8%	91.1%	104.2%	158.5%	146.7%

- From those wards that did have an SUI within the reporting period all but one had a 'green' or 'amber' rating for their bank usage.
- There was 1 fill rate indicator that reported as 'red' – Cedar Ward; with all remaining indicators reporting as either 'green' or 'blue'

The Patient Safety investigation team have been asked to specifically consider staffing levels and skill mix in relation to their investigation of inpatient SI's to support more robust triangulation of staffing data and aid root cause analysis. During the reporting period there were no actions attributable to low staffing levels or skill mix within inpatient services. However, there were some contributory findings highlighted with regards staffing within community based teams.

The Right Staffing programme will consider as part of its delivery the skill mix of staffing establishments.

3.4.3 There were a total of 4 Level 4 incidents that occurred within the reporting period. These are summarised below utilising the bank fill rate and staffing fill rates as comparative data:

No. of L4 Incidents	Ward	Bank Usage	Staffing Fill Rate			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Tunstall Ward	1.7%	109.9%	109.8%	102.7%	100.3%
1	Hamsterley Ward	21.5%	95.8%	102.8%	146.3%	153.9%
1	Roseberry Wards	12.3%	100.3%	101.1%	102.0%	102.2%
1	Rowan Ward	10.8%	91.1%	104.2%	158.5%	146.7%

- From those wards that did have a L4 incident within the reporting period all had a 'green' or 'amber' rating for their bank usage.
- All fill rate indicators are reporting as either 'green' or 'blue'.

3.4.4 There were 30 level 3 self-harm incidents occurred within the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No. L3 (self-harm)	Ward	Bank Usage	Staffing Fill Rate			
			RN Days	RN Nights	HCA Days	HCA

Incidents						Nights
6	Ward 15 Friarage	20.7%	70.2%	106.0%	122.6%	103.8%
5	Elm Ward	25.1%	92.0%	98.2%	112.5%	108.1%
4	Newberry Centre	9.6%	87.2%	113.8%	129.4%	134.7%
4	Clover/Ivy	29.2%	82.9%	102.9%	117.9%	162.6%
3	Brambling Ward	15.9%	91.9%	103.6%	100.8%	112.1%
2	Ebor Ward	7.3%	94.8%	101.4%	88.6%	99.2%
2	Farnham Ward	9.3%	106.7%	101.3%	103.9%	100.8%
1	Bilsdale Ward	14.2%	86.6%	105.7%	133.8%	116.5%
1	Bransdale Ward	25.5%	82.8%	107.3%	156.8%	141.9%
1	Cedar Ward	37.8%	121.0%	136.8%	125.4%	117.8%
1	Cedar Ward (NY)	8.9%	106.8%	109.4%	107.8%	114.8%
1	Lincoln Ward	14.1%	97.2%	100.9%	107.0%	101.7%
1	The Orchards (NY)	2.0%	95.2%	88.0%	100.0%	110.4%
1	Talbot Direct Care	0.6%	63.8%	94.9%	64.6%	77.6%
1	The Evergreen Centre	12.2%	89.3%	114.5%	150.1%	136.7%
1	Westwood Centre	14.8%	103.5%	91.4%	159.4%	197.7%
1	Newtondale Ward	16.7%	101.6%	76.8%	102.0%	127.2%
1	Sandpiper Ward	22.9%	90.0%	80.1%	118.0%	182.9%

- From the 37 level 3 self-harm incidents this equated to 18 wards across 5 localities.
- Durham & Darlington and Teesside had the highest number of level 3 incidents in the reporting period with 9 incidents in total.
- Ward 15 had the highest number of level 3 incidents across the reporting period with 6 incidents.
- 4 out of 18 wards reported as ‘red’ for their bank usage whilst all the others reported either as ‘amber’ or ‘green’.
- There were 13 fill rate indicators that reported as ‘red’ whilst the others all reported as either ‘green’ or ‘blue’.

3.4.5 There were 31 complaints raised during the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No. of Complaints	Ward	Bank Usage	Staffing Fill Rate			
			RN Days	RN Nights	HCA Days	HCA Nights
4	Elm Ward	25.1%	92.0%	98.2%	112.5%	108.1%
3	Maple Ward	21.1%	85.0%	95.2%	116.1%	115.1%
3	Tunstall Ward	1.7%	109.9%	109.8%	102.7%	100.3%
3	Westwood Centre	14.8%	103.5%	91.4%	159.4%	197.7%
2	Ayckbourn Unit Danby Ward	11.5%	82.5%	86.0%	107.6%	103.8%
2	Birch Ward	24.7%	85.3%	100.5%	121.1%	132.7%
1	Ayckbourn Unit Esk Ward	11.0%	75.0%	102.5%	114.5%	97.7%
1	Bilsdale Ward	14.2%	86.6%	105.7%	133.8%	116.5%
1	Cedar Ward	37.8%	121.0%	136.8%	125.4%	117.8%
1	Cedar Ward (NY)	8.9%	106.8%	109.4%	107.8%	114.8%

1	Farnham Ward	9.3%	106.7%	101.3%	103.9%	100.8%
1	Minster Ward	10.8%	97.9%	102.6%	93.0%	101.2%
1	Overdale Ward	15.3%	86.8%	101.1%	119.0%	101.3%
1	Stockdale Ward	17.9%	95.9%	106.5%	139.9%	121.6%
1	Newberry Centre	9.6%	87.2%	113.8%	129.4%	134.7%
1	Northdale Centre	31.2%	84.9%	97.1%	118.2%	97.3%
1	Lark	14.3%	85.1%	101.0%	103.6%	94.7%
1	Newtondale Ward	16.7%	101.6%	76.8%	102.0%	127.2%
1	Cherry Tree House	5.5%	93.3%	102.8%	83.3%	112.2%
1	Westerdale North	4.8%	100.6%	100.8%	114.4%	107.5%

- None of the complaints raised cited issues with staffing levels or skill mix. However, there were 2 complaints that did raise concerns with regards to staff attitude being negative (Elm Ward, Durham and Darlington; and Westwood, Teesside).
- Durham and Darlington locality had the highest number of complaints in the reporting period with 14 complaints raised.
- From those that had complaints raised 3 wards reported as 'red' for bank usage whilst the remaining wards reported either as 'amber' or 'green'
- 12 fill rate indicators were reporting as 'red' with 9 of these relating to registered nurses on days. All other metrics are reporting as either 'green' or 'blue'.

3.4.6 The Trust's Positive and Safe team continues to focus on high users of control and restraint. A high proportion of the Trust usage of prone and other forms of restraint is related to a small number of wards, and individual patients within those wards, and the various factors which may be contributing to this form part of the positive and safe remit.

3.4.7 The top 10 highest reported users of such techniques are defined further in the following table:

Ward	Locality	Bank Usage	Incidents of Restraint			
			Incidents	PRO used	Other	Restraint Total
The Evergreen Centre	Teesside	12.2%	864	1	1405	1406
Sandpiper Ward	Forensics	22.9%	418	18	968	986
Newberry Centre	Teesside	9.6%	690	2	914	916
Westwood Centre	Teesside	14.8%	304	3	519	522
Cedar Ward	Durham & Darlington	37.8%	251	17	458	475
Acomb Garth	York and Selby	6.5%	253		278	278
Oak Rise	York and Selby	5.2%	126		223	223
Elm Ward	Durham & Darlington	25.1%	119	3	175	178
Springwood	North Yorkshire	15.6%	127		148	148
Bek-Ramsey Ward	Durham & Darlington	7.8%	110	11	124	135

- The Evergreen Centre had 864 incidents requiring the use of restraint during the reporting period. This equated to 1406 restraints of which 1 was recorded as 'Prone'.
- 2 of the wards identified within the top 10 had a 'red' rating for their bank usage whilst the others reported as either 'amber' or 'green'.

3.4.8 This can be further correlated when looking at the 4 fill rate indicators as follows:

Ward	Staffing Fill Rate			
	RN Days	RN Nights	HCA Days	HCA Nights
The Evergreen Centre	89.3%	114.5%	150.1%	136.7%
Sandpiper Ward	90.0%	80.1%	118.0%	182.9%
Newberry Centre	87.2%	113.8%	129.4%	134.7%
Westwood Centre	103.5%	91.4%	159.4%	197.7%
Cedar Ward	121.0%	136.8%	125.4%	117.8%
Acomb Garth	98.0%	97.8%	111.7%	221.0%
Oak Rise	103.7%	98.2%	103.3%	137.1%
Elm Ward	92.0%	98.2%	112.5%	108.1%
Springwood Community Unit	62.9%	95.7%	124.9%	140.5%
Bek-Ramsey Ward	141.6%	100.5%	119.9%	98.9%

3.4.9 The use of Prone restraint will continue to be monitored within the Positive and Safe team and monthly within the Right Staffing reports, however, it is worth highlighting that during the reporting period there were 84 episodes of Prone used. This is an increase of 4 when compared to the previous 6 month report.

3.4.10 Until the MH and LD TEWV safer staffing dashboard is created, NICE Guidance for Safe Staffing for nursing in adult inpatient wards in acute hospitals provides helpful indicators to support Right Staffing that has been used as below to provide indicative information on whether safe nursing care is being provided.

The 9 indicators include:

- Adequacy of meeting patients' nursing care needs
- Falls
- Pressure ulcers
- Medication administration errors
- Missed breaks
- Nursing overtime
- Planned, required and available nurses for each shift
- High levels and / or ongoing reliance on temporary nursing
- Compliance with any mandatory training

3.4.11 The Right Staffing programme will develop a ward dashboard of safe nursing indicators for mental health which we can begin to report against. As an interim approach appendix 6 contains the 9 safe nursing indicators and presents this into a single dashboard.
This section won't discuss all of these metrics but the ones that haven't been discussed to date within this report.

3.4.12 Falls that have resulted in significant harm for all inpatient services have been examined. Within the reporting period there have been a total of 2 incidents across 2 wards. The ward and teams that these each relate to are as follows:

Locality	Speciality	Ward / Team	Number of incidents
Durham & Darlington	MHSOP	Roseberry Ward	1
North Yorkshire	MHSOP	Rowan Ward	1

- All of the falls incidents have occurred within the older people's service due to other health problems that they may encounter such as reduced vision, mobility and balance problems.

- In turning to the triangulation of data with the safe nursing indicators the following is of relevance:

    - All fill rate indicators for the 2 wards listed are reporting as either 'green' or 'blue'.
    - Both wards are reporting as 'amber' for bank usage
    - Agency and overtime are reporting as 'green' for both wards

3.4.13 Data in relation to pressure ulcers was obtained covering the reporting period. There were 6 incidents reported across 4 wards as follows:

Locality	Speciality	Ward / Team	Number of incidents
Teesside	AMH	Lustrum Vale	2
Forensics	Forensic MH	Mallard	2
Durham & Darlington	MHSOP	Oak Ward	1
North Yorkshire	MHSOP	Rowan Lea	1

- 2 of the 4 incidents occurred within older people's service which would be expected.
- In turning to the triangulation of staffing data:

    - Lustrum Vale and Mallard had at least one metric within the staffing fill rate that was classified as 'red'. All other fill rate indicators are reporting as either 'green' or 'blue'
    - Lustrum Vale and Mallard are reporting as 'amber' for bank usage whilst the others are reporting as 'green'
    - Agency workers were utilised within Rowan Lea.
    - Overtime was worked across all of the wards listed.

3.4.14 It is not possible to draw any meaningful conclusions from this data however the data does support the need to further review levels of clinical activity and safe nursing indicators across MHSOP. This will be picked up through the establishment review process.

3.4.15 There were 378 incidents of medication errors reported within the reporting period across 62 wards. The top 6 wards are shown as follows:

Locality	Specialty	Ward / Team	Number of incidents
Teesside	CYPS	Westwood Centre	33
York & Selby	MHSOP	Acomb Garth	17
Teesside	CYPS	The Evergreen Centre	16
York & Selby	Adults	Minster	14
York & Selby	LD	Oak Rise	13
Forensics	Forensic MH	Brambling	13

Durham & Darlington	Adults	Willow	12
Teesside	Adults	Lustrum Vale	12

- Lustrum Vale, Willow Ward and The Evergreen Centre all have at least 1 fill rate reporting as 'red'. All other fill rate indicators are reporting as either 'green' or 'blue'.
- Bank usage across all wards listed in the Top 6 are reporting as 'green' or 'amber' for their bank usage.
- Agency worked was only undertaken within 5 of the wards listed. All of which are reporting as 'green'.
- Overtime working occurred within all of the wards listed.

3.4.16 In terms of shifts worked without a break there were 3,380 shifts worked within the reporting period where breaks were not given. The top 5 wards were as follows:

Ward	No of eligible shifts	No. of eligible shifts without breaks 1st Jun 17 - 30th Nov 17	% of shifts without break	Days without breaks	Nights without break
Newberry Centre	4167	518	12%	316	202
Westwood Centre	3859	298	8%	169	129
Meadowfields	1886	158	8%	26	132
The Evergreen Centre	4306	155	4%	113	42
Sandpiper Ward	2410	135	6%	72	63

- The majority of the shifts where breaks were not given occurred on day shifts.
- It is not possible to highlight the reasons as to why breaks are not given due to this not being reported within the HealthRoster system.
- The absence of breaks is now being monitored on the report-out walls by localities.

This can be further correlated when looking at the 4 fill rate indicators as follows:

Ward Name	Staffing Fill Rate - Day - Registered Nurses	Staffing Fill Rate - Night - Registered Nurses	Staffing Fill Rate - Day - Unregistered Nurses	Staffing Fill Rate - Night - Unregistered Nurses	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours
Newberry Centre	87.2%	113.8%	129.4%	134.7%	9.6%	0.3%	5.9%
The Evergreen Centre	89.3%	114.5%	150.1%	136.7%	12.2%	2.0%	4.6%
Westwood Centre	103.5%	91.4%	159.4%	197.7%	14.8%	0.0%	10.0%
Sandpiper Ward	90.0%	80.1%	118.0%	182.9%	22.9%	0.0%	4.1%
Meadowfields	80.6%	96.5%	82.6%	111.0%	14.9%	8.9%	0.7%

- There are 5 fill rate indicators' that are reporting as 'red' of which 3 are in relation to registered nurses on days. All other indicators are reporting as either 'green' or 'blue'

- All wards listed are reporting as either 'amber' or 'green' for bank usage
- 3 of the 5 wards have utilised agency workers
- All wards listed have utilised overtime.

3.4.17 Breaks not taken due to clinical need is being monitored through the clinical report outs.

3.5 Reporting, investigating and acting on incidents

3.5.1 The NQB guidance advises NHS providers to follow best practice guidance in the investigation of all patient safety incidents, including root cause analysis for serious incidents. As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified. In addition NHS providers should consider reports of the 'red flag' issues suggested in the NICE guidance, and any other incident where a patient was or could have been harmed, as part of the risk management of patient safety incidents. Incidents must be reviewed alongside other data sources, including local quality improvement data (e.g. for omitted medication) clinical audits or locally agreed monitoring information, such as delays or omissions of planned care. Furthermore, NHS providers should actively encourage all staff to report any occasion where a less than optimal level of suitably trained or experienced staff harmed or seems likely to harm a patient. These locally reported incidents should be considered patient safety incidents rather than solely staff safety incidents, and they should be routinely uploaded to the National Reporting and Learning System.

3.5.2 The patient safety investigation team have been asked specifically to consider staffing levels and skill mix in relation to their investigation of inpatient serious incidents to support more robust triangulation of staffing data and aid root cause analysis.

3.5.3 It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. Within the reporting period there were 111 incidents raised citing issues with staffing. This is an increase of 37 when compared to the previous 6 month report. The incidents citing staffing problems were from across the following localities which may demonstrate the increased focus on appropriate escalation:

Locality	Number of incidents raised	Trend on previous 6 month
North Yorkshire	25	↑ (11)
Durham & Darlington	19	↑ (16)
Teesside	18	↑ (12)
Forensics	31	↑ (27)
York and Selby	18	↑ (8)

The Datix incidents citing staffing issues can be summarised as follows:

- An incident was reported highlighting that on the 5th August 2017 Harland (night duty) were left without a registered nurse. This has been fully investigated.
- From those incidents raised citing concerns with staffing levels, the following is of relevance:

- 77% of the incidents raised were in relation to night duty
- Forensic Services accounted for 36% of all incidents raised followed by North Yorkshire who accounted for 22%.
- Moving staff around to cover shortfalls on other wards presented concern
- Enhanced observations increasing staffing requirements also presented concern
- Concerns expressed with regards to staff not having the appropriate training (MOVA)
- During October and November there were 10 incidents reported whereby agency staff had not attended for duty. This was mainly within the York and Selby locality.
- Short notice sickness also caused issues across the trust.

- The issues reported from those incidents raised citing staffing levels included the following:

  - Observations not being able to be carried out
  - Breaks not being taken
  - Staff and patient safety compromised
  - Undue stress and anxiety for staff
  - Wards not running on required staffing levels
  - Patient activities being cancelled
  - Patient leave not being facilitated

The trust adopted an escalation process to ensure a standard approach was adopted across the Trust and a timely response to ensure patient safety is not compromised. The escalation process will be reviewed as part of the Right Staffing programme to ensure that it is delivering what it was intended to do since its introduction. Monthly monitoring of this occurs within the monthly Safe Staffing reports.

It is anticipated that the introduction of the Duty Nurse Coordinator on site at night will support and enhance practice out of hours and lead to improved escalation and resolution of incidents.

3.6 Patient, staff and carer feedback

3.6.1 The NQB guidance states that Boards must ensure that their organisations foster a culture of professionalism and responsiveness in healthcare professionals, so that staff feels able to use their professional judgement to raise concerns and make suggestions for change that improves care. This includes ensuring the organisation has policies to support clinical staff to uphold professional codes of practice. In addition trusts should proactively seek the views of patients, carers and staff and the board should routinely consider any feedback relevant to staffing capacity, capability and morale, such as national and local surveys, stories, complaints and compliments.

3.6.2 A further analysis of the 31 complaints has been undertaken to identify whether there were any specific issues rose citing staffing levels. The review concluded that there were no complaints raised citing concerns with staffing levels or skill mix. There were however, 2 complaints that did highlight concerns with regards to negative staff attitude.

3.6.3 In addition analysis has been undertaken with regards to patient and carer feedback that has been submitted in relation to the friends and family test. In April 2017 the Trust introduced a new system (Meridian) to capture the friends and family test and a new question was introduced; is there anything we could do to make the service better? 120 comments were received that suggested more staff was required within our inpatient wards trust wide to support further activities including supporting leave and enhance communication.

3.6.4 The trust receives compliments and these are captured and published via the weekly e-Bulletin. A total of 102 compliments were received during the reporting period specifically in relation to highlighting a number of individuals and commend the work they have undertaken. These compliments cover all localities. From the total number of compliments there was nothing highlighted that was specific to actual staffing levels.

3.6.5 Future development of this particular aspect will be undertaken as part of the Right Staffing programme that will seek to triangulate specific comments against a range of care quality indicators and metrics ensuring that this is accessible in a single dashboard.

3.7 Care hours per patient day (CHPPD)

3.7.1 Although there is currently no requirement for TEWV to report nationally the care hours per patient day, the Trust did take part in a recent pilot which also included AHP's. This has been reported previously to the board. From April 2018 there is to be a mandated requirement for the trust to publish CHPPD and clarity has been sought that this will only include nursing staff at this point in time. The Right Staffing programme will be reviewing this data once reporting commences in order to better understand what 'good' looks like for TEWV.

3.8 Draft LD Staffing Guidance "An improvement resource for learning disability services (2016) NQB

3.8.1 Previous reports have highlighted the Learning Disability specific safe staffing guidance which built on the general NQB guidance of 2016. This guidance included the outlining of an approach to conducting staffing reviews, and the need for flexible contingency planning and an adaptable workforce in view of future service models. A regional task and finish group has since been established by Health Education England to review the current picture around Learning Disability nurse training, recognising some of the issues around recruitment and pre-registration training highlighted earlier in our own report (section 3.2.4)

3.8.2 Further guidance has since emerged in draft format for mental health services; 'Safe sustainable and productive staffing, an improvement resource from mental health services' (2017). As with previous guidance this is structured around the three NQB themes of right staff, right shills, right place and time, and highlights the need to undertake evidence – based workforce planning including strategic establishment reviews. The review requires a combination of professional judgment and evidence based tools, with the Hurst tool remaining the recommended format. It makes the following recommendations which Boards should seek assurance on:

- **Right Staff:**
  - The organisation has systems to monitor staffing requirements across all services (based on acuity and demand) and these are measured and reviewed against actual team staffing levels.
  - There is an agreed process for escalating to the board significant issues that affect safe and sustainable staffing
  - Staffing reports take account of local factors that affect safe delivery of services.
  - The annually agreed 'headroom' percentage uplift reflects organisational needs, is deliverable and achieved.
  - Clinical leaders and managers have allocated sufficient time to supervise and lead effectively.
  - There is an annual review of the safe, sustainable, staffing references benchmarking data that the organisation has access to (both internal and external).

- **Right Skills:**
  - The organisation has processes to identify, analyse and implement evidence-based practice across services.
  - Where new care models are developed, a clear plan exists to support staff so that the change takes place safely and affordably.
  - There are clear plans to evaluate the changes and both are reviewed.
  - The organisation takes an evidence-based approach to support efficient and effective team working.
  - The organisation has systems and processes to promote staff's physical and emotional wellbeing and prevent fatigue and burnout.
  - The organisation has a strategy for retaining staff, which clearly states learning and development opportunities for all staff groups and plans for attracting, recruiting and retaining staff, aligned with the workforce plan.

- **Right Place and Time:**
  - Standard approaches across services prevent unwarranted clinical variation in service provision.
  - Technology is available to staff to undertake their duties safely, efficiently and effectively.
  - Embedded quality improvement methods enable clinical teams to identify waste and make changes at service level to improve quality.
  - Regular reviews of shift patterns and e-Rostering support the efficient delivery of care and treatment.
  - Thresholds for using bank and agency staffing are set, monitored and responded to, with temporary staff recruited wherever possible from in-house staffing banks.
  - Service models and staffing deployment reflect demand, including seasonal or other variation (across seven-day services where appropriate).

3.8.3 The document sets out a recommended approach to establishment reviews, which has been taken into account within the restructured Right Staffing programme and its work streams. Where the programme considers the multidisciplinary workforce which includes the community based services.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

No direct risks to patient safety from the staffing data have been identified in this 6 monthly report. There is a risk to CQC compliance if we fail to achieve our planned registered nursing levels on a daily basis. This will need to be closely monitored through the monthly and 6 monthly staffing reports to Board; mitigation is being addressed through the initiatives set out in this report that will be delivered through the Right Staffing programme.

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. We are continuing to monitor via the Right Staffing work stream the emerging issue of qualified day cover to further understand this and the use of the evidence based tools to review nursing establishments.

4.3 Legal and Constitutional (including the NHS Constitution):

The Care Quality Commission and NHS England have set regulatory and contractual requirements that the Trust ensures adequate and appropriate staffing levels and skill mix to deliver safe and effective care. Inadequate staffing can result in non-compliance action and contractual breach. The March 2013 NHS England and CQC directives set out specific requirements that will be checked through inspection and contractual monitoring as they are also included in standard commissioning contracts.

The Trust has complied with these directives to date.

4.4 Equality and Diversity:

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

4.5 Other implications:

There are no other implications identified

5.0 RISKS:

5.1 The trust recognises the current pressures in activity and acuity of in-patient services, recruitment issues and the risks of being unable to have the right staff in the right place at the right time across our services. EMT has supported the establishment of a Right Staffing programme board led by the Director of Nursing and Governance to build on the existing Right Staffing approach and mitigate the identified risks.

6.0 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 Right Staffing programme and its workstreams will continue to review existing processes and prepare for the new requirements and any new guidance throughout the next two financial years. Data collection and analysis will be further developed and reported upon in future reports.

6.3 Despite extensive analysis of the available data in this report, there are no clear correlations between these strands of data at present highlighting patient safety or significant quality issues.

6.4 It is clear that flexible staffing is being used on a regular basis to meet patient need and demand. Initiatives set out in this paper attempt to address having the right staff in the right place at the right time in order that staffing resources can be better planned and utilised.

7.0 RECOMMENDATIONS:

- That the Board of Directors notes the outputs of the reports and raises any issues for further investigation and development.

Emma Haimes, Head of Quality Data and Patient Experience
Stephen Scorer, Associate Director of Nursing
Joe Bergin, Right Staffing Programme Manager
Elizabeth Moody, Director of Nursing and Governance

January 2018

Budgeted and Actual Staffing Establishments in WTE

Appendix 1

Locality	WARD	Speciality	Establishment at 01/06/17				Establishment at 30/11/17				Comparison 01/06/17 to 30/11/17 Budget v Actual WTE hours			
			Registered Staff		Unregistered Staff		Registered staff		Unregistered staff		Registered Staff		Unregistered Staff	
			Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
Durham & Darlington	Cedar Ward	Adults	8.50	9.80	14.30	15.00	15.30	16.60	14.80	12.00	6.80	6.80	0.50	-3.00
	Birch Ward	Adults	9.60	10.40	15.90	13.70	9.60	11.10	14.30	12.70	0.00	0.70	-1.60	-1.00
	Primrose Lodge	Adults	8.60	6.00	11.40	10.00	9.60	6.80	11.40	12.00	1.00	0.80	0.00	2.00
	Willow Ward	Adults	8.60	9.40	12.40	12.10	9.60	10.60	12.40	11.50	1.00	1.20	0.00	-0.60
	Maple Ward	Adults	8.60	9.30	11.40	11.60	9.60	10.30	11.40	12.60	1.00	1.00	0.00	1.00
	Elm Ward	Adults	8.60	7.80	11.40	10.40	9.60	7.80	12.40	12.40	1.00	0.00	1.00	2.00
	Farnham Ward	Adults	8.60	10.60	11.40	10.60	9.60	8.60	11.40	11.00	1.00	-2.00	0.00	0.40
	Tunstall Ward	Adults	8.60	12.00	11.40	11.60	9.60	10.40	11.40	11.10	1.00	-1.60	0.00	-0.50
	Holly Unit	CYPS	4.60	3.80	5.60	4.80	5.60	6.60	5.60	4.80	1.00	2.80	0.00	0.00
	Bek, Talbot Wards	LD	9.60	8.60	25.70	25.00	9.60	8.60	22.90	23.30	0.00	0.00	-2.80	-1.70
	Ceddesfeld Ward	MHSOP	8.60	8.40	13.20	15.30	8.60	8.20	13.20	15.50	0.00	-0.20	0.00	0.20
	Hamsterley Ward	MHSOP	8.60	9.40	13.20	13.00	9.60	9.40	13.20	13.10	1.00	0.00	0.00	0.10
	Oak Ward	MHSOP	8.60	8.80	11.40	12.30	9.60	8.80	12.40	13.30	1.00	0.00	1.00	1.00
	Roseberry Wards	MHSOP	8.60	6.70	12.40	12.00	8.60	7.70	12.40	11.00	0.00	1.00	0.00	-1.00
Forensics	Clover/Ivy	Forensics LD	8.10	6.00	20.20	17.80	8.10	7.00	20.20	16.00	0.00	1.00	0.00	-1.80
	Thistle Ward	Forensics LD	10.70	5.00	14.80	14.40	10.70	7.00	14.80	13.90	0.00	2.00	0.00	-0.50
	Northdale Centre	Forensics LD	8.10	8.00	26.80	21.70	8.10	10.00	26.80	21.20	0.00	2.00	0.00	-0.50
	Oakwood	Forensics LD	8.10	8.10	6.60	8.80	9.10	6.10	6.60	8.00	1.00	-2.00	0.00	-0.80
	Eagle/Osprey	Forensics LD	8.10	9.80	17.50	17.10	9.10	5.70	17.50	14.20	1.00	-4.10	0.00	-2.90
	Harrier/Hawk	Forensics LD	8.10	5.80	20.20	16.90	8.10	6.80	20.20	17.00	0.00	1.00	0.00	0.10
	Langley Ward	Forensics LD	8.10	7.00	8.30	7.00	8.10	7.00	83.00	7.00	0.00	0.00	74.70	0.00

	Kestrel/Kite	Forensics LD	8.10	9.80	22.00	22.60	8.10	8.70	22.00	20.90	0.00	-1.10	0.00	-1.70
	Brambling Ward	Forensics MH	8.10	7.00	13.20	14.70	8.10	8.00	13.20	14.00	0.00	1.00	0.00	-0.70
	Jay Ward	Forensics MH	8.10	7.50	13.20	12.80	8.10	7.90	13.20	13.90	0.00	0.40	0.00	1.10
	Sandpiper Ward	Forensics MH	10.70	8.50	17.90	14.10	10.70	9.90	17.10	18.50	0.00	1.40	-0.80	4.40
	Merlin	Forensics MH	10.70	9.50	15.30	14.20	10.70	8.90	15.30	15.10	0.00	-0.60	0.00	0.90
	Swift Ward	Forensics MH	8.10	7.90	15.30	14.10	8.10	7.80	15.30	16.60	0.00	-0.10	0.00	2.50
	Fulmar Ward.	Forensics MH	8.10	8.10	15.30	14.20	0.00	0.00	0.00	0.00	-8.10	-8.10	-15.30	-14.20
	Lark	Forensics MH	8.10	7.40	13.20	14.00	8.10	8.00	13.20	13.40	0.00	0.60	0.00	-0.60
	Kirkdale Ward	Forensics MH	8.10	7.90	15.30	14.80	8.10	9.90	15.30	13.80	0.00	2.00	0.00	-1.00
	Mallard Ward	Forensics MH	8.10	5.60	15.30	15.50	8.10	8.20	15.30	15.80	0.00	2.60	0.00	0.30
	Mandarin	Forensics MH	8.10	7.90	13.20	12.50	8.10	8.70	13.20	15.30	0.00	0.80	0.00	2.80
	Nightingale Ward	Forensics MH	8.10	7.90	13.20	13.20	8.10	8.90	13.20	14.50	0.00	1.00	0.00	1.30
	Linnet Ward	Forensics MH	8.10	7.90	13.20	13.00	8.10	8.30	13.20	13.00	0.00	0.40	0.00	0.00
	Newtondale Ward	Forensics MH	10.70	10.00	17.90	17.40	10.70	10.90	17.90	16.80	0.00	0.90	0.00	-0.60
North Yorkshire	The Orchards	Adults	11.40	11.40	5.40	5.40	11.40	11.60	5.40	4.70	0.00	0.20	0.00	-0.70
	Danby Ward	Adults	8.10	5.00	10.70	9.80	8.10	5.00	10.70	11.00	0.00	0.00	0.00	1.20
	Esk Ward	Adults	10.10	7.40	10.70	11.60	11.10	7.40	10.70	10.90	1.00	0.00	0.00	-0.70
	Ward 15 Friarage	Adults	9.10	6.00	10.70	9.50	10.10	7.00	10.70	11.50	1.00	1.00	0.00	2.00
	Cedar Ward (NY)	Adults	9.10	7.70	15.20	10.00	10.10	8.20	15.20	13.50	1.00	0.50	0.00	3.50
	Ward 14	MHSOP	8.10	7.80	10.00	9.40	9.10	7.70	10.00	9.40	1.00	-0.10	0.00	0.00
	Rowan Ward	MHSOP	8.90	9.30	12.70	11.30	9.90	9.30	12.70	10.40	1.00	0.00	0.00	-0.90
	Springwood	MHSOP	8.10	6.00	12.50	10.40	9.10	6.40	12.50	11.40	1.00	0.40	0.00	1.00
	Rowan Lea	MHSOP	8.10	8.40	17.90	19.40	9.10	9.00	17.90	17.90	1.00	0.60	0.00	-1.50
Teesside	Bedale Ward	Adults	8.20	7.00	13.70	11.80	8.20	10.00	13.70	14.10	0.00	3.00	0.00	2.30
	Bilsdale Ward	Adults	8.20	8.00	11.00	12.00	9.20	11.80	11.00	13.60	1.00	3.80	0.00	1.60
	Bransdale Ward	Adults	8.20	7.80	10.00	9.00	9.20	10.60	10.00	12.90	1.00	2.80	0.00	3.90

	Overdale Ward	Adults	8.20	8.60	11.00	9.40	9.20	9.60	11.00	7.60	1.00	1.00	0.00	-1.80
	Stockdale Ward	Adults	8.20	8.80	11.00	10.90	9.20	10.20	11.00	12.80	1.00	1.40	0.00	1.90
	Lincoln Ward	Adults	9.70	6.90	12.90	13.90	0.00	0.00	0.00	0.00	-9.70	-6.90	-12.90	-13.90
	Lustrum Vale	Adults	10.30	8.50	11.00	10.30	10.30	9.70	11.00	10.30	0.00	1.20	0.00	0.00
	Baysdale	CYPS	6.70	7.60	12.70	13.30	7.70	6.30	12.70	12.50	1.00	-1.30	0.00	-0.80
	Newberry Centre	CYPS	12.70	14.00	15.20	17.00	13.02	18.90	15.22	19.90	0.32	4.90	0.02	2.90
	The Evergreen Centre	CYPS	13.50	15.00	18.70	23.70	14.50	17.30	18.70	29.80	1.00	2.30	0.00	6.10
	Westwood Centre	CYPS	14.70	14.00	16.50	18.90	17.10	16.40	16.40	22.80	2.40	2.40	-0.10	3.90
	Thornaby Road	LD	3.60	3.40	11.90	9.20	3.80	4.00	11.90	9.70	0.20	0.60	0.00	0.50
	Aysgarth	LD	6.00	6.00	11.50	9.20	6.00	6.00	11.50	10.30	0.00	0.00	0.00	1.10
	Bankfields Court Flats	LD	21.90	17.80	67.80	43.50	21.90	18.40	67.80	41.90	0.00	0.60	0.00	-1.60
	Bankfields Court Unit 2	LD												
	Bankfields Court Unit 3	LD												
	Bankfields Court Unit 4	LD												
	The Lodge	LD												
	Wingfield Ward	MHSOP	8.80	8.80	9.10	8.80	8.80	5.60	9.10	6.10	0.00	-3.20	0.00	-2.70
	Westerdale South	MHSOP	8.20	10.20	11.00	13.90	8.70	15.30	11.00	18.60	0.50	5.10	0.00	4.70
	Westerdale North	MHSOP	8.20	8.40	11.00	11.40	9.70	15.50	11.00	14.20	1.50	7.10	0.00	2.80
	Ebor Ward	Adults	9.40	8.50	11.70	10.70	9.40	9.10	11.70	9.60	0.00	0.60	0.00	-1.10
	Minster Ward	Adults	9.40	9.90	11.70	6.80	10.40	8.90	11.70	8.80	1.00	-1.00	0.00	2.00
York & Selby	Cherry Tree House	MHSOP	11.70	9.40	14.50	14.20	11.70	8.50	14.50	13.20	0.00	-0.90	0.00	-1.00
	Oak Rise	ALD	9.40	12.40	21.20	17.00	9.40	11.70	21.20	15.00	0.00	-0.70	0.00	-2.00
	Acomb Garth	MHSOP	11.00	8.70	13.50	17.40	11.00	7.80	13.50	14.80	0.00	-0.90	0.00	-2.60
	Meadowfields	MHSOP	9.30	8.20	13.50	11.80	9.30	7.80	14.50	11.20	0.00	-0.40	1.00	-0.60

Average fill rate covering the period of 1st June 2017 to 30th November 2017

Appendix 2

Ward Name	Locality	Speciality	Bed Numbers (NOV)	6 Months - 1st June 2017 - 30th November 2017					
				Registered Average %		Unregistered Average %		Bank Usage vs Actual Hours	
				Day	Night	Day	Night	Hours	% against Actual Hours
Bek-Ramsey Ward	Durham & Darlington	LD	11	141.6%	100.5%	119.9%	98.9%	2014.15	7.8%
Birch Ward	Durham & Darlington	Adults	15	85.3%	100.5%	121.1%	132.7%	5040.49	24.7%
Cedar Ward	Durham & Darlington	Adults	10	121.0%	136.8%	125.4%	117.8%	10318.12	37.8%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	91.5%	99.5%	116.1%	101.6%	1107.01	5.9%
Elm Ward	Durham & Darlington	Adults	20	92.0%	98.2%	112.5%	108.1%	4560.04	25.1%
Farnham Ward	Durham & Darlington	Adults	20	106.7%	101.3%	103.9%	100.8%	1536.00	9.3%
Hamsterley Ward	Durham & Darlington	MHSOP	15	95.8%	102.8%	146.3%	153.9%	4847.44	21.5%
Holly Unit	Durham & Darlington	CYPS	4	148.0%	118.8%	131.8%	163.6%	793.62	12.1%
Maple Ward	Durham & Darlington	Adults	20	85.0%	95.2%	116.1%	115.1%	3494.33	21.1%
Oak Ward	Durham & Darlington	MHSOP	12	95.8%	98.4%	99.2%	100.8%	479.76	2.9%
Primrose Lodge	Durham & Darlington	Adults	15	74.2%	98.9%	124.8%	100.0%	1884.00	11.8%
Roseberry Wards	Durham & Darlington	MHSOP	15	100.3%	101.1%	102.0%	102.2%	2004.41	12.3%
Talbot Direct Care	Durham & Darlington	CYPS	1	63.8%	94.9%	64.6%	77.6%	80.50	0.6%
Tunstall Ward	Durham & Darlington	Adults	20	109.9%	109.8%	102.7%	100.3%	288.00	1.7%
Willow Ward	Durham & Darlington	Adults	15	89.8%	100.2%	122.9%	101.7%	1166.99	7.1%
Brambling Ward	Forensics	Forensics MH	13	91.9%	103.6%	100.8%	112.1%	2724.48	15.9%
Clover/Ivy	Forensics	Forensics LD	12	82.9%	102.9%	117.9%	162.6%	7620.26	29.2%
Eagle/Osprey	Forensics	Forensics LD	10	79.1%	101.5%	90.2%	99.4%	2485.01	13.5%
Fulmar Ward.	Forensics	Forensics MH	12	97.2%	102.6%	124.4%	176.2%	5245.25	26.7%
Harrier/Hawk	Forensics	Forensics LD	10	76.8%	107.1%	104.6%	108.9%	3344.18	15.0%
Jay Ward	Forensics	Forensics MH	5	85.1%	102.8%	96.6%	101.7%	1412.50	8.7%
Kestrel/Kite.	Forensics	Forensics LD	16	83.4%	100.2%	114.2%	143.1%	4739.50	18.3%
Langley Ward	Forensics	Forensics LD	10	75.6%	100.0%	111.5%	112.7%	1760.08	13.8%
Lark	Forensics	Forensics MH	15	85.1%	101.0%	103.6%	94.7%	2233.00	14.3%
Linnet Ward	Forensics	Forensics MH	17	85.3%	105.4%	118.2%	128.5%	3249.95	17.3%
Mallard Ward	Forensics	Forensics MH	16	89.7%	106.6%	107.3%	150.4%	3948.27	18.8%
Mandarin	Forensics	Forensics MH	16	84.3%	105.2%	137.2%	155.2%	5308.65	25.4%
Merlin	Forensics	Forensics MH	10	106.2%	91.9%	157.4%	216.9%	9968.33	33.3%
Newtondale Ward	Forensics	Forensics MH	20	101.6%	76.8%	102.0%	127.2%	3802.65	16.7%
Nightingale Ward	Forensics	Forensics MH	16	78.5%	100.8%	97.9%	95.1%	1858.75	11.8%

Northdale Centre	Forensics	Forensics LD	12	84.9%	97.1%	118.2%	97.3%	9024.90	31.2%
Oakwood	Forensics	Forensics LD	8	81.4%	100.0%	180.9%	100.0%	829.75	6.9%
Sandpiper Ward	Forensics	Forensics MH	8	90.0%	80.1%	118.0%	182.9%	6092.75	22.9%
Swift Ward	Forensics	Forensics MH	10	82.7%	99.4%	100.9%	103.8%	2891.25	16.0%
Thistle	Forensics	Forensics LD	5	61.2%	102.4%	112.3%	97.3%	1827.92	10.7%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	82.5%	86.0%	107.6%	103.8%	1710.25	11.5%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	75.0%	102.5%	114.5%	97.7%	1714.75	11.0%
Cedar Ward (NY)	North Yorkshire	Adults	14	106.8%	109.4%	107.8%	114.8%	1806.55	8.9%
Rowan Lea	North Yorkshire	MHSOP	20	97.3%	105.3%	116.1%	101.1%	2007.11	9.0%
Rowan Ward	North Yorkshire	MHSOP	16	91.1%	104.2%	158.5%	146.7%	2154.50	10.8%
Springwood Community Unit	North Yorkshire	MHSOP	14	62.9%	95.7%	124.9%	140.5%	2868.32	15.6%
The Orchards (NY)	North Yorkshire	Adults	10	95.2%	88.0%	100.0%	110.4%	263.00	2.0%
Ward 14	North Yorkshire	MHSOP	10	89.6%	102.6%	104.1%	102.5%	307.00	2.0%
Ward 15 Friarage	North Yorkshire	Adults	12	70.2%	106.0%	122.6%	103.8%	3050.75	20.7%
Aysgarth	Teesside	LD	6	96.6%	102.2%	98.7%	99.2%	3023.50	22.4%
Bankfields Court Flats	Teesside	LD	6	78.2%	114.9%	87.9%	98.3%	1451.27	12.5%
Bankfields Court Unit 2	Teesside	LD	5	110.5%	102.9%	108.8%	122.3%	2549.06	16.5%
Bankfields Court Unit 3	Teesside	LD	6	78.9%	91.2%	99.2%	98.7%	767.25	5.6%
Bankfields Court Unit 4	Teesside	LD	6	100.7%	107.0%	90.9%	98.0%	1071.83	8.6%
Baysdale	Teesside	CYPS	6	112.1%	101.1%	98.4%	98.6%	893.95	6.0%
Bedale Ward	Teesside	Adults	10	73.1%	75.0%	171.7%	135.6%	6140.40	26.5%
Bilsdale Ward	Teesside	Adults	14	86.6%	105.7%	133.8%	116.5%	2404.33	14.2%
Bransdale Ward	Teesside	Adults	14	82.8%	107.3%	156.8%	141.9%	4814.47	25.5%
Kirkdale Ward	Teesside	Adults	16	86.5%	101.1%	117.9%	102.2%	2862.50	15.7%
Lincoln Ward	Teesside	Adults	20	97.2%	100.9%	107.0%	101.7%	2212.58	14.1%
Lustrum Vale	Teesside	Adults	20	77.6%	104.2%	127.9%	107.4%	3839.75	22.7%
Newberry Centre	Teesside	CYPS	14	87.2%	113.8%	129.4%	134.7%	2341.49	9.6%
Overdale Ward	Teesside	Adults	18	86.8%	101.1%	119.0%	101.3%	2386.98	15.3%
Stockdale Ward	Teesside	Adults	18	95.9%	106.5%	139.9%	121.6%	3103.22	17.9%
The Evergreen Centre	Teesside	CYPS	16	89.3%	114.5%	150.1%	136.7%	4147.02	12.2%
The Lodge	Teesside	LD	1	95.4%	92.3%	81.7%	94.5%	453.32	4.5%
Westerdale North	Teesside	MHSOP	18	100.6%	100.8%	114.4%	107.5%	811.25	4.8%
Westerdale South	Teesside	MHSOP	14	91.0%	106.2%	184.9%	185.6%	10333.99	34.4%
Westwood Centre	Teesside	CYPS	12	103.5%	91.4%	159.4%	197.7%	4862.25	14.8%
Wingfield Ward	Teesside	MHSOP	10	90.6%	104.3%	100.0%	97.8%	2560.25	21.1%
Acomb Garth	York and Selby	MHSOP	14	98.0%	97.8%	111.7%	221.0%	1637.50	6.5%
Cherry Tree House	York and Selby	MHSOP	18	93.3%	102.8%	83.3%	112.2%	1065.00	5.5%

Ebor Ward	York and Selby	Adults	12	**94.8%**	**101.4%**	**88.6%**	**99.2%**	1160.50	7.3%
Meadowfields	York and Selby	MHSOP	14	**80.6%**	**96.5%**	**82.6%**	**111.0%**	2614.25	14.9%
Minster Ward	York and Selby	Adults	12	**97.9%**	**102.6%**	**93.0%**	**101.2%**	1676.00	10.8%
Oak Rise	York and Selby	LD	8	**103.7%**	**98.2%**	**103.3%**	**137.1%**	1144.75	5.2%
Total			895	**90.0%**	**99.7%**	**114.9%**	**119.7%**	208193.18	15.7%

	Blue	Green	Red
Fill Rate	120% and over	90 - 119.9%	89.99% or less

	Green	Amber	Red
Bank Usage	10% or less	11% - 24.9%	25% and over

Absence Factors and Additional Staffing Usage **Appendix 3**

Ward Name	Locality	Speciality	Overtime		Agency		Bank		Maternity		Sickness		Vacancies	
			Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours
Danby Ward	North Yorkshire	Adults	1013	6.8%	356.8	2.4%	1710.3	11.5%	93.0	0.6%	460.0	3.1%	1563.8	9.2%
Esk Ward	North Yorkshire	Adults	366.5	2.4%	0.0	0.0%	1714.8	11.0%	982.5	6.3%	0.0	0.0%	1601.3	8.1%
Bedale Ward	Teesside	Adults	1271.37	5.5%	184.0	0.8%	6140.4	26.5%	0.0	0.0%	655.0	2.8%	1653.8	6.7%
Bilsdale Ward	Teesside	Adults	994.87	5.9%	57.5	0.3%	2404.3	14.2%	0.0	0.0%	1106.5	6.6%	840.0	4.8%
Birch Ward	Durham & Darlington	Adults	1083.27	5.3%	180.0	0.9%	5040.5	24.7%	1666.4	8.2%	1684.5	8.3%	1031.3	4.7%
Bransdale Ward	Teesside	Adults	686.35	3.6%	46.0	0.2%	4814.5	25.5%	0.0	0.0%	846.0	4.5%	1683.8	9.6%
Cedar Ward	Durham & Darlington	Adults	925.18	3.4%	0.0	0.0%	10318.1	37.8%	0.0	0.0%	2256.0	8.3%	843.8	2.6%
Cedar Ward (NY)	North Yorkshire	Adults	464.64	2.3%	4420.5	21.7%	1806.6	8.9%	366.0	1.8%	1074.0	5.3%	3603.8	18.0%
Ebor Ward	York and Selby	Adults	450.72	2.8%	701.0	4.4%	1160.5	7.3%	0.0	0.0%	596.5	3.8%	1747.5	10.6%
Elm Ward	Durham & Darlington	Adults	739.09	4.1%	72.0	0.4%	4560.0	25.1%	480.0	2.6%	1152.0	6.3%	1106.3	6.6%
Farnham Ward	Durham & Darlington	Adults	532.67	3.2%	0.0	0.0%	1536.0	9.3%	0.0	0.0%	1280.2	7.8%	558.8	3.7%
Kirkdale Ward	Teesside	Adults	574.73	3.2%	67.5	0.4%	2862.5	15.7%	517.5	2.8%	3129.3	17.2%	1012.5	5.6%
Lincoln Ward	Teesside	Adults	365.43	2.3%	0.0	0.0%	2212.6	14.1%	637.5	4.1%	786.0	5.0%	1260.0	8.6%
Lustrum Vale	Teesside	Adults	544	3.2%	0.0	0.0%	3839.8	22.7%	46.0	0.3%	3921.3	23.2%	1053.8	5.7%
Maple Ward	Durham & Darlington	Adults	685.23	4.1%	264.0	1.6%	3494.3	21.1%	712.5	4.3%	2813.5	17.0%	326.3	2.0%
Minster Ward	York and Selby	Adults	1288.81	8.3%	778.5	5.0%	1676.0	10.8%	75.0	0.5%	420.0	2.7%	1245.0	8.4%
Overdale Ward	Teesside	Adults	480.25	3.1%	11.5	0.1%	2387.0	15.3%	1105.5	7.1%	828.5	5.3%	1080.0	6.6%
Primrose Lodge	Durham & Darlington	Adults	619.33	3.9%	12.0	0.1%	1884.0	11.8%	0.0	0.0%	1739.0	10.9%	607.5	4.3%
Stockdale Ward	Teesside	Adults	753.9	4.3%	80.5	0.5%	3103.2	17.9%	176.0	1.0%	1497.6	8.6%	708.8	4.9%
The Orchards (NY)	North Yorkshire	Adults	1102.51	8.2%	0.0	0.0%	263.0	2.0%	138.0	1.0%	372.0	2.8%	330.0	1.9%
Tunstall Ward	Durham & Darlington	Adults	758.19	4.5%	12.0	0.1%	288.0	1.7%	0.0	0.0%	2016.5	12.0%	551.3	3.4%
Ward 15 Friarage	North Yorkshire	Adults	496.88	3.4%	301.3	2.0%	3050.8	20.7%	415.8	2.8%	967.3	6.5%	817.5	6.1%
Willow Ward	Durham & Darlington	Adults	523.23	3.2%	12.0	0.1%	1167.0	7.1%	0.0	0.0%	1280.0	7.8%	472.5	3.0%
Baysdale	Teesside	CYPS	1190.03	8.0%	0.0	0.0%	894.0	6.0%	435.0	2.9%	1674.5	11.2%	675.0	3.7%
Holly Unit	Durham & Darlington	CYPS	413.16	6.3%	0.0	0.0%	793.6	12.1%	0.0	0.0%	1215.0	18.5%	450.0	7.7%
Newberry Centre	Teesside	CYPS	1446.93	5.9%	67.5	0.3%	2341.5	9.6%	0.0	0.0%	1421.5	5.8%	12135.0	49.6%
Talbot Direct Care	Durham & Darlington	CYPS	454.3	3.6%	0.0	0.0%	80.5	0.6%	0.0	0.0%	273.0	2.1%	2321.3	16.7%
The Evergreen Centre	Teesside	CYPS	1548.18	4.6%	664.0	2.0%	4147.0	12.2%	1642.5	4.8%	2763.5	8.1%	468.8	1.3%
Westwood Centre	Teesside	CYPS	3267.04	10.0%	0.0	0.0%	4862.3	14.8%	574.5	1.8%	1195.0	3.6%	1023.8	4.2%
Clover/Ivy	Forensics	FLD	1647.98	6.3%	98.0	0.4%	7620.3	29.2%	1226.3	4.7%	936.8	3.6%	1826.3	7.1%

Eagle/Osprey	Forensics	FLD	653.25	3.5%	180.5	1.0%	2485.0	13.5%	1203.8	6.5%	1056.5	5.7%	1372.5	6.7%
Harrier/Hawk	Forensics	FLD	1253.06	5.6%	22.5	0.1%	3344.2	15.0%	0.0	0.0%	862.5	3.9%	1972.5	9.0%
Kestrel/Kite.	Forensics	FLD	976.71	3.8%	67.5	0.3%	4739.5	18.3%	978.8	3.8%	1680.3	6.5%	750.0	2.7%
Langley Ward	Forensics	FLD	354.83	2.8%	22.5	0.2%	1760.1	13.8%	0.0	0.0%	1372.3	10.7%	678.8	5.2%
Northdale Centre	Forensics	FLD	1549.58	5.4%	791.0	2.7%	9024.9	31.2%	712.5	2.5%	1010.9	3.5%	2580.0	8.8%
Oakwood	Forensics	FLD	772.84	6.5%	0.0	0.0%	829.8	6.9%	288.8	2.4%	785.8	6.6%	266.3	1.8%
Thistle	Forensics	FLD	844.42	4.9%	22.5	0.1%	1827.9	10.7%	0.0	0.0%	21.0	0.1%	2122.5	13.2%
Brambling Ward	Forensics	FMH	302.25	1.8%	0.0	0.0%	2724.5	15.9%	877.5	5.1%	2225.8	13.0%	581.3	4.1%
Fulmar Ward.	Forensics	FMH	549.2	2.8%	0.0	0.0%	5245.3	26.7%	247.5	1.3%	619.2	3.2%	1961.3	5.1%
Jay Ward	Forensics	FMH	795.4	4.9%	0.0	0.0%	1412.5	8.7%	0.0	0.0%	948.0	5.8%	701.3	4.9%
Lark	Forensics	FMH	1006.46	6.4%	0.0	0.0%	2233.0	14.3%	375.0	2.4%	1929.8	12.3%	1222.5	8.4%
Linnet Ward	Forensics	FMH	851.89	4.5%	0.0	0.0%	3250.0	17.3%	1721.3	9.2%	273.8	1.5%	1076.3	6.3%
Mallard Ward	Forensics	FMH	626.55	3.0%	0.0	0.0%	3948.3	18.8%	540.0	2.6%	728.5	3.5%	798.8	4.3%
Mandarin	Forensics	FMH	1513.4	7.2%	0.0	0.0%	5308.7	25.4%	585.0	2.8%	1931.0	9.2%	1297.5	6.7%
Merlin	Forensics	FMH	1379.24	4.6%	0.0	0.0%	9968.3	33.3%	4.0	0.0%	427.5	1.4%	2246.3	6.4%
Newtondale Ward	Forensics	FMH	1381.12	6.1%	0.0	0.0%	3802.7	16.7%	1113.8	4.9%	1826.3	8.0%	1875.0	8.5%
Nightingale Ward	Forensics	FMH	1047.1	6.7%	0.0	0.0%	1858.8	11.8%	2488.3	15.9%	575.1	3.7%	697.5	4.2%
Sandpiper Ward	Forensics	FMH	1088.94	4.1%	0.0	0.0%	6092.8	22.9%	0.0	0.0%	545.3	2.1%	1106.3	5.0%
Swift Ward	Forensics	FMH	1216.73	6.7%	0.0	0.0%	2891.3	16.0%	1404.0	7.8%	954.8	5.3%	577.5	2.9%
Aysgarth	Teesside	LD	644.75	4.8%	0.0	0.0%	3023.5	22.4%	0.0	0.0%	3190.8	23.7%	495.0	3.3%
Bankfields Court Flats	Teesside	LD	710.67	6.1%	0.0	0.0%	1451.3	12.5%	30.0	0.3%	1141.0	9.8%	0.0	0.0%
Bankfields Court Unit 2	Teesside	LD	1331.87	8.6%	0.0	0.0%	2549.1	16.5%	520.0	3.4%	244.7	1.6%	705.0	3.8%
Bankfields Court Unit 3	Teesside	LD	1310.28	9.6%	0.0	0.0%	767.3	5.6%	0.0	0.0%	568.5	4.2%	105.0	0.3%
Bankfields Court Unit 4	Teesside	LD	868.18	7.0%	0.0	0.0%	1071.8	8.6%	0.0	0.0%	264.0	2.1%	0.0	0.0%
Bek-Ramsey Ward	Durham & Darlington	LD	2761.58	10.7%	144.0	0.6%	2014.2	7.8%	1090.5	4.2%	3637.5	14.1%	337.5	1.4%
Oak Rise	York and Selby	LD	514.08	2.3%	1932.2	8.7%	1144.8	5.2%	427.5	1.9%	2213.3	10.0%	1297.5	5.5%
The Lodge	Teesside	LD	337.74	3.4%	0.0	0.0%	453.3	4.5%	0.0	0.0%	318.3	3.2%	0.0	0.0%
Acomb Garth	York and Selby	MHSOP	213.62	0.8%	7272.5	28.9%	1637.5	6.5%	1410.0	5.6%	3073.0	12.2%	1747.5	5.6%
Ceddesfeld Ward	Durham & Darlington	MHSOP	445.33	2.4%	36.0	0.2%	1107.0	5.9%	0.0	0.0%	1509.7	8.0%	266.3	1.4%
Cherry Tree House	York and Selby	MHSOP	953.55	4.9%	2704.0	14.0%	1065.0	5.5%	975.0	5.0%	2794.5	14.4%	2032.5	10.3%
Hamsterley Ward	Durham & Darlington	MHSOP	1466.76	6.5%	1064.8	4.7%	4847.4	21.5%	0.0	0.0%	3358.5	14.9%	255.0	1.2%
Meadowfields	York and Selby	MHSOP	130.5	0.7%	1560.3	8.9%	2614.3	14.9%	444.0	2.5%	1514.3	8.6%	1143.8	6.7%
Oak Ward	Durham & Darlington	MHSOP	519.32	3.1%	0.0	0.0%	479.8	2.9%	0.0	0.0%	1267.5	7.7%	225.0	1.0%
Roseberry Wards	Durham & Darlington	MHSOP	159.83	1.0%	0.0	0.0%	2004.4	12.3%	0.0	0.0%	302.5	1.9%	840.0	5.0%
Rowan Lea	North Yorkshire	MHSOP	1128.41	5.1%	261.4	1.2%	2007.1	9.0%	951.7	4.3%	2224.7	10.0%	386.3	1.9%
Rowan Ward	North Yorkshire	MHSOP	391.5	2.0%	3889.0	19.6%	2154.5	10.8%	78.0	0.4%	1802.0	9.1%	498.8	1.6%
Springwood	North Yorkshire	MHSOP	824.59	4.5%	1786.3	9.7%	2868.3	15.6%	0.0	0.0%	1689.9	9.2%	1830.0	9.6%

Ward 14	North Yorkshire	MHSOP	1100	7.2%	45	0.3%	307.0	2.0%	0.0	0.0%	146.3	1.0%	641.3	4.0%
Westerdale North	Teesside	MHSOP	691.43	4.1%	299	1.8%	811.3	4.8%	0.0	0.0%	2222.3	13.2%	956.3	5.8%
Westerdale South	Teesside	MHSOP	854.6	2.8%	1646.0	5.5%	10334.0	34.4%	2828.3	9.4%	561.5	1.9%	502.5	1.8%
Wingfield Ward	Teesside	MHSOP	417.91	3.4%	115	0.9%	2560.3	21.1%	1191.0	9.8%	2010.0	16.5%	562.5	3.5%

	Green	Amber	Red
Overtime	0 - 2.9%	3- 3.9%	4% and over
Agency	0 - 2.9%	3- 3.9%	4% and over
Bank Usage	0 - 10%	11 - 24.9%	25% and over
Maternity	0 - 1.9%	2 - 4.9%	5% and over
Sickness	0 - 1.9%	2 - 4.9%	5% and over
Vacancies	0 - 4.9%	5 - 9.9%	10% and over

Quality Indicators - 6 Month Total

Appendix 4

Ward Name	Locality	Speciality	Bank Usage vs Actual Hours		Quality Indicators					Incidents of Restraints				Registered Average %		Unregistered Average %	
			Hours	% against Actual Hours	Number of SUIs	Number of Level 4 Incidents	Number of Level 3 (Self-Harm) Incidents	Number of Complaints	Number of PALS	Number of Incidents	Number of PRO Restraints Used	Number of Other Restraints Used	Total Number of Restraints Used	Day	Night	Day	Night
Danby Ward	North Yorkshire	AMH	1710.3	11.5%				2	7	18		30	30	82.5%	86.0%	107.6%	103.8%
Esk Ward	North Yorkshire	AMH	1714.8	11.0%				1	6	29		42	42	75.0%	102.5%	114.5%	97.7%
Bedale Ward	Teesside	AMH	6140.4	26.5%					5	83	3	142	145	73.1%	75.0%	171.7%	135.6%
Bilsdale Ward	Teesside	AMH	2404.3	14.2%			1	1	3	15	3	28	31	86.6%	105.7%	133.8%	116.5%
Birch Ward	Durham & Darlington	AMH	5040.5	24.7%				2	6					85.3%	100.5%	121.1%	132.7%
Bransdale Ward	Teesside	AMH	4814.5	25.5%			1		6	25		31	31	82.8%	107.3%	156.8%	141.9%
Cedar Ward	Durham & Darlington	AMH	10318.1	37.8%	2		1	1	3	251	17	458	475	121.0%	136.8%	125.4%	117.8%
Cedar Ward (NY)	North Yorkshire	AMH	1806.6	8.9%			1	1	7	51	1	99	100	106.8%	109.4%	107.8%	114.8%
Ebor Ward	York and Selby	AMH	1160.5	7.3%			2		3	14		21	21	94.8%	101.4%	88.6%	99.2%
Elm Ward	Durham & Darlington	AMH	4560.0	25.1%			5	4	18	119	3	175	178	92.0%	98.2%	112.5%	108.1%
Farnham Ward	Durham & Darlington	AMH	1536.0	9.3%	1		2	1	5	9		11	11	106.7%	101.3%	103.9%	100.8%
Kirkdale Ward	Teesside	AMH	2862.5	15.7%					2	9		9	9	86.5%	101.1%	117.9%	102.2%
Lincoln Ward	Teesside	AMH	2212.6	14.1%			1		6	6		6	6	97.2%	100.9%	107.0%	101.7%
Lustrum Vale	Teesside	AMH	3839.8	22.7%	1				1	5		11	11	77.6%	104.2%	127.9%	107.4%
Maple Ward	Durham & Darlington	AMH	3494.3	21.1%				3	13	13	3	12	15	85.0%	95.2%	116.1%	115.1%
Minster Ward	York and Selby	AMH	1676.0	10.8%				1	2	27	1	36	37	97.9%	102.6%	93.0%	101.2%
Overdale Ward	Teesside	AMH	2387.0	15.3%				1	8	9		9	9	86.8%	101.1%	119.0%	101.3%
Primrose Lodge	Durham & Darlington	AMH	1884.0	11.8%					1					74.2%	98.9%	124.8%	100.0%
Stockdale Ward	Teesside	AMH	3103.2	17.9%				1	6	28	1	40	41	95.9%	106.5%	139.9%	121.6%
The Orchards (NY)	North Yorkshire	AMH	263.0	2.0%			1		1					95.2%	88.0%	100.0%	110.4%
Tunstall Ward	Durham & Darlington	AMH	288.0	1.7%	1	1		3	10	5		5	5	109.9%	109.8%	102.7%	100.3%
Ward 15 Friarage	North Yorkshire	AMH	3050.8	20.7%			6		6	18		27	27	70.2%	106.0%	122.6%	103.8%
Willow Ward	Durham & Darlington	AMH	1167.0	7.1%					1	7		11	11	89.8%	100.2%	122.9%	101.7%
Baysdale	Teesside	CYPS	894.0	6.0%										112.1%	101.1%	98.4%	98.6%
Holly Unit	Durham & Darlington	CYPS	793.6	12.1%						3		5	5	148.0%	118.8%	131.8%	163.6%

Newberry Centre	Teesside	CYPS	2341.5	9.6%			4	1	7	690	2	914	916	87.2%	113.8%	129.4%	134.7%
Talbot Direct Care	Durham & Darlington	CYPS	80.5	0.6%			1			32	1	60	61	63.8%	94.9%	64.6%	77.6%
The Evergreen Centre	Teesside	CYPS	4147.0	12.2%			1		3	864	1	1405	1406	89.3%	114.5%	150.1%	136.7%
Westwood Centre	Teesside	CYPS	4862.3	14.8%			1	3	5	304	3	519	522	103.5%	91.4%	159.4%	197.7%
Clover/Ivy	Forensics	FLD	7620.3	29.2%			4		5	80		156	156	82.9%	102.9%	117.9%	162.6%
Eagle/Osprey	Forensics	FLD	2485.0	13.5%					4	1		1	1	79.1%	101.5%	90.2%	99.4%
Harrier/Hawk	Forensics	FLD	3344.2	15.0%					14	9	2	14	16	76.8%	107.1%	104.6%	108.9%
Kestrel/Kite.	Forensics	FLD	4739.5	18.3%					8	5	1	10	11	83.4%	100.2%	114.2%	143.1%
Langley Ward	Forensics	FLD	1760.1	13.8%										75.6%	100.0%	111.5%	112.7%
Northdale Centre	Forensics	FLD	9024.9	31.2%				1	8	17	3	28	31	84.9%	97.1%	118.2%	97.3%
Oakwood	Forensics	FLD	829.8	6.9%										81.4%	100.0%	180.9%	100.0%
Thistle	Forensics	FLD	1827.9	10.7%					8	24		48	48	61.2%	102.4%	112.3%	97.3%
Brambling Ward	Forensics	FMH	2724.5	15.9%			3		3	82		133	133	91.9%	103.6%	100.8%	112.1%
Fulmar Ward.	Forensics	FMH	5245.3	26.7%					5	33	1	52	53	97.2%	102.6%	124.4%	176.2%
Jay Ward	Forensics	FMH	1412.5	8.7%					2	13	2	21	23	85.1%	102.8%	96.6%	101.7%
Lark	Forensics	FMH	2233.0	14.3%				1	6					85.1%	101.0%	103.6%	94.7%
Linnet Ward	Forensics	FMH	3250.0	17.3%					10	11		17	17	85.3%	105.4%	118.2%	128.5%
Mallard Ward	Forensics	FMH	3948.3	18.8%					4	9		9	9	89.7%	106.6%	107.3%	150.4%
Mandarin	Forensics	FMH	5308.7	25.4%					14	87		99	99	84.3%	105.2%	137.2%	155.2%
Merlin	Forensics	FMH	9968.3	33.3%					9	63	5	97	102	106.2%	91.9%	157.4%	216.9%
Newtondale Ward	Forensics	FMH	3802.7	16.7%			1	1	4	5		6	6	101.6%	76.8%	102.0%	127.2%
Nightingale Ward	Forensics	FMH	1858.8	11.8%					3	1		1	1	78.5%	100.8%	97.9%	95.1%
Sandpiper Ward	Forensics	FMH	6092.8	22.9%			1		4	418	18	968	986	90.0%	80.1%	118.0%	182.9%
Swift Ward	Forensics	FMH	2891.3	16.0%					2	38		60	60	82.7%	99.4%	100.9%	103.8%
Aysgarth	Teesside	LD	3023.5	22.4%						5		5	5	96.6%	102.2%	98.7%	99.2%
Bankfields Court Flats	Teesside	LD	1451.3	12.5%										78.2%	114.9%	87.9%	98.3%
Bankfields Court Unit 2	Teesside	LD	2549.1	16.5%						1		1	1	110.5%	102.9%	108.8%	122.3%
Bankfields Court Unit 3	Teesside	LD	767.3	5.6%					2	61	2	92	94	78.9%	91.2%	99.2%	98.7%
Bankfields Court Unit 4	Teesside	LD	1071.8	8.6%						40		60	60	100.7%	107.0%	90.9%	98.0%
Bek-Ramsey Ward	Durham & Darlington	LD	2014.2	7.8%						110	11	124	135	141.6%	100.5%	119.9%	98.9%
Oak Rise	York and Selby	LD	1144.8	5.2%					2	126		223	223	103.7%	98.2%	103.3%	137.1%
The Lodge	Teesside	LD	453.3	4.5%						5		10	10	95.4%	92.3%	81.7%	94.5%
Acomb Garth	York and Selby	MHSOP	1637.5	6.5%					2	253		278	278	98.0%	97.8%	111.7%	221.0%
Ceddesfeld Ward	Durham & Darlington	MHSOP	1107.0	5.9%						31		42	42	91.5%	99.5%	116.1%	101.6%
Cherry Tree House	York and Selby	MHSOP	1065.0	5.5%				1	3	19		23	23	93.3%	102.8%	83.3%	112.2%
Hamsterley Ward	Durham & Darlington	MHSOP	4847.4	21.5%	1	1				37		41	41	95.8%	102.8%	146.3%	153.9%

Meadowfields	York and Selby	MHSOP	2614.3	14.9%						9		10	10	80.6%	96.5%	82.6%	111.0%
Oak Ward	Durham & Darlington	MHSOP	479.8	2.9%					2	7		8	8	95.8%	98.4%	99.2%	100.8%
Roseberry Wards	Durham & Darlington	MHSOP	2004.4	12.3%	1	1			3	9		10	10	100.3%	101.1%	102.0%	102.2%
Rowan Lea	North Yorkshire	MHSOP	2007.1	9.0%					4	63		102	102	97.3%	105.3%	116.1%	101.1%
Rowan Ward	North Yorkshire	MHSOP	2154.5	10.8%	1	1				42		80	80	91.1%	104.2%	158.5%	146.7%
Springwood	North Yorkshire	MHSOP	2868.3	15.6%						127		148	148	62.9%	95.7%	124.9%	140.5%
Ward 14	North Yorkshire	MHSOP	307.0	2.0%					1	28		35	35	89.6%	102.6%	104.1%	102.5%
Westerdale North	Teesside	MHSOP	811.3	4.8%				1	3	7		8	8	100.6%	100.8%	114.4%	107.5%
Westerdale South	Teesside	MHSOP	10334.0	34.4%					1	31		38	38	91.0%	106.2%	184.9%	185.6%
Wingfield Ward	Teesside	MHSOP	2560.3	21.1%					1	2		3	3	90.6%	104.3%	100.0%	97.8%

Safe Nursing Indicators - 6 Month Total **Appendix 5**

Ward Name	Locality	Speciality	Safe Nursing Indicators											
			Falls resulting in significant harm	Pressure Ulcers	Medication Errors	Missed Breaks	Staffing Fill Rate - Day - Registered Nurses	Staffing Fill Rate - Night - Registered Nurses	Staffing Fill Rate - Day - Unregistered Nurses	Staffing Fill Rate - Night - Unregistered Nurses	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours	Mandatory Training (Nov 17)
Danby Ward	North Yorkshire	Adults			6	7	82.5%	86.0%	107.6%	103.8%	11.5%	2.4%	6.8%	91.33%
Esk Ward	North Yorkshire	Adults			3	23	75.0%	102.5%	114.5%	97.7%	11.0%	0.0%	2.4%	94.68%
Bedale Ward	Teesside	Adults			6	31	73.1%	75.0%	171.7%	135.6%	26.5%	0.8%	5.5%	94.83%
Bilsdale Ward	Teesside	Adults			5	41	86.6%	105.7%	133.8%	116.5%	14.2%	0.3%	5.9%	93.01%
Birch Ward	Durham & Darlington	Adults				5	85.3%	100.5%	121.1%	132.7%	24.7%	0.9%	5.3%	81.87%
Bransdale Ward	Teesside	Adults			4	21	82.8%	107.3%	156.8%	141.9%	25.5%	0.2%	3.6%	93.14%
Cedar Ward	Durham & Darlington	Adults			10	2	121.0%	136.8%	125.4%	117.8%	37.8%	0.0%	3.4%	93.75%
Cedar Ward (NY)	North Yorkshire	Adults			5	48	106.8%	109.4%	107.8%	114.8%	8.9%	21.7%	2.3%	80.92%
Ebor Ward	York and Selby	Adults			9	49	94.8%	101.4%	88.6%	99.2%	7.3%	4.4%	2.8%	86.85%
Elm Ward	Durham & Darlington	Adults			8	45	92.0%	98.2%	112.5%	108.1%	25.1%	0.4%	4.1%	83.09%
Farnham Ward	Durham & Darlington	Adults				9	106.7%	101.3%	103.9%	100.8%	9.3%	0.0%	3.2%	85.29%
Kirkdale Ward	Teesside	Adults			6	9	86.5%	101.1%	117.9%	102.2%	15.7%	0.4%	3.2%	85.00%
Lincoln Ward	Teesside	Adults			5	27	97.2%	100.9%	107.0%	101.7%	14.1%	0.0%	2.3%	86.40%
Lustrum Vale	Teesside	Adults		2	12	29	77.6%	104.2%	127.9%	107.4%	22.7%	0.0%	3.2%	73.19%
Maple Ward	Durham & Darlington	Adults			5	20	85.0%	95.2%	116.1%	115.1%	21.1%	1.6%	4.1%	82.15%
Minster Ward	York and Selby	Adults			14	106	97.9%	102.6%	93.0%	101.2%	10.8%	5.0%	8.3%	94.88%
Overdale Ward	Teesside	Adults			6	7	86.8%	101.1%	119.0%	101.3%	15.3%	0.1%	3.1%	85.20%
Primrose Lodge	Durham & Darlington	Adults			4		74.2%	98.9%	124.8%	100.0%	11.8%	0.1%	3.9%	91.64%
Stockdale Ward	Teesside	Adults			5	37	95.9%	106.5%	139.9%	121.6%	17.9%	0.5%	4.3%	91.64%
The Orchards (NY)	North Yorkshire	Adults			3	34	95.2%	88.0%	100.0%	110.4%	2.0%	0.0%	8.2%	93.65%
Tunstall Ward	Durham & Darlington	Adults			4	11	109.9%	109.8%	102.7%	100.3%	1.7%	0.1%	4.5%	94.47%
Ward 15 Friarage	North Yorkshire	Adults				35	70.2%	106.0%	122.6%	103.8%	20.7%	2.0%	3.4%	84.59%

Willow Ward	Durham & Darlington	Adults			12	10	89.8%	100.2%	122.9%	101.7%	7.1%	0.1%	3.2%	86.15%
Baysdale	Teesside	CYPS			3	18	112.1%	101.1%	98.4%	98.6%	6.0%	0.0%	8.0%	80.55%
Holly Unit	Durham & Darlington	CYPS				16	148.0%	118.8%	131.8%	163.6%	12.1%	0.0%	6.3%	83.90%
Newberry Centre	Teesside	CYPS			6	518	87.2%	113.8%	129.4%	134.7%	9.6%	0.3%	5.9%	90.48%
Talbot Direct Care	Durham & Darlington	CYPS			1	6	63.8%	94.9%	64.6%	77.6%	0.6%	0.0%	3.6%	81.13%
The Evergreen Centre	Teesside	CYPS			16	155	89.3%	114.5%	150.1%	136.7%	12.2%	2.0%	4.6%	85.04%
Westwood Centre	Teesside	CYPS			33	298	103.5%	91.4%	159.4%	197.7%	14.8%	0.0%	10.0%	90.09%
Clover/Ivy	Forensics	Forensics LD			6	98	82.9%	102.9%	117.9%	162.6%	29.2%	0.4%	6.3%	88.98%
Eagle/Osprey	Forensics	Forensics LD				20	79.1%	101.5%	90.2%	99.4%	13.5%	1.0%	3.5%	96.06%
Harrier/Hawk	Forensics	Forensics LD			5	32	76.8%	107.1%	104.6%	108.9%	15.0%	0.1%	5.6%	98.69%
Kestrel/Kite.	Forensics	Forensics LD			5	32	83.4%	100.2%	114.2%	143.1%	18.3%	0.3%	3.8%	92.86%
Langley Ward	Forensics	Forensics LD			2	4	75.6%	100.0%	111.5%	112.7%	13.8%	0.2%	2.8%	93.03%
Northdale Centre	Forensics	Forensics LD			10	93	84.9%	97.1%	118.2%	97.3%	31.2%	2.7%	5.4%	81.63%
Oakwood	Forensics	Forensics LD			1	8	81.4%	100.0%	180.9%	100.0%	6.9%	0.0%	6.5%	92.22%
Thistle	Forensics	Forensics LD			4	16	61.2%	102.4%	112.3%	97.3%	10.7%	0.1%	4.9%	96.90%
Brambling Ward	Forensics	Forensics MH			13	46	91.9%	103.6%	100.8%	112.1%	15.9%	0.0%	1.8%	94.56%
Fulmar Ward.	Forensics	Forensics MH			2	39	97.2%	102.6%	124.4%	176.2%	26.7%	0.0%	2.8%	86.67%
Jay Ward	Forensics	Forensics MH			5	40	85.1%	102.8%	96.6%	101.7%	8.7%	0.0%	4.9%	95.58%
Lark	Forensics	Forensics MH			11	63	85.1%	101.0%	103.6%	94.7%	14.3%	0.0%	6.4%	87.22%
Linnet Ward	Forensics	Forensics MH			11	73	85.3%	105.4%	118.2%	128.5%	17.3%	0.0%	4.5%	88.08%
Mallard Ward	Forensics	Forensics MH		2	4	120	89.7%	106.6%	107.3%	150.4%	18.8%	0.0%	3.0%	85.33%
Mandarin	Forensics	Forensics MH			5	65	84.3%	105.2%	137.2%	155.2%	25.4%	0.0%	7.2%	90.27%
Merlin	Forensics	Forensics MH			6	124	106.2%	91.9%	157.4%	216.9%	33.3%	0.0%	4.6%	92.90%
Newtondale Ward	Forensics	Forensics MH			2	93	101.6%	76.8%	102.0%	127.2%	16.7%	0.0%	6.1%	87.06%
Nightingale Ward	Forensics	Forensics MH			2	40	78.5%	100.8%	97.9%	95.1%	11.8%	0.0%	6.7%	83.80%
Sandpiper Ward	Forensics	Forensics MH			1	135	90.0%	80.1%	118.0%	182.9%	22.9%	0.0%	4.1%	83.54%
Swift Ward	Forensics	Forensics MH			8	39	82.7%	99.4%	100.9%	103.8%	16.0%	0.0%	6.7%	90.73%
Aysgarth	Teesside	LD			4		96.6%	102.2%	98.7%	99.2%	22.4%	0.0%	4.8%	88.09%
Bankfields Court Unit 2	Teesside	LD			1	81	110.5%	102.9%	108.8%	122.3%	16.5%	0.0%	8.6%	92.74%
Bankfields Court Unit 3	Teesside	LD			1		78.9%	91.2%	99.2%	98.7%	5.6%	0.0%	9.6%	85.20%

Bankfields Court Unit 4	Teesside	LD					100.7%	107.0%	90.9%	98.0%	8.6%	0.0%	7.0%	
The Lodge	Teesside	LD					95.4%	92.3%	81.7%	94.5%	4.5%	0.0%	3.4%	
Bankfields Court Flats	Teesside	LD					78.2%	114.9%	87.9%	98.3%	12.5%	0.0%	6.1%	
Bek-Ramsey Ward	Durham & Darlington	LD			5	1	141.6%	100.5%	119.9%	98.9%	7.8%	0.6%	10.7%	95.62%
Oak Rise	York and Selby	LD			13	18	103.7%	98.2%	103.3%	137.1%	5.2%	8.7%	2.3%	90.43%
Acomb Garth	York and Selby	MHSOP			17	18	98.0%	97.8%	111.7%	221.0%	6.5%	28.9%	0.8%	79.79%
Ceddesfeld Ward	Durham & Darlington	MHSOP			1	9	91.5%	99.5%	116.1%	101.6%	5.9%	0.2%	2.4%	86.57%
Cherry Tree House	York and Selby	MHSOP			4	10	93.3%	102.8%	83.3%	112.2%	5.5%	14.0%	4.9%	89.86%
Hamsterley Ward	Durham & Darlington	MHSOP			1	26	95.8%	102.8%	146.3%	153.9%	21.5%	4.7%	6.5%	84.28%
Meadowfields	York and Selby	MHSOP			9	158	80.6%	96.5%	82.6%	111.0%	14.9%	8.9%	0.7%	94.20%
Oak Ward	Durham & Darlington	MHSOP		1	6	2	95.8%	98.4%	99.2%	100.8%	2.9%	0.0%	3.1%	82.65%
Roseberry Wards	Durham & Darlington	MHSOP	1			14	100.3%	101.1%	102.0%	102.2%	12.3%	0.0%	1.0%	93.32%
Rowan Lea	North Yorkshire	MHSOP		1	3	49	97.3%	105.3%	116.1%	101.1%	9.0%	1.2%	5.1%	71.80%
Rowan Ward	North Yorkshire	MHSOP	1		1	62	91.1%	104.2%	158.5%	146.7%	10.8%	19.6%	2.0%	84.62%
Springwood	North Yorkshire	MHSOP			1	3	62.9%	95.7%	124.9%	140.5%	15.6%	9.7%	4.5%	90.60%
Ward 14	North Yorkshire	MHSOP			8	51	89.6%	102.6%	104.1%	102.5%	2.0%	0.3%	7.2%	91.85%
Westerdale North	Teesside	MHSOP			6	16	100.6%	100.8%	114.4%	107.5%	4.8%	1.8%	4.1%	89.00%
Westerdale South	Teesside	MHSOP			1	24	91.0%	106.2%	184.9%	185.6%	34.4%	5.5%	2.8%	77.38%
Wingfield Ward	Teesside	MHSOP			2	41	90.6%	104.3%	100.0%	97.8%	21.1%	0.9%	3.4%	87.96%

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 30 January 2018**
TITLE:	**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 07 December 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 York and Selby and Forensic services where key concerns were around staffing, capacity and demand, poor audit results and the transition of services from Humber to TEWV.
- Report from the Patient Safety Group.
- Quarterly updates on Infection, Prevention and Control, Health, Safety, Security and Fire, Drug and Therapeutics.
- CQC compliance and Safeguarding & Public Protection assurance updates and the results of the CQC Mental Health Community Survey.
- The validation Audit of Emergency Response Bags.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 07 December 2017.
- Note the confirmed minutes of the meeting held on 02 November 2017 (appendix 1).

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 30 January 2018**
TITLE:	**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 07 December 2017.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principal risks and concerns, together with assurances and progress from North Yorkshire and Tees.

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

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

4.1 YORK AND SELBY LMGB

The Committee noted the LMGB report for York and Selby noting the top concerns which were the transition of services from Humber to TEWV, capacity and demand issues with CAMHS services, Access and Wellbeing Service, IAPT and staffing with gaps in the workforce.

Assurance was provided to the Committee that mitigating actions were in place to address these concerns.

4.2 FORENSIC SERVICES LMGB

The Committee noted the LMGB report for Forensic Services noting the top concerns which were the ongoing issues with staffing, the disappointing result following an audit of emergency equipment and an audit of clinical supervision.

Assurance was provided that Forensic Services took immediate action to rectify the areas where compliance was not achieved and that Modern Matrons will be monitoring respective clinical areas on a regular basis to ensure standards are met.

The Committee was assured that areas of concern were being addressed with mitigating actions in place to ensure 100% compliance with the emergency equipment standard. Following some focused work to explore the issues impacting on supervision the service has achieved 100% compliance.

4.4 **Patient Safety**

The Committee noted the assurance report of the Patient Safety Group, together with the Patient Safety Group Quality Report for period 1 to 30 September 2017, Thematic Review of Durham City Affective Disorder Service, Positive and Safe Update Report for Quarter 2 and a Falls Report for Quarter 2.

There are no matters of escalation.

4.5 **Infection, Prevention and Control**

The Committee noted an update on current Infection, Prevention and Control issues and were provided assurance on the work streams relating to Quarter 2.

One area of concern was around the standard of cleanliness audits by hotel services which has reduced to below 80%. A Kaizen event has revealed that a new electronic method of scoring has contributed to the decline in score resulting in the top 10 areas being worked through.

4.6 **Safeguarding and Public Protection**

The Committee was assured that the Trust continues to meet the legal requirements for safeguarding adults and children within the legislative framework.

The Committee noted the following reports:

(a) The exception report, which identified a potential risk of not achieving the agreed trajectories for Safeguarding Level 3 training with penalties attached.

Assurance was provided that the compliance rate was at its highest to date however has not reached the 98% target and all efforts were being made to improve this position.

(b) Annual report of the Safeguarding and Public Protection Group

There has been an increase in safeguarding activity across the year for the Trust and the team continue to act as a single point of contact for Multi-Agency Safeguarding Hubs (MASH).
The challenges for the coming year will be capacity within the team to address the increase in work.

(c) Assurance report of the Safeguarding and Public Protection Sub-Group.

There are no matters of escalation.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 Compliance with CQC Requirements Report

The Committee was assured that all actions raised by CQC Mental Health Act (MHA) inspections were being addressed following three reports received.

The key matters discussed were the outcome of four MHA inspections and mitigating actions to remedy areas of concern as well as discussion and actions around the report of top issues and themes raised in 2017/18 year to date. The Committee received a summary of key points discussed at the CQC Engagement meeting and that Holly and Baysdale units were now registered with Ofsted. Findings from the monthly independent review of the units have been positive.

The Committee requested further information on Oak Ward where four environmental issues were raised at ward level following peer review inspection.

5.2 Health, Safety, Security and Fire Report

The Committee received the quarterly Health, Safety, Security and Fire Report.

There are no matters of escalation.

5.3 CQC Mental Health Community Survey Results - 2017

The Committee noted the results from the National Community Mental Health Survey 2017. The key areas discussed were:

There was a slight improvement on the response rate of 29%, (28% last year), which was above the national response rate of 26%. When comparing the Trust with other organisations the scores were identified as “about the same” as others across all 10 sections.

The main issue of note was the declining rating around care experience which has dropped from 74.3% in 2016 to 70.9%. Further scrutiny of how this will be improved was underway.

5.4 Clinical Audit of Emergency Response Bags (re-audit 2017)

The Committee considered the Clinical Audit report which had revealed policy compliance issues which posed potential risks to patient safety.

Immediate actions were taken to address the areas of non-compliance and the position subsequently improved to 100% compliant.

The Committee has requested a further position statement at its February 2018 meeting and felt this was a matter to escalate to the Board of Directors.

5.5 Drug and Therapeutics

Assurance was provided on the monitoring of quality and performance data, planned work streams for the implementation of safe and economic use of medicines and compliance with best practice standards.

There were no matters for escalation.

5.6 **Issues that impact on the Trust's strategic or key operational risks.**

The Committee noted concerns around recruitment of core trainees and the low take up of numbers and felt this was a matter to escalate to the Board of Directors.

6. IMPLICATIONS

6.1 **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.

6.2 **Financial/value for money**

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

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

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

6.4 **Equality and Diversity**

There are no issues to note.

7. CONCLUSIONS

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

8. RECOMMENDATIONS

That the Board of Directors is asked to note the issues raised at the Quality Assurance Committee meeting on 07 December 2017 and to note the confirmed minutes of the meeting held on 02 November 2017 (appendix 1).

Elizabeth Moody
Director of Nursing & Governance
January 2018

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 5 OCTOBER 2017, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Dr Nick Land, Medical Director
Mr Brent Kilmurray, Chief Operating Officer
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr Richard Simpson, Non-Executive Director
Mrs Shirley Richardson, Non-Executive Director
Mrs Jennifer Illingworth, Director of Quality Governance

In attendance:
Mr Steve Dawson, Interim Head of Nursing for York and Selby
Mrs Lorraine Ferrier, Head of Nursing for Durham and Darlington (for minute 17/128)
Mrs Ruth Hill, Head of Service for York and Selby (for minute 17/129)
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Donna Sweet, Service Development Manager for Durham and Darlington
Mr Steve Wright, Deputy Medical Director
Mr Christopher Williams, Chief Pharmacist (for minute 17/135)

17/125 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Mrs Lesley Bessant, Chairman of the Trust, Mr Colin Martin, Chief Executive, Mr Patrick Scott, Head of Service for Durham and Darlington and Mrs Karen Agar, Associate Director of Nursing & Governance.

17/126 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 7 September 2017 be signed as a correct record by the Chairman of the Committee.

17/127 ACTION LOG

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

17/81 Safeguarding: check whether HM Prisons require to undertake level 3 safeguarding training.

Completed

17/84 Further work required around indicator 5 of TEWV, WRES information before being presented to the BoD.

Completed

17/86 Future Health and Safety reports to show fire incidents broken down by hospital location.

This action would be brought forward to December 2017 when the next Health, Safety, Security and Fire report would be presented to QuAC.

17/97 D&D LMGB report: page 6, adult LD non-compliance due to referrals being rejected - add more context to this in future reports.
This information would be incorporated into the next Durham and Darlington Services LMGB report and brought back to QuAC in February 2018.

17/110 Concerns and implications of decommissioning locked rehab beds be taken to EMT at the end of September 2017 for further consideration and to gain a better understanding of the overall position.

Due to Mr Martin not being present at the meeting this action would be deferred to the 2 November 2017 QuAC meeting.

17/128 DURHAM AND DARLINGTON LMGB REPORT

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

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

(1) Staffing across the locality.

(i) There were pressures across all services, particularly inpatients and West Park Hospital. In addition, there were high numbers of retirements expected in the forthcoming year and recruitment continued to be difficult.
On this matter it was noted that agency staff were helping to alleviate the pressures and the recruitment position was expected to improve by the end of October 2017 with some new registered nurses in place.

(2) Bankfields Staffing

(i) There were ongoing issues with trying to cover the unit with qualified staff.
On this matter it was noted that contingency plans were in place to help alleviate the staffing shortages, due to sickness, skill mix and maternity leave, however this was having an impact upon the Crisis Team and the Team managers who were working shifts in Bankfields.
This matter had been escalated to the Durham and Darlington locality risk register.

(ii) With regard to the Ofsted registration for Bankfields, this was expected to take around 16 weeks, however the Trust had tried to expedite this and a reference for Mr Paul Newton, Director of PIPS had been completed recently and returned.

(3) Access to CAMHS Tier 4 beds.

(i) A root cause analysis had been undertaken of a 14 year old that had been admitted to Cedar ward and had been classed as a 'never event'. Some lessons had been learned and an action plan had been produced.
There had also been another recent incident of a 17 year old admitted to an adult ward and this remained an area of concern.

On this matter it was noted that discussions were underway to find solutions to this problem, including how Tier 3 and 4 could work better together.

Committee members sought clarification on the following matters:

(i) A significant serious incident had taken place at the crisis house at Shildon and staff had dealt extremely well with a very difficult situation.
Members expressed their thanks and appreciation to the staff that had been affected by the incident.

(ii) Behavioural Activation (BA) awareness would be rolled out across AMH teams, which had been found to be effective in dealing with depression and it was anticipated would be included in the new NICE guidelines for depression.
The Committee requested a stand-alone report on progress with the implementation of BA in six months' time at its meeting to be held on 5 April 2017.

Action: Mr P Scott

(iii) The risk register, (page 12), item 98, "…failure to effectively manage bed compliment could result in patients being admitted out of the locality or to the 'wrong' type of bed that does not meet their needs…"
This risk was showing a high target risk, whilst also showing improvement and needed to be unpicked and clarified.

Action: Mr P Scott

17/129 YORK AND SELBY SERVICES LMGB REPORT

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

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

(1) Capacity and demand issues and ongoing issues in CAMHS.
On this matter it was noted that the CCG had identified some concerns around the delivery of the service and a meeting would take place to review the service issues, which had been identified following analysis of the capacity and demand.

(2) Staffing, with gaps in workforce and the associated operational and contractual implications encompassing IAPT, CAMHS Consultants and MHSOP inpatient staffing. Recruitment initiatives were ongoing and all inpatient posts had been advertised.

(3) Ongoing estate challenges around the quality of work and responsiveness to reporting of estate issues via NHS Property Services.

In addition the Committee discussed the following matters:

(1) The significant improvement around the relationship with Local Authorities and delayed discharges.
There were regular weekly delayed transfer discussions as there were still a large number of blocked beds and there would be a review of MH services for older people towards the end of 2017, which would encompass all the challenges around this issue.

(2) The impact on staff following the Management of Change.

On this matter it was noted that within LD the introduction of 12 hour shifts had caused mixed feelings, staff had been given choice over the start and end times of shifts and Mr D Levy would be undertaking a research project on this to incorporate staff experiences as well as the inpatient perspective.

17/130 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee received a verbal update on Patient Safety.

Mrs Illingworth noted the following:

(1) The Patient Safety Group had not met in September 2017 due to a clash with the TEWV annual Nursing Conference. A further meeting would take place during October 2017.

(2) There were no matters of escalation to the Quality Assurance Committee.

(3) Assurance was provided to the Committee that the Learning from Deaths Policy had been formally ratified by the Board of Directors at its meeting held on 26 September 2017.

17/131 SAFGUARDING & PUBLIC PROTECTION EXCEPTION REPORT

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

Arising from the report it was noted that:

(1) All serious case reviews across the locality areas were progressing with action plans being monitored within respective safeguarding boards, with oversight by the Safeguarding and Public Protection sub-Group.
(2) Formal notice had been received of the NHS England led independent care and treatment investigation following the homicide of a young person in York. It was expected that the independent investigation would be completed in six months.
(3) Middlesbrough would undertake a Domestic Homicide Review into the death of woman and the trial was expected to be around December 2017.
On this matter Mrs Illingworth confirmed that the Trust did not have any involvement with the perpetrator.

17/132 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

Key matters highlighted from the report were that the Ofsted registration had been approved for Holly and Baysdale to be social care based residences for children. An inspection was expected between 1 October 2017 and 31 March 2018.
On this matter it was noted that there would be monthly reviews undertaken by the Trust as well as the annual inspection by Ofsted.

Following discussion the following matter was noted:

(1) The potential overlap between the CQC information received by QuAC and the Mental Health Legislation Committee.

(i) Mr Simpson noted that the MHL Committee was currently reviewing its terms of reference and this matter would be picked up in those discussions.

(ii) It was recognised that the MHA inspections from a qualitative perspective would be fed through to QuAC, whereas the Mental Health Act Committee would gain the legislative point of view ensuring that the Trust adhered with Mental Health Legislation and policy.

(iii) Mrs Richardson highlighted that one of the key governance drivers would be about who delivers change.

17/133 WORKFORCE AND STAFFING QUARTERLY REPORT

The Committee received and noted the Workforce and Staffing Quarterly Report.

Arising from the report it was noted that:

(1) The draft Workforce Disability Equality Standard (WDES) paper, detailing metrics being piloted in a number of NHS organisations, would become operational for all NHS organisations from 1 April 2018. The first public report would be made available from April 2019.

(2) The Trust already reported some of the information set out in the WDES metrics, however there would be additional focus upon the experiences of disabled staff within the NHS and actions would be taken by employers in response to feedback from and about disabled staff.

Mr Levy highlighted that the experience of disabled staff was quite poor compared to staff that were not disabled and that 36% of staff did not make a declaration as to whether they see themselves as disabled or not.

Following discussion the following comments were raised:

(1) The wording of the information in the staff equality data (page 11) around being over represented for age groups would read better with some benchmarking data.
(2) The indicator on page 7, table 16, “the percentage difference between the Trust Board, voting, non-voting and NED membership is -8% in all categories” should be re-worded to enable better understanding of the meaning.

Action: Mr D Levy

17/134 CLINICAL EFFECTIVENESS QUARTERLY REPORT

The Committee noted the Clinical Audit and Effectiveness quarterly report.

Arising from the report it was noted that:

(1) There were currently eight audits that were behind schedule and mitigating actions were in place to address this. The completion status of the clinical audit programme was 21.55%.
On this matter it was noted that performance against audits normally picked up pace towards the end of the financial year. In addition, there were four new members of staff to support the clinical audit programme of work.

(2) The clinical audit of Emergency Response Bags had rated as red due to low compliance and the potential to cause risk.

All teams with missing equipment had been followed up to ensure that emergency bags were complete and a validation audit had been proposed for 10% of teams. On this matter it was agree that:

(i) Talking to colleagues in Pharmacy following their successful audits would help improve this audit.
(ii) That the 10% validation audit should be increased and a stand-alone report should be brought back to the Quality Assurance Committee at its meeting to be held on 7 December.

Action: Mrs J Illingworth/Mrs E Moody

17/135 DRUG & THERAPUETICS REPORT

The Committee received and noted the Drug and Therapeutics (D&T) Report.

Arising from the report it was highlighted that:

- A range of actions had been agreed by the D&T to support improved and standardised allergy recording across TEWV. This would be monitored by EMT.

- Clozapine intramuscular injection (unlicensed) had been approved for use in named patient applications.
  On this matter it was noted that:

  (i) This drug was not experimental as Clozapine is typically used in oral doses, however it would be specifically the injection form used that was unlicensed. This method of administration of the drug would be to enable patients to go back to taking oral Clozapine within a given time period (of around 10 days) and would only be used in Forensic Services.
  (ii) A review of the use of this drug would go back to the D&T Committee in six months and be reported back to QuAC at that time.

- The increase in price for Olanzapine and Quetiapine drugs going up from £2 for 28 tablets to a range in cost from £32 to £108 for 28 tablets. The Committee was assured that this was expected to be a short term issue.

In addition the Committee noted that the current Chairman of the Drug & Therapeutics Committee Dr Paul Walker would continue to Chair the meetings until the end of the financial year.

17/136 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

17/137 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 be escalated to the Board.

17/138 ANY OTHER BUSINESS

There was no other business to note.

17/139 COMMITTEE MEETING EVALUATION

There was nothing to note.

17/140 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 2 November 2017,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email papers/reports by Thursday 26 October 2017 to Donna Oliver donnaoliver1@nhs.net

The meeting concluded at 4.15pm

Item 10

BOARD OF DIRECTORS

DATE:	**30th January 2018**
TITLE:	**Equality and Diversity Update**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Assurance and approval**

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

Executive Summary:

The purpose of this report is:

- to update the BOD on progress made so far with the Workforce Race Equality Standard (WRES) action plan (appendix1 p.7) and to seek approval of the detailed action plans developed for indicators 2,3 and 4 (appendix 2 p16).
- For the BOD to review and approve the Trust's EDS2 document and gradings (appendix 3 p 23) prior to publication on the trust website.
- For the BOD to review and approve the Trust's Equality, Diversity and Human Rights policy as required by the Mental Health Act Code of Practice (appendix 4 p 68).

.

Recommendations:

- The BOD is asked to note the progress made with the WRES action plan (appendix 1) and to approve the detailed plan for indicators 2,3, and 4 (appendix 2)
- The BOD is asked to approve the trust's EDS2 document prior to its publication (appendix 3)
- The BOD is asked to note that the gradings for the workforce focused EDS2 metrics have been agreed as developing. Action plans to address these issues are required. It has been agreed by JCC that these will the plans in place for the WRES and the Disability confident scheme (see 3.4 for further details)
- The BOD is asked to agree that the EDS2 metrics relating to staff are reviewed in two years' time and those relating to patients in three years' time.

- The BOD is asked to review and approve the trust's Equality, Diversity and Human Rights Policy as required by the Mental Health Act Code of Practice. (Appendix 4)

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**30th January 2018**
TITLE:	**Equality and Diversity Update.**

1.0 INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to update Board of Directors on the WRES action plan and to seek approval for the more detailed action plans that have been developed for indicators 2, 3 and 4 since the WRES was presented to Board in July 2017.

1.2 The report also requests that the Board of Directors review and approve the revised TEWV EDS2 document prior to its publication on the trust website as mandated by NHS England.

1.3 The report requests that the Board of Directors review and approve the trust's Human Rights, Equality and Diversity Policy as required by the Mental Health Act Code of Practice.

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The trust is required to publish its Workforce Race Equality Standard (WRES) and associated action plan annually. The action plan and the WRES figures were signed off by BOD in July 2017 and published on the trust website.

2.2 NHS England suggest that it is good practice for Boards of Directors to be informed regularly on progress with the WRES action plan.

2.3 The Equality Delivery System (EDS) was commissioned by the National Equality and Diversity Council in 2010 and launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The Trust is required to grade itself against a number of outcomes and to have those gradings agreed through public consultation.

2.4 The Mental Health Act Code of Practice requires commissioners and providers should have in place a human rights and equality policy for service provision and practice in relation to the Act, which should be reviewed at Board (or equivalent) level at least annually.

3.0 KEY ISSUES:

3.1 Progress has been made with the WRES action plan as can be seen from the updated plan (see appendix 1) though the early activity has been more focused upon better understanding what the WRES information is telling us rather than implementing actions

3.2 The Board is asked to note changes in the original timescales to the following actions:

- The BAME leadership programme for bands 5-7 will run in February and March and participants have been recruited.
- The analysis of the research with BAME staff is taking longer than expected due to the unexpectedly high number of responses (284) and the amount of qualitative data that has been received. It is expected to be completed by the end of March 2018.
- The Bullying and Harassment Resolution and Reporting procedure is in draft format and is currently undergoing consultation. It is expected to be ratified by April 2018.

3.3 Attached at appendix 2 is a more detailed action plan for indicators 2, 3 and 4 for the BOD to discuss and approve. Due to the postponement of the WRES update paper from November 2017 to January 2018 work has already started on this action plan.

3.4 The EDS2 guidance allows for organisations, based on evidence and insight, to be selective in their choice of services they review. Organisations might also look at particular aspects of protected characteristics. The premise is that a focus on all services, across all outcomes, for all aspects of all protected characteristics, can be overwhelming and unmanageable. It is proposed that in respect of workforce there ought to be a particular focus on race and disability issues because of their significance within TEWV.

3.5 The EDS2 process requires organisations to consult on their proposed gradings with the public and the workforce. Consultation took place with JCC about the workforce focused sections (3 and 4) on 7th November 2017. Feedback was received following this meeting and the gradings were finally agreed at the JCC meeting on 2nd January 2018

3.6 The EDS2 guidance suggests that a consultation on the proposed grading for sections 1 and 2 takes place with users of the trust's services. This has posed particular difficulties for a mental health and learning disability trust when compared to an acute or ambulance trust, as a much smaller proportion of the general public have used our services.
The Board is asked to note the difficulties that have been experienced in gaining feedback on the EDS2 service focused metrics. Details of this are included on pages 25 - 26 of this document.

3.7 The BOD is asked to agree that the EDS2 metrics relating to staff are reviewed in two years' time and those relating to patients in three years' time.

3.8 The trust's Human Rights, Equality and Diversity Policy was reviewed by the Mental Health Act Legislation Committee (MHLC) on 19th October 2017. They approved some minor changes to the policy and recommended that the Board ratify the policy.

4 IMPLICATIONS:

4.1 Compliance with the CQC fundamental Standards:

4.1.1 It is a requirement of the CQC fundamental standards that the Trust meets its obligations under the Equality Act 2010 and the Human Rights Act 1998.This includes the WRES and EDS2

4.2 Financial/Value for Money:

4.2.1 Financial penalties can be incurred for non- compliance with the legislative requirements of both the Equality Act and the Human Rights Act. This may also result in reputational loss for the Trust

4.3 Legal and Constitutional (including the NHS Constitution):

4.3.1 The Trust must demonstrate compliance with statutory equality and human rights requirements. Failure to do so may result in legal action and subsequent financial penalties and damage to the Trust's reputation as both an employer of choice and a provider of quality healthcare.

4.4 Equality and Diversity:

4.4. The Trust must demonstrate compliance with statutory and contractual equality requirements and 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 RISKS:

5.1 None have been identified

6 CONCLUSIONS:

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

6.2 Progress has been made with the WRES action plan with all actions on track with the exceptions of those identified in 3.2 above

6.3 The TEWV EDS2 grading has been revised following a period of consultation as required by NHS England, and subject to approval will be published on the TEWV website.

6.4 The Human Rights, Equality and Diversity Policy has been reviewed and as required by the Mental Health Act Code of Practice.

.

7 RECOMMENDATIONS:

7.1 The Board of Directors is asked to note the progress made with the WRES action plan (appendix 1) and to approve the detailed plan for indicators 2,3, and 4 (appendix 2)

7.2 The Board of Directors are asked to approve the EDS2 document for publication (appendix 3) and to agree the review schedule (see 3.7).

7.3 The Board of Directors is asked to approve the Human Rights, Equality and Diversity policy (appendix 4).

Sarah Jay
Head of Equality and Human Rights

Julie Barfoot
Equality, Diversity and Human Rights Officer

David Levy
Director of Human Resources and Organisational Development

APPENDIX 1

WORKFORCE RACE EQUALITY STANDARD Q 1 UPDATE

2016/2017

making a difference together

	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.	

WORKFORCE RACE EQUALITY STANDARD

	Indicator.	Data for reporting 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	January 2018 Update
	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	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.	1. The BAME leadership programme is being developed, with input from the BAME staff network. A programme will start in February 2018.
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.	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	1. Report has been completed 2. Further action plan has been developed which is attached to report

				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 a two year rolling average of the current year and the previous year.	BAME staff are 2.08 times more likely to enter the disciplinary process than white staff	BAME staff are 2.03 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. .	1. Report has been completed. 2. Research with BAME staff has been completed and analysis is underway but will not be completed until March 2018 due to the number of responses 3. Further action plan has been developed which is attached .
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	White staff are 1.15 times more likely to access non- mandatory training and CPD compared to BAME staff	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 information at present.	1. Research is being undertaken with BAME staff which will seek their views on the likelihood of them accessing non- mandatory training and 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.	1. Evidence from research is currently being analysed. Due to the number of responses this is going to take longer to analyse and will be completed in March 2018. 2. Further action plan has been developed and is attached 3. BAME leadership programme has been developed with input from the BAME staff network. A programme will start in February 2018
	National NHS Staff Survey indicators (or				

	equivalent). For each of the four staff survey indicators, <u>compare the outcomes of the responses for White and BME staff</u>.				
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White:27.95% BAME: 37.23%	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 Trust's Positive approaches training will be undertaken so that the training includes: • How to respond to and manage verbal abuse and aggression. • The debriefing tool for both staff and patients following incidents to include verbal abuse and aggression. This will be completed by December 2017 2. A review will be undertaken of the process in place for supporting staff following harassment, bullying or abuse by patients, relatives or the public. Following this a guidance document will be produced. This will be completed by end of January 2018. 3. To include within the development of the Making a Difference Together priority mutual expectations of behaviour for staff and service users. These will then be publicised on posters etc. throughout the trust. This will be completed by end February 2018. 4. For EMT to receive monthly reports from DATIX on the levels of	1. The review is underway and will be completed following the development of the draft guidance document described below. 2. The review is underway. An event is to be held on 25th January 2018 to develop a draft guidance document. This will be included in the trust Security Procedures document. 3.As part of the making a difference together consultation it has been proposed to develop a trust compact between staff and service users which will include this issue. 4. A review is taking place of how to provide EMT with this information in the light of changes to workforce reporting.

				harassment, bullying and abuse of staff from protected groups by patients, relatives or the public.	
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White: 17.32% BAME: 19.19%	The gap between BAME 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.	Although the difference 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	The Bullying and Harassment Reporting and Resolution procedure is currently out for consultation and will be ratified in April 2018.
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	White: 93.65% BAME: 94.29%	There is no significant 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: 5.02% BAME: 3.06%	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%	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 November 2017	• The new Medical Director is from a BAME background. He will take up post in March 2018. • An audit of access rates for BAME and disabled staff to leadership and management development will be undertaken to establish a baseline. To

					be completed by March 2018. • An analysis of promotion rates by ethnicity will be completed by March 2018.

APPENDIX 2

WORKFORCE RACE EQUALITY STANDARD

2016/2017

ACTION PLAN FOR INDICATORS 2, 3 and 4

WRES METRIC	ACTIONS all of which are to be completed by end of March 2018 unless shown	RATIONALE FOR ACTION	UPDATE ON ACTION
Metric 2.Relative likelihood of staff being appointed from shortlisting across all posts	1. Analysis of relative likelihood of staff being appointed from shortlisting by band.	Evidence from the NHS England publication 2016 Data analysis Report for NHS Trusts suggests: it is important to identify specific areas where BAME staff are less likely to be appointed from shortlisting	
	2. Analysis of whether qualifications from abroad impact on the relative likelihood of staff being appointed from shortlisting for bands 8a and above	Feedback from staff consultation suggests that there may be differences in the likelihood of BAME candidates being appointed from shortlisting if they have qualifications from UK rather than from abroad	
	3. To run two three month trials to evaluate which interventions work best at improving the likelihood of BAME staff being appointed from shortlisting: • To provide training in unconscious bias and regular feedback on rates of recruitment for BAME/ White candidates from shortlisting for people who recruit frequently. • To compare the rates of appointment of these panels with the rates of appointment at recruitment	Evidence from the NHS England publication 2016 Data analysis Report for NHS Trusts suggests: • The research is clear in that unconscious bias training may help prompt discussion of difficult issues, but it is holding decision-makers to account that is the best means of preventing bias in decision-making. • "Batch recruitment"– recruitment to two or three posts together is likely to increase the likelihood	

	fairs. This action to be completed by the end of June 2018.	of a better mix of appointees and mitigate the impact of unconscious bias	
	4. To develop a procedure to formalise secondment and acting up opportunities. To identify how many temporary changes in banding take place that have not gone through a recruitment process or HR operations over a 3 month period and seeking clarification of the reasons.	Evidence from the NHS England publication 2016 Data analysis Report for NHS Trusts suggests: Formalising access to “acting up” opportunities to prevent discrimination is a key opportunity for career progression. Prior experience of acting into a post is widely seen as a means of ensuring those individuals have an inbuilt advantage when a substantive post is filled. Opportunities to join projects, pilot initiatives, shadow more senior staff, be seconded for fixed period, or access mentoring all risk discriminatory practices unless access to them is formalised and monitored. There is growing evidence that the key to staff development is opportunities for “stretch assignments” such as acting up, secondment, involvement in project teams or developing pilots	
	5. To identify how many BAME and how many white candidates have been rated as being above the line during a 3 month period.	To better understand the differences in the likelihood of being appointed from shortlisting for BAME candidates compared to white candidates. In addition to	

		build confidence that the organisation is serious about valuing BAME talent and has taken steps to end unfair practices throughout career progression. Evidence from the NHS England publication 2016 Data analysis Report for NHS Trusts suggests: Years of perceived, and real, unfair practice will make many staff cautious about going for jobs and then being told "you were very good but on the day someone else was better".	
WRES Metric 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 a two year rolling average of the current year and the previous year	1.To analyse disciplinaries for BAME and White staff comparing : • The reasons for the disciplinary • The sanctions imposed, particularly whether counselling was recommended • The level of appeals and the success of appeals • Any patterns in geographical location of disciplinaries for BAME staff.	Evidence from the NHS England publication 2016 Data analysis Report for NHS Trusts suggests: .Some individual trusts, in response to the publications of the WRES data on disciplinary action, have carried out similar, local, root cause analyses of their own disciplinary cases. Having analysed their data those trusts were able to identify specific hot spots (department, shift, profession), discuss the issue with staff and managers, and develop approaches which specifically tackle that issue.	
	2. To analyse capability proceedings for BAME and white staff in particular the reasons that capability processes have been	Evidence from the NHS England publication 2016 Data analysis Report for NHS Trusts suggests:	

	started.	The informal stage of the disciplinary process was critical in sorting out minor issues and that some managers were hindered in this process by a lack of confidence in applying informal strategies with BME staff. Managers were more likely to discipline BME staff over insignificant matters.	
	3. To consider the usefulness of incorporating the Incident Decision making tree into the trust's disciplinary procedure.	Evidence from the NHS England publication 2016 Data analysis Report for NHS Trusts suggests: Some trusts have developed a checklist which draws on some of the principles of the Incident Decision Tree to determine whether managers should proceed with an investigation – an approach which is likely to produce less focus on blame and arguably less likelihood of bias (The National Patient Safety Agency, 'Incident Decision Tree', February 2004)	
Metric 4 Relative likelihood of staff accessing non-mandatory training and CPD.	1.To consider how to formalise secondment and acting up opportunities by identifying how many temporary changes in banding take place that have not gone through a recruitment process or HR operations over a 3 month period and seeking clarification of the reasons.	Evidence from the NHS England publication 2016 Data analysis Report for NHS Trusts suggests: Formalising access to "acting up" opportunities to prevent discrimination is a key opportunity for career progression. Prior experience of acting into a post is widely seen as a means of	

		ensuring those individuals have an inbuilt advantage when a substantive post is filled. Opportunities to join projects, pilot initiatives, shadow more senior staff, be seconded for fixed period, or access mentoring all risk discriminatory practices unless access to them is formalised and monitored. There is growing evidence that the key to staff development is opportunities for "stretch assignments" such as acting up, secondment, involvement in project teams or developing pilots	
	2. To ask Picker to analyse the responses for the National Staff Survey relating to personal development by ethnicity.	To gain better information about the access to non- mandatory training and CPD for BAME staff in the trust. This is due to concerns that some BAME staff have expressed in feedback about the BAME leadership course and in the responses to the research questions, about applications to such opportunities being blocked before they are received by the relevant departments.	

Appendix 3

List of contacts for consultation with EDS2

Following consultation with the Healthwatch leads a questionnaire was developed for use by organisations and individuals who had knowledge of our services, asking them for feedback on the service focused sections of EDS2(1 and 2). These were sent to the following organisations.

Local Authority E&D contacts

Kirsty.McNally@sunderland.gov.uk

Erik.Scollay@middlesbrough.gov.uk

Satnam.singh@stockton.gov.uk

Claire.holt@durham.gov.uk

Mary.gallagher@durham.gov.uk

Helen.whiting@darlington.gov.uk

Catherine.Grimwood@hartlepool.gov.uk

Healthwatch

Natasha Judge M/bro +Redcar

Julia Catherall – County Durham

Sian Balsam – York

Nigel Ayre – North Yorkshire

Diane Lax – Darlington

Stephen Thomas – Hartlepool

Toni McHale – Stockton

Lesley Pratt – York

RACE

Shazia Noor NUR Fitness

LGBT

Jake Furby – YorkLGBTForum@gmail.com

TRANSAWARE

clevelandtransaware@gmail.com

York Consultation for EDS2

Joseph Rowntree Foundation

Healthwatch (York)

CONSULTATION PROCESS

1 The consultation process is also provided as part of the evidence submitted for EDS2 document. Evidence was gained from a cross locality World Mental Health day where the general public were asked to complete a survey. Voices for Choices (local charitable organisation) disseminated to the groups they facilitate. Local Healthwatch groups were accessed in their

monthly TEWV meeting and agreed to circulate it within their E-Bulletins. Local authorities were sent the survey monkey link to fill in and send back. There was a paper survey and a Survey monkey available for people to dispatch to the groups that they consult around local mental health and learning disability services with.

2. The EDS2 document itself has presented particular difficulties with gathering feedback on the proposed grading. The EDS2 guidance suggests that a consultation on the proposed grading takes place with users of the trust's services. This has posed particular difficulties for a mental health and learning disability trust when compared to an acute or ambulance trust, as a much smaller proportion of the general public have used our services.

3. Healthwatch representatives felt they could not complete the survey from a service perspective and preferred to send it for public consultation via a questionnaire on survey monkey. However, this has only yielded 3 completed surveys.

4. Local authority representatives have not completed the survey, with no feedback from them it is difficult to ascertain why.

5. In addition a number of organisations with whom the trust has done work to access particular protected groups were approached for feedback.

EQUALITY DELIVERY SYSTEM FOR THE NHS
ED2S SUMMARY REPORT

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the 9 steps for EDS2 Implementation as outlined in the 2013 EDS2 guidance document. The document can be found at: http/www.england/nhs.uk/wp-content/uploads/2013/11eds-nov131.pdf.

The EDS2 Summary Report is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS Organisation name:		Tees, Esk and Wear NHS Foundation Trust
Organisation's Board lead for EDS2:		David Levy, Director of Human Resources and Organisational Development
Organisation's EDS2 lead (name/email):		Sarah Jay, Equality and Diversity Lead. Email: sarahjay@nhs.net
Level of stakeholder involvement in EDS2 grading and subsequent actions:		The Trust has consulted on its grading with local Health Watch, members of the public, representatives of protected groups, local authorities around the region and the trust's JCC

Organisation's Equality Objectives (including duration period):

The objectives described below form part of a four year Equality, Diversity and Human Rights (EDHR) Strategy. Each objective is accompanied by a set of actions that can be found in the EDHR annual work plan.

The Durham and Darlington overall objective is:
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. This objective was subsumed by the trust wide 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.
Links to EDS outcomes 1.1, 1.2, 2.1 and 2.3 Focus on: Disability and age

The York and Selby overall objective is:
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.
Links to EDS outcomes 1.1, 1.2, 2.1 and 2.3 Focus on age and mental health

The Forensic services objectives are:
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.
Link to EDS outcomes 1.1, 1.2, 2.1 and 2.3

The Teesside objectives are:
Objective 1
To continue implementation of the Green light audit in adult services, building on the work carried out last year and completing the self-assessment. The actions will be to undertake the Green light self-assessment audit tool and move from red to amber categories in all areas that relate to TEWV. Focus on Learning Disability, Mental Health. Link to EDS outcomes 1.1, 1.2, 1.4, 1.5, 2.2 and 2.3
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 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.
EDS outcomes 1.1, 1.2, 1.4, 1.5, 2.2 and 2.3.

The North Yorkshire objective is:
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. EDS outcomes 1.1, 1.2, 2.1 and 2.3.
Focus on: gender (sex) and rural communities

The Trust Wide Workforce objective is:
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 EDS outcomes 3.4, 3.6, 4.1, 4.2 and 4.3. Focus on: Race, disability, religion or belief and sexual orientation

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

The Equality, Diversity and Human Rights Steering Group
The group meets every quarter to progress the Trusts Equality and Human Rights work. Members of the group include senior clinical representatives from the services, corporate service leads, service users' representatives and a designated Governor. The steering group is chaired by the Director of Human Resources and Organisational Development (HROD). The deputy chairs are the Deputy Director of HROD and the Equality, Diversity and Human Rights Lead.

The Trust has a designated Equality, Diversity and Human Rights Team. The team focuses on delivering on the legislative requirements of the equality act 2010 by taking these principles and putting them into practice across TEWV services and in employment. The team also works with policy and service leads to conduct equality analyses on all new and reviewed policies - this is to ensure that the Trusts impact on equality is well considered before decisions are made.

Green Lights Initiative
The Trust has invested a considerable amount of resource into the Green Lights initiative over the past 4 years. The initiative which comes from The Foundation for People with Learning Disabilities aims to improve mental health care for people with learning disabilities, ensuring that each person has access to appropriate care.

BAME Dementia Awareness
Work has been taking place with South Asian communities across Stockton and Middlesbrough to raise awareness on dementia and dementia services. TEWV Mental Health Services for Older People have appeared on local community radio and have been engaging with community groups to discuss how the Trust can support in a positive, non-intrusive way that respects cultural diversity.

Forensic Services - Support for LGB&T service users
Work began three years ago and looked at how Forensic Services could better engage with service users who identify as LGB&T. This work is

set to continue over the next three years and includes engaging with and meeting the needs of service users who identify as trans (transgender) and looking at how the Trust can best meet the needs of LGB&T people in times of distress and/or mental ill health.

British Institute of Human Rights - Project Partner
Delivering Compassionate Care: Connecting Human Rights to the Front-line is an exciting new initiative that was launched in 2014 by the British Institute of Human Rights, supported by the Department of Health. This project was developed in the wake of recent failures of care and seeks to place human rights at the heart of mental health services, helping to ensure front-line staff are empowered to fulfil the vital role they can play in respecting and protecting the dignity and human rights of patients.

The Trust has now completed the three year project and being a part of this has led to some exciting new developments such as the inclusion of Human Rights in mandatory E and D training and an increased awareness across the Trust of Human Rights Principles and Practices and how these impact on the delivery of mental health and learning disability care.

Compassionate Management Project
Compassion, sensitivity to the suffering and needs of ourselves and others, accompanied by a commitment to alleviate and prevent this in a wise way, is key in innovation, performance and leadership. With a focus on quality patient-centred care and staff wellbeing, compassion is key to all we do as a Trust so by placing compassion central to all, together we can further build safe places to work and flourish; compassion also helps us to perform well in our roles, adapt to pressures and ultimately create better outcomes and experiences for the people who use our services. The first stage of the project was delivered to over 200 senior clinical leads working in adult mental health services.

Going forward, the compassionate management project will be expanded across all specialties and into corporate services. It is hoped that the project contributes to a positive culture by working together with other project leads and directors.

Disability Access Checks
The Health and Safety Team carry out routine checks that are aimed at identifying and removing barriers to access for people who have disabilities. This followed a successful pilot project which helped the Trust to identify barriers that are often not seen and can be missed by people who do not have a disability.

ARCH Recovery College
The Trust has an established recovery college in Durham. In York, the Discovery Hub is a TEWV service which works closely with Converge, a Recovery College hosted by York St. John University. The recovery college provides education and support for service users and their carers who want to learn more about mental health. The college is currently seeking to work in partnership with Mind to establish Recovery Colleges in Teesside and are working with voluntary sector providers in Scarborough to establish a pilot there. The Trust has established a Virtual College and has been available since November 2016.

Trust Experts by experience
The Trust works in collaboration and co-production with service users. The Experts are a group of people who have accessed or are currently accessing Trust services. Their experiences ensure that the Trust considers a wide range of viewpoints and perspectives. Trust Experts also have access to a wide range of developmental opportunities including Leadership Training and volunteering opportunities which can, and has helped some Experts to secure paid employment in the Trust.

The Diversity Engagement Group (DEG)
Staff who identify with the protected groups can access the DEG for support. The group also works with the Trust to help it develop more as an inclusive employer. Staff who access the DEG include: staff who identify as BAME, LGB&T, staff who have a religious or philosophical belief and physical disability. The group meets bi-monthly and have been involved in providing ideas for scenarios that feature in the equality, diversity and human rights training. The group is also involved in working with the deputy director of HR and the Equality, Diversity and Human Rights Lead to understand the analysis of the staff and patient 'Friends and Family Test' outcomes.

Trust Membership Team
The Trust has been working to ensure that its membership is representative and in December 2015 undertook a campaign to recruit public members of the Foundation Trust across York and Selby following the transfer of services in that area. In addition to this, through the project additional members were recruited in Harrogate and Wetherby and Hambleton and Richmondshire with a total of 750 members recruited over the 2 weeks of the face to face campaign.

The membership of the Trust as at 31 March 2017 was representative of the local community.

In November 2015 the Council of Governors approved an Involvement and Engagement Framework which outlined the Trusts intentions to involve and engage with service users and carers in the development and delivery of our services through recognising the critical importance of working in partnership with the users of our services and their carers to design and deliver high quality person centred services which promotes recovery.

Some of the valuable work undertaken through involvement activities have included:

- Recruiting staff including medical and nursing positions with in excess of 50 interview panels including a service user or carer.
- Training a range of nursing students, doctors and those staff undertaking NVQ qualifications.
- Participating in a range of inspections of wards and working environments under Patient Led Assessment of the Care Environment (PLACE) and internal inspections against the Care Quality commission (CQC) Fundamental Standards.

• Participating in service user and advocate leadership training which provides a mechanism for self-development and confidence building.
• Assisting in the planning and delivery of conferences, sharing experiences and views.
• Assisting the Trust with plans to become smoke free.
• Joining a number of formal meeting groups contributing to the assurance of quality and safety of services.
• Significant work in looking at force reduction with service users using their own experiences to change culture and approaches.
• A number of service users joining the experts by experience programme and assisting the Trust to embed recovery principles in all aspects of work.
• Employment of two experts by experience coordinators (previous attendees of the experts by experience programme).
• Development of 14 involvement peer roles within the organisations working alongside staff in the delivery of care and support.

The NHS Staff Friends and Family Test
Kerry Jones, the lead for the NHS staff Friends and Family Test is working with the Trust Equality, Diversity and Human Rights Team to ensure that the Trust has access to accurate information about the experiences of people from different protected groups.

<table>
<tr><th>Goal</th><th>Outcome</th><th colspan="3">Grade and Reason for rating</th><th>Outcome links to an Equality Objective</th></tr>
<tr><td></td><td></td><td colspan="3">Services are commissioned, procured, designed and delivered to meet the health needs of local communities.</td><td></td></tr>
<tr><td rowspan="2">Better health outcomes.</td><td>1.1</td><td>Grade

Undeveloped
☐

Developing
☐

Achieving
☑

Excelling
☐</td><td colspan="2">Which characteristics fare well

Age
☑

Disability
☑

Gender reassignment
☐

Marriage and civil partnership
☑

Pregnancy and maternity
☐

Race
☑

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td><td>☑</td></tr>
<tr><td colspan="5">Evidence drawn upon for rating

Our approach
The Trust is a ‘provider’ of Mental Health and Learning Disability services. Our services are provided based on the requirements set out by commissioners. These criteria and provisions are regularly reviewed and revised to ensure that they continue to meet people’s needs.

Services commissioned by Clinical Commissioning Groups (CCGs) are managed on a geographical basis in four localities covering, Durham and Darlington; Teesside; North Yorkshire and York and Selby.</td></tr>
</table>

	There is also a Trust-wide Locality for Forensic Services. Each is led by a Director of Operations and a Deputy Medical Director who report to the Chief Operating Officer. Further to this we: • Have a mix of corporate and service driven Equality Objectives which are reviewed every 4 years • Have an Equality and Human Rights Annual Work Plan to support ongoing and new work • A dedicated Equality, Diversity and Human Rights Team that provide advice, support and guidance for staff working in services to ensure that service users' needs are met. • We produce an Annual Publication of Equality Information in line with legislative requirements • Have a successful Equality, Diversity and Human Rights Steering Group which meets quarterly, produces an agenda, minutes, matters arising and associated actions • Our staff also conduct equality analyses on all ratified documents and during service design to ensure effective and accessible services. We have an Equality Analysis policy, guidance and screening form. Equality Analyses are carried out on all TEWV Policies, procedures, strategies and there is a procurement screening process in place • Hold regular Trust Board Seminars that focus on equality, diversity and human rights • Work in partnership with the British Institute of Human Rights • Carry out Disability Access Checks and Reasonable Adjustments where needed to ensure that people with a wide range of disabilities are able to access our services in the same way as non-disabled people • Have a successful and accessible interpreting and translation service which includes British Sign Language to support our Deaf Communities throughout the region • Have refreshed our Mandatory Equality, Diversity and Human Rights Training to ensure it is current and progressive • Deliver Unconscious Bias, bullying, harassment and discrimination new session on personal effectiveness course (PEP) and Leadership and Management Course (LAMD) • We produce Equality Data for services so that they can meet the needs of people accessing their services. We also look at which groups are not accessing services by comparing our data with the local data from the national census We publish the following information in line with government requirements, including: • Trust Business Plan 2016 - 2019 • Trust Annual Report 2016 - 2017 • Trust Quality Account 2016 – 2017 • Trust Quality Strategy 2014 - 2019 We have improved our Patient Care Record System (PARIS) in our equality data fields to allow for more accurate recording of protected characteristic information for service users Patient experience and NHS Friends and family survey results are accessible to all staff and displayed in clinical areas, comments are made available for teams to view.

	The NHS Patient Friends and Family Test results (FFT) for assessment and treatment areas and recovery areas form part pf CQUIN reports. NHS FFT information is available for in-patient areas and feedback from Data Governance reports Equality, Diversity and Human Rights are also discussed and minuted at: • Executive Management Team meeting agenda/minutes • QuAC and QuAG meeting agenda/minutes • Locality Management and governance Board meeting agenda/minutes • CQC inspection, reports and feedback (Trust rated good) • Pals and complaints • Datix incidents – We receive electronic notification of any incident involving patient to staff / staff to patient / visitor to staff etc. in relation to discrimination and harassment • Kaizen Project Office - Agenda for planning meetings, patient questionnaires • Meeting peoples specific needs is part of the Clinical pathway patient engagement standards We have worked with CDDFT Procurement team to ensure equality was included within the Invitation to Tender (ITT) and Terms & Conditions All Project Management forms are embedded with Equality Analysis Screening Form others include where relevant: • Service specifications and building plans • CQRG Reports • EMT Reports • Serious untoward incidents action plans Some recent positive improvements relating to Equality, Diversity and Human Rights include the: • Admission, Transfer and Discharge of service users within hospital and residential settings Policy • Harm minimisation Project and Training • Positive Approach Project and training

<table>
<tr><td></td><td colspan="4"></td></tr>
<tr><td rowspan="3">Better health outcomes</td><td></td><td colspan="3">Individual people’s health needs are assessed and met in appropriate and effective ways</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">1.2</td><td rowspan="2">Grade

Undeveloped
☐

Developing
☐

Achieving
☑

Excelling
☐</td><td colspan="2">Which characteristics fare well</td><td rowspan="2">☑</td></tr>
<tr><td>Age
☑

Disability
☑

Gender reassignment
☐

Marriage and civil partnership
☑</td><td>Pregnancy and maternity
☐

Race
☑

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td></tr>
</table>

	Evidence drawn upon for rating As 1.1 + Our approach: Because our services are provided to people with different and complex needs, health needs are assessed and met in a number of different ways and tailored to the individual. Our patient and record information system 'PARIS' ensures that there is a standardised process for assessment and care planning. Service users and their carers are actively involved in this process either in their family home and/or within an inpatient setting. Social services, public health and local authorities work alongside staff and service users have access to full multi-disciplinary teams. Individual care plans are completed and are a reflection of how needs are to be met. Teams have information about a range of health and social care services that may provide additional support to individual care plans. The Trust is a registered provider of services within the Care Quality Commissions framework and a range of outcomes set by the CQC are fully complied with. In relation to patient experience the Trust gathers feedback including demographic information from service users and carers via electronic hand held devices and kiosks. There are a range of accessible information leaflets. There are CQC Inspections and 'mock CQC Inspections' as a way of the Trust assuring itself that standards are being met. Patients and their carers attend individual reviews and are supported to share their views on services. The Trust also uses the NHS friends and family test to ensure that levels of patient satisfaction remain high. This can now be broken down by the protected groups which means we can see if there are differences in experience for patients from particular protected groups. We carry out thorough 'mock CQC Inspections' as a way of assuring ourselves those standards are being met We host Diversity Champions training with master classes held on LGB&T awareness, Disability, Race and Ethnicity, Unconscious Bias, bullying harassment and discrimination and Gender awareness. We produce leaflets for service users and carers on 'How we make sure you are treated fairly' and 'Human Rights – Speaking up for myself' in plain English and easy read We also have access to• patient data by protected group

	The Equality, Diversity and Human Rights Lead reports to the Quality Assurance Committee and the Executive Management team providing information and recommendations We have a dedicated advanced nurse practitioner for the deaf The Trust has a multi faith Chaplaincy Team, and has developed a 'Spirituality flower' and staff resources to support people from different faith groups and people who want to explore and know more about spirituality We produce a quarterly magazine called Insight which included many equality and diversity themes We have an internal e-bulletin news articles, InTouch (intranet) articles and Equality and Diversity Pages that staff can access for information, support and signposting We have embedded the Care Programme Approach and Standard Care Policy and Framework into service delivery. We have a current physical health care project – linked 'Reducing Premature Mortality for those with Serious Mental Illness We continue our work in the Green Lights project - access to mental health care for people with learning disabilities

<table>
<tr><td rowspan="3">Better health outcomes</td><td></td><td colspan="3">Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed</td><td>Outcome links to an objective</td></tr>
<tr><td>1.3</td><td>Grade

Undeveloped
☐

Developing
☐

Achieving
☑

Excelling
☐</td><td colspan="2">Which characteristics fare well

Age
☑

Disability
☑

Gender reassignment
☐

Marriage and civil partnership
☑

Pregnancy and maternity
☐

Race
☑

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td><td>☑</td></tr>
<tr><td></td><td colspan="4">Evidence drawn upon for rating

As 1.1 and 1.2 +
We have protocols in place to ensure that transitions between our services are smooth and efficient.
E.G. Transfer of Care from Child and Adolescent to Adult Services Protocol and Clinical Pathways</td></tr>
</table>

<table>
<tr><td rowspan="2">Better health outcomes</td><td></td><td colspan="3">When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse</td><td rowspan="2">☑</td></tr>
<tr><td>1.4</td><td>Grade

Undeveloped
☐

Developing
☐

Achieving
☑

Excelling
☐</td><td colspan="2">Which characteristics fare well

Age
☑

Disability
☑

Gender reassignment
☐

Marriage and civil partnership
☑

Pregnancy and maternity
☐

Race
☑

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 1.1, 1.2 and 1.3 +
Our approach:
The Trust has a number of ways of ensuring that people’s safety is prioritised. Assurance processes are inclusive of all protected groups and action is taken and lessons learned when a negative impact is identified.

Quality Assurance Committees (QuAC)
The Quality and Assurance Committee (QuAC) has the key purpose of providing assurance to the Board of Directors and Council of Governors on the quality and safety of the operational clinical services as outlined in the Quality Strategy.

Divisional Quality and Assurance Groups (QuAg)
The prime purpose of the Divisional Quality and Assurance Groups is the development of quality within the specialty that is</td></tr>
</table>

	covered by the Divisional QuAG. The main role of the Senior Clinical Director is therefore to develop and support the specialty's quality development agenda. The Divisional QuAG provides the "thought" leadership for each specialty promoting a positive, patient focused culture. The Divisional QuAG develops standards of best practise, informed for example by lessons learned by SUIs, patient experience reports, benchmarking etc. They have responsibility for analysing new national policies and strategies that will be relevant, for example National Dementia Strategy, National Autism Strategy etc. and to provide advice to the Trust on the implications of new national policies and strategies and what action the Trust should be taking. Our suite of policies, processes and procedures includes: • Incident Reporting and Investigation Policy • Incident Procedure Manual • Datix (incident reporting system) and SBARDS – Briefings re serious incidents • Information Security and Risk Policy • Clinical Safeguarding Adults Protocol • Clinical Safeguarding Children Policy • Clinical Child Visiting Policy • Clinical MAPPA Protocol • Clinical Risk Assessment and Management Policy • Clinical Engagement and Observation Procedure • Raising Serious Concerns and Whistleblowing Procedure • TEWV Nursing Strategy • Clinical Practice Policies, Procedures and protocols • Training and registration of Nurses and allied professionals • Mandatory Training • Clinical audit • CQC inspections and mock CQC inspections • Health and Safety audits • Security Procedure • Training and registration of Nurses and allied professionals • Health and Safety audits and disability access checks • Whistle blowing policy • Induction and training registers • Lessons learned bulletin, project forms and action plan database • Commissioner Quality review Group (CQRG) report (outlining how many actions completed).

<table>
<tr><td rowspan="2">Better health outcomes, continued</td><td rowspan="2">1.5</td><td colspan="3">Screening, vaccination and other health promotion services reach and benefit all local communities</td><td>Outcome links to an objective</td></tr>
<tr><td>Grade

Undeveloped
☐

Developing
☐

Achieving
☑

Excelling
☐</td><td colspan="2">Which characteristics fare well

Age
☑

Disability
☑

Gender reassignment
☐

Marriage and civil partnership
☑

Pregnancy and maternity
☐

Race
☑

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 1.1, 1.2, 1.3, and 1.4 +
We ensure that all service users have access to Flu vaccinations and we monitor take up. We issue resource packs that are available for staff to use with people with learning disabilities so that all are fully informed about their choices and understand the health screening processes. We provide support to primary care regarding understanding of screening procedures to inform capacity decisions.
We ensure that all our service users have an understanding of the benefits of exercise and healthy eating. Many of our inpatient hospitals have gyms and staff that are trained in physical education, some services cook meals with service users (dependent on need) to enable them to continue to eat healthily once they leave hospital.
We have a highly successful smoking cessation programme.</td></tr>
</table>

<table>
<tr><td rowspan="2">Improved patient access and experience</td><td></td><td colspan="3">People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds</td><td>Outcome links to an objective</td></tr>
<tr><td>2.1</td><td>Grade

Undeveloped
☐

Developing
☐

Achieving
☑

Excelling
☐</td><td colspan="2">Which characteristics fare well

Age
☑

Disability
☑

Gender reassignment
☐

Marriage and civil partnership
☑

Pregnancy and maternity
☐

Race
☑

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 1.1, 1.2, 1.3, 1.4 and 1.5+
The Trust would not deny anyone access to its services, however on some occasions it may be appropriate for a person to be referred to another service if it is felt that their needs would be better met by another provider e.g. primary care services.

The Trust also looks at access for older people and people with disabilities. We completed disability access checks on our hospital and in our out-patients settings. If we identify an issue or a potential issue we ensure that the barrier (e.g. a very heavy door or lack of clear signage) is removed, improved or that there is a reasonable adjustment in place for people who otherwise may struggle to use the service. We want everyone to benefit from our services. On occasion we find that we cannot make modifications to all our sites (listed buildings etc.). When this happens alternative arrangements are made such as home visits or</td></tr>
</table>

	visits in a local G.P surgery if the person does not want their appointment at home. Our equality, diversity and Human rights team is on hand to ensure that staff can ask questions about access needs and this often leads to service improvements. People access our services in a number of ways, including: • GP referral • Improving Access to Psychological Therapies referral – people can self-refer into our IAPT services and a referral may sometimes be made. Please note we are not the provider of IAPT services in Teesside • A person may be picked up by police under Section 136 of the Mental Health Act • The Police may request street triage, we attend and an admission or referral is made • Our crisis team attend an incident and an admission or referral is made if appropriate. • A person may present at A&E and the liaison team see them and recommend admission or a referral • Social services may make a referral

<table>
<tr><td rowspan="2">Improved patient access and experience</td><td></td><td colspan="3">People are informed and supported to be as involved as they wish to be in decisions about their care</td><td>Outcome links to an objective</td></tr>
<tr><td>2.2</td><td>Grade

Undeveloped
☐

Developing
☐

Achieving
☑

Excelling
☐</td><td colspan="2">Which characteristics fare well

Age
☑

Disability
☑

Gender reassignment
☐

Marriage and civil partnership
☑

Pregnancy and maternity
☐

Race
☑

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 1.1, 1.2, 1.3, 1.4 , 1.5 and 2.1 +
Our approach:
Care planning supports service users to engage with clinical staff and discuss what will happen should they become unwell.
Information Governance

The Trust's Information Governance Policy pulls together the complex law relating to keeping people's confidential information safe. Confidentiality and information sharing guidance describes how the Trust discusses with services users the choices they have around how their information is used. It further describes how the Trust meets the needs of services users during the times they lack capacity to make decisions about their information. The Records Management Policy defines the competencies of staff who deal with patient information and the processes that are followed to keep patient information safe.</td></tr>
</table>

	All policy and procedure documents undergo an equality analysis which includes consultation with groups that include people (staff, patients, carers, support groups etc.) from across the protected groups. The consultation process is identified on the equality analysis. Full consultation with staff ensures that people from all the protected groups have an opportunity to raise concerns regarding the content of policy documents and any negative impact, or the impact of the service they apply to, would have or does have on them. Consultation with patients and carers enables the considerations of those with particular needs to be met. Accessible Patient Information All our patient information has Information Standard accreditation www.theinformationstandard.org/members this includes a plain English certification. Information is also available in a number of different formats. The Mental Health Act Team has information available about people's rights in a number of different languages and has recently published leaflets in easy read. The Information Governance Team has leaflets in the Trusts core languages and other languages are available when a need is identified. Pharmacy services provide information about medication choice and medication which is available in different languages and formats. Information is also available on our website at http://www.tewv.nhs.uk/medication there are different styles of leaflets and an audio facility. The Mental Health Act (MHA) Team The MHA allows certain decisions to be made about treatment for mental health conditions when a person is detained under the Act. In general a person can make their own decisions about their care or treatment, and that is as true of a person who has a mental ill health as it is of anyone else. The Mental Capacity Act (MCA) protects the right of people to make their own decisions, and provides a framework for assisting people to make their own decisions and authorises a decision that is in the best interests of a person where that person lacks the capacity to make a particular decision, due to a disturbance in the functioning of their mind or brain. The MCA allows a person to make statements of preference and advance refusals of treatment should they lose the capacity to make a particular decision in the future. Patient and Carer Involvement The Patient and Carer Involvement (PCI) Team implements the 'Triangle of Care' Document's six key elements to ensure carers have appropriate support and information that meets their needs. This involves working with external Carer Support Organisations to involve them with our inpatient and community teams. The PCI team support service users and their carers to be involved with the Trust. This includes a service user 'reader's panel' which is managed by the PCI team, further supporting the Trust to produce information that is accessible to all protected groups. Supporting people to be involved in decisions about their care Service users are involved in the process of assessing their needs, care planning and review in order to meet their needs through

	a standardised process that is documented on PARIS. Care Programme Approach processes may also be used .When decisions are made they are done in full consultation with the patient their carer and/or their advocate. Where the person lacks capacity to make certain decisions then it is done either through a 'best interest decision' or through the Court of Protection. Where major decisions are to be made about lifestyle an Independent Mental Capacity Advocate could be appointed by commissioners/care management

		People report positive experiences in the NHS			Outcome links to an objective
Improved patient access and experience	2.3	Grade Undeveloped ☐ Developing ☐ Achieving ☑ Excelling ☐	Which characteristics fare well Age ☑ Disability ☑ Gender reassignment ☐ Marriage and civil partnership ☐	Pregnancy and maternity ☐ Race ☑ Religion or belief ☑ Sex ☑ Sexual orientation ☑	☑
	Evidence drawn upon for rating As 1.1, 1.2, 1.3, 1.4 , 1.5, 2.1, 2.2 + The Trust has a number of ways of monitoring the experiences of people who identify with protected groups who access Trust services. The Trust analyses the experiences of service users from different protected groups using the patient Friends and Family Test.				

<table>
<tr><td></td><td></td><td colspan="3">People’s complaints about services are handled respectfully and efficiently</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">Improved patient access and experience</td><td rowspan="2">2.4</td><td rowspan="2">Grade

Undeveloped
☐

Developing
☐

Achieving
☑

Excelling
☐</td><td colspan="2">Which characteristics fare well</td><td rowspan="2">☑</td></tr>
<tr><td>Age
☑

Disability
☑

Gender reassignment
☐

Marriage and civil partnership
☐</td><td>Pregnancy and maternity
☐

Race
☑

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 1.1, 1.2, 1.3, 1.4 , 1.5, 2.1, 2.2 , 2.3 +
Complaints are handled within agreed timescales, involving the complainant as far as possible. Complainants are regularly updated regarding progress.

Patient views are regularly sought by use of questionnaires and internal inspections. There is a PALS helpline available with free phone number and facility for mobile/text contacts. All issues raised including those relating to equality are forwarded to operational services and specialist services are informed where necessary.

The Patient and Carer involvement Team undertake inspections, visits and interview panels with the assistance of patients and carers.</td></tr>
</table>

	Datix Incident Reporting and Monitoring Datix is the trust's incident reporting system. When Trust staff are involved in or witness an incident, a Datix incident report is completed so that the incident can be investigated. Datix is widely used across the NHS for incident reporting. Logged incidents of a discriminatory nature are instantly viewable to all the departments who need to know about them, including the equality and diversity lead. Datix allows the Trust to identify problems and patterns quickly, so that the trust can act on them in a timely way. Communications Team Service users, families and carers sometimes submit complaints via the tewv.enquiries@nhs.net (trust generic) email address. These are acknowledged on the same working day and passed through to the correct department. The sender is also informed about which the correct department is should they wish to contact them directly.

<table>
<tr><td></td><td></td><td colspan="3">Fair NHS recruitment and selection processes lead to a more representative workforce at all levels</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">A representative and supported workforce</td><td rowspan="2">3.1</td><td rowspan="2">Grade

Undeveloped
☐

Developing
☑

Achieving
☐

Excelling
☐</td><td colspan="2">Which protected characteristics fare well</td><td rowspan="2">☑</td></tr>
<tr><td>Age
☑

Disability
☐

Gender reassignment
☐

Marriage and civil partnership
☑</td><td>Pregnancy and maternity
☐

Race
☐

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

The Trust strives to ensure that its recruitment and selection processes are fair and lead to a representative workforce. We encourage and recognise the business benefits of having a diverse workforce that can meet the challenges of delivering person centred care to our communities.

We also recognise that diversity should be encouraged at every level in both clinical and corporate services. We know that a more diverse workforce and diverse leadership enables us to be even more innovative, creative and solution focused.

We also monitor staff experience through the NHS Staff Survey and the NHS Friends and Family Test. We are able to review</td></tr>
</table>

	staff experiences which in turn enables us to be an inclusive employer. Although we have BAME staff that are representative of our community these are mainly doctors and are not evenly distributed throughout all levels of the organisation. We believe disability is under reported on ESR (electronic staff record) so we are unable to ascertain how representative we are of our community in regards to this characteristic. Sources of evidence include: • Annual workforce monitoring and analysis • NHS Jobs captures monitoring information for all applicants • Equal pay audit • Equality and diversity mandatory training compliance rate • NHS Staff survey medium term analysis, associated corporate and local action planning • Increased use of service users and carers in the recruitment process • Evaluation of a process to recruit staff who exhibit positive value based behaviours •WRES and associated action plans 2017 - 18 •Disability confident action plan 2017 - 18

<table>
<tr><td></td><td></td><td colspan="3">The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">A representative and supported workforce</td><td rowspan="2">3.2</td><td rowspan="2">Grade

Undeveloped
☐

Developing
☑

Achieving
☐

Excelling
☐</td><td colspan="2">Which protected characteristics fare well</td><td rowspan="2">☑</td></tr>
<tr><td>Age
☑

Disability
☐

Gender reassignment
☑

Marriage and civil partnership
☐</td><td>Pregnancy and maternity
☐

Race
☐

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 3.1 +
The Trust has carried out an equal pay audit and will continue to ensure that people are paid fairly and in line legislative requirements.
Sources of evidence:
• Annual workforce monitoring and analysis
• NHS Jobs captures monitoring information for all applicants
• Equal pay audit</td></tr>
</table>

	• Equality and diversity mandatory training compliance rate • NHS Staff survey medium term analysis, associated corporate and local action planning • Increased use of service users and cares in the recruitment process • Evaluation of a process to recruit staff who exhibit positive value based behaviours

<table>
<tr><td></td><td></td><td colspan="3">Training and development opportunities are taken up and positively evaluated by all staff</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">A representative and supported workforce</td><td rowspan="2">3.3</td><td rowspan="2">Grade

Undeveloped
☐

Developing
☑

Achieving
☐

Excelling
☐</td><td colspan="2">Which protected characteristics fare well</td><td rowspan="2">☑</td></tr>
<tr><td>Age
☑

Disability
☐

Gender reassignment
☐

Marriage and civil partnership
☑</td><td>Pregnancy and maternity
☐

Race
☐

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 3.1 and 3.2 +
The Trust recognises the value of training and staff having access to development opportunities, but more than that we want our staff to have a positive experience whilst receiving training.

We have been reviewing our training and looking at how we can improve the style and delivery of the training.

We need to be able to balance the need to provide our staff with training that enables them to do their job to a high standard,</td></tr>
</table>

	whilst considering staffing levels on wards and in operational offices. We are looking at modernising the way in which mandatory training is delivered and we are currently considering the use of webinar and other media. This means that staff will be travelling less, able to sit at a desk with a computer near to where they work and receive on-line training with a trainer who can connect to staff that are located anywhere within the Trust. Staff can make a drink, have their training and then return to work which means they are out of the ward/office for less time but still receive high quality training. We are also reviewing the way we deliver e-learning. Sources of evidence: • Annual workforce monitoring and analysis • Mandatory training compliance rate • Appraisal audits • NHS Staff survey medium term analysis, associated corporate and local action planning •Training evaluation and Trainer assessment •The trust has concerns about its BAME and disabled staff's access to training and development and promotion as indicated in its WRES action plan and disability confident action plan.

<table>
<tr><td></td><td></td><td colspan="3">When at work, staff are free from abuse, harassment, bullying and violence from any source</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">A representative and supported workforce</td><td rowspan="2">3.4</td><td rowspan="2">Grade

Undeveloped
☐

Developing
☑

Achieving
☐

Excelling
☐</td><td colspan="2">Which protected characteristics fare well</td><td rowspan="2">☑</td></tr>
<tr><td>Age
☑

Disability
☐

Gender reassignment
☐

Marriage and civil partnership
☑</td><td>Pregnancy and maternity
☐

Race
☐

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 3.1, 3.2 and 3.3 +
The Trust understands the impact of abusive behaviours and how they can impact on patient care and human rights. We saw how this behaviour resulted in the investigation and subsequent public inquiry at Mid Staffordshire NHS Foundation Trust.

We are working to ensure that no one is bullied, harassed or discriminated against. An example of this is that we have reviewed our Equality, Diversity and Human Rights Training to include further information about what these behaviours are and how they could manifest either at work or in the delivery of services.</td></tr>
</table>

	There is now a Trust 'speak up champion' and first contact officers that our staff can access to discuss issues at work or workplace behaviours that are affecting them. The trust recognises that its BAME staff experience higher levels of abuse than its white staff and is taking action to address this as part of the WRES and related action plan 2017/18. The trust is currently developing a bullying and harassment resolution procedure which will be in place by April 2018. Sources of evidence: • NHS Jobs captures monitoring information for all applicants • Annual workforce monitoring and analysis • Equality, Diversity and Human Rights training • NHS Staff survey medium term analysis, associated corporate and local action planning • Established a Trust reference group • Whistleblowing and raising serious concerns procedure • Datix incident reporting procedure, follow up processes and monitoring • Grievance procedure • Disciplinary procedure • Confidential support line • Employee support officers • Staff Retreats

<table>
<tr><td></td><td></td><td colspan="3">Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">A representative and supported workforce</td><td rowspan="2">3.5</td><td rowspan="2">Grade

Undeveloped
☐

Developing
☑

Achieving
☐

Excelling
☐</td><td colspan="2">Which protected characteristics fare well</td><td rowspan="2">☑</td></tr>
<tr><td>Age
☑

Disability
☐

Gender reassignment
☐

Marriage and civil partnership
☑</td><td>Pregnancy and maternity
☐

Race
☐

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 3.1, 3.2, 3.3 and 3.4 +
We offer a range of flexible working opportunities that are balanced and in line with service requirements.

We also recognise that more than ever people want the benefits of balancing work and life. We offer a wide range of employment opportunities to suit everyone. Many of our most skilled and experienced clinicians and corporate staff are electing to work flexibly as they near retirement or work beyond their retirement.</td></tr>
</table>

	This has benefits for the Trust and for the staff member. We are able to retain their knowledge and skills, whilst they are able to enjoy the benefits of reduced working hours/days whilst being valued for their expertise. The Trust is seeking to improve the experience of staff with disabilities and their access to a range of reasonable adjustments. This is addressed in the Disability Confident workplan Sources of evidence: • Developed material to support managers who have staff that may require adjustments to me made to the normal working environment • NHS Jobs captures monitoring information for all applicants • Annual workforce monitoring and analysis • NHS Staff survey medium term analysis, associated corporate and local action planning • Grievance procedure • Employee support officers • Retreats • Flexible working procedure • Flexible retirement options • Option for staff to increase annual leave allowance • Staff Rostering policy

<table>
<tr><td></td><td></td><td colspan="3">Staff report positive experiences of their membership of the workforce</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">A representative and supported workforce</td><td rowspan="2">3.6</td><td rowspan="2">Grade

Undeveloped
☐

Developing
☑

Achieving
☐

Excelling
☐</td><td colspan="2">Which protected characteristics fare well</td><td rowspan="2">☑</td></tr>
<tr><td>Age
☑

Disability
☐

Gender reassignment
☐

Marriage and civil partnership
☑</td><td>Pregnancy and maternity
☐

Race
☐

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

As 3.1, 3.2, 3.3, 3.4 and 3.5 +
The Trust has attained the 'Investors on People - Gold' level standard which we believe demonstrates our commitment to staff. We also monitor the experiences of staff using a variety of different means.

We want our staff to know how much they are valued and that they have a stake in the direction of the Trust and its values.

Sources of evidence:
• NHS Jobs captures monitoring information for all applicants
• Annual workforce monitoring and analysis</td></tr>
</table>

	• Equality, Diversity and Human Rights training • NHS Staff survey medium term analysis, associated corporate and local action planning • Quarterly friends and family test and analysis, associated action planning • Established a Trust reference group • Whistleblowing and raising serious concerns procedure • Datix incident reporting procedure, follow up processes and monitoring • Grievance procedure • Disciplinary procedure • Confidential support line • Employee support officer • Staff Retreats •NHS Staff Friends and Family Test •Investors in People Gold •Research to better understand issues for BAME, disabled and LGB staff • The Trust recognises that there is a difference in experience and outcome for its BAME and disabled staff. It is addressing this issue in its WRES action plan and Disability Confident Action plan.

<table>
<tr><td></td><td></td><td colspan="3">Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations</td><td>Outcome links to an objective</td></tr>
<tr><td>Inclusive leadership</td><td>4.1</td><td>Grade

Undeveloped
☐

Developing
☑

Achieving
☐

Excelling
☐</td><td colspan="2">Which protected characteristics fare well

Age
☑

Disability
☐

Gender reassignment
☐

Marriage and civil partnership
☑

Pregnancy and maternity
☐

Race
☐

Religion or belief
☑

Sex
☑

Sexual orientation
☑</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

The Trust Board of Directors has ratified and approved all equality and human rights processes and protocols that the Equality, Diversity and Human Rights Team have requested. We believe that this shows a genuine commitment to ensuring that the Trust promotes equality within the organisation. All formal papers within the trust require the completion of a section on equality and diversity however the trust feels that it could improve the quality of these.
Equality and Human Rights are standard items at the Quality and Assurance Group and the Director of Human Resources and Organisational Development attends this meeting to ensure that the Trust is aware of its legislative duty to promote, foster and eliminate discrimination in employment and service delivery.</td></tr>
</table>

	Beyond the Trust, the Equality, Diversity and Human Rights Lead and Officer regularly attend a monthly regional meeting where ideas and best practice are shared and discussed. Many senior clinical and corporate managers in the Trust are 'Diversity Champions' and attend regular master classes on a range of equality and human rights issues. Sources of evidence: • Equality analysis policy and guidance • Associated library of equality analyses • Interpreting and translation policy and guidance • Dress code policy • Project management framework • Equality, Diversity and Human Rights Steering Group minutes • Various articles of Trust board or EMT supporting equality related activity

<table>
<tr><td></td><td></td><td colspan="3">Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">Inclusive leadership</td><td rowspan="2">4.2</td><td rowspan="2">Grade

Undeveloped
☐

Developing
☑

Achieving
☐

Excelling
☐</td><td colspan="2">Which protected characteristics fare well</td><td></td></tr>
<tr><td>Age
☑

Disability
☐

Gender reassignment
☐

Marriage and civil partnership
☑</td><td>Pregnancy and maternity
☑

Race
☐

Religion or belief
☑

Sex
☑

Sexual orientation</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

The Trust has a ratified and established Equality analysis policy, guidance, screening form. Recently the equality analysis proforma has been included in all templates for policy writers including the policy template, the guidance template and the procedure and protocol templates.
We felt it was essential for staff to understand that equality analysis is part of the policy writing process. Equality analyses are also carried out on Trust projects, and service developments.
The Trust also has equality and human rights included in the report template so that staff are able to say within the report that</td></tr>
</table>

	equality or human rights are a factor in their considerations. The Equality, Diversity and Human Rights Lead also reports to the Executive Management Team twice a year and as often as required. Although the standard reporting document is used for all such committees which include a standard paragraph on equality and diversity issues the trust considers that the quality of these could be improved.

<table>
<tr><td></td><td></td><td colspan="3">Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination</td><td>Outcome links to an objective</td></tr>
<tr><td>Inclusive leadership</td><td>4.3</td><td>Grade

Undeveloped
☐

Developing
☑

Achieving
☐

Excelling
☐</td><td colspan="2">Which protected characteristics fare well

Age
☑

Disability
☐

Gender reassignment
☐

Marriage and civil partnership
☑

Pregnancy and maternity
☑

Race
☐

Religion or belief
☑

Sex
☑

Sexual orientation
☐</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Evidence drawn upon for rating

There is support available for new and existing managers. We make sure that all our managers receive the same mandatory training as non-managerial staff so that they are able to see what staff can expect from them.

We also run courses on managing and the recruitment process which includes equality and diversity within them. The Leadership and Management Course we host, now includes a session on unconscious bias, bullying harassment and discrimination.

Sources of evidence:</td></tr>
</table>

	• Developed material to support managers who have staff that may require adjustments to me made to the normal working environment • Annual workforce monitoring and analysis • Equality and diversity training compliance rates • Trust Values training • Productive conversations training • Leadership and management development programme • NHS Staff survey medium term analysis, associated corporate and local action planning • Trust reference group • Appraisal audits • Developed and piloted a process to recruit staff who exhibit positive value based behaviours • Increased use of service users and cares in the recruitment process • Whistleblowing and raising serious concerns procedure • Datix incident reporting procedure, follow up processes and monitoring • Grievance procedure • Disciplinary procedure • Employee support officers • Staff Retreats • Staff Mindfulness Courses • Human Rights, Equality and Diversity Policy • Reasonable Adjustments Toolkit • Policy and Equality Analysis Audit •WRES and Disability confident action plans

APPENDIX 4

Human Rights, Equality and Diversity Policy
Ref: HR-0013-v7

Status:

Contents

1 Introduction

The NHS Constitution states that **'The NHS belongs to us all'**, it is with this principle in mind that this policy has been written.
The Trust is under increasing pressure to deliver high quality services, with limited resources to an increasingly diverse population whose needs and expectations are growing year on year. At the heart of the Trust is a commitment to provide comprehensive and flexible services that meet people's needs and are available and accessible to all. In order for the Trust to be equipped to deliver its services in a respectful, fair and inclusive way, the Trust must become more innovative in how it can meet the different needs of service users and make best use of the resources it has, most notably its people.

In employment matters the Trust recognises that harassment, discrimination, bullying and victimisation are destructive behaviours that can happen within any team, in any organisation. Wherever they exist they contribute and exacerbate poor mental health and wellbeing, add to workplace stress and lower team morale. This in turn can result in increased sickness absence levels, high staff turnover and can ultimately result in mental ill health.

If bullying is allowed to thrive within an organisation it becomes a destructive force that can prohibit open challenge, whistleblowing or raising concerns. Staff may become fearful of reprisal (victimisation) from both managerial and non-managerial colleagues. Left unchecked this can have a direct impact on the safety and quality of patient care as was highlighted in the Francis Report into Mid Staffordshire Hospital. The Trust considers all of the above mentioned abusive behaviours as 'avoidable and unjustifiable harm'.

"Patients must be the first priority in all of what the NHS does… protected from avoidable harm and any deprivation of their basic human rights" **The Francis Inquiry Report.**

"The culture at the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff; there was an atmosphere of fear, of adverse repercussions" **The Francis Inquiry Report.**

Trust staff have a duty of care towards their colleagues, service users, their relatives and carers or anyone else they come into contact with whilst engaged in Trust business

1.1 Who this policy applies to

This policy applies to the following groups of people. Expected standards of behaviour can be found in section 4.0 Roles and Responsibilities

- The Chief Executive and The Trust Board of Directors including Non-Executive Directors
- All Trust Managers, regardless of role, grade or position
- All Trust staff regardless of role, grade or position

- Bank Workers and Agency Workers
- Service users, their carers, relatives and friends
- Trust Governors
- Trust experts by experience
- Trust Volunteers
- Hospital Managers
- Contractors

2 Purpose – why we need this policy

This policy sets out how the organisation complies with applicable human rights and equality legislation (MHA CoP 2015, para.3.15)

2.1 Services

Human Rights belong to everyone. They are the basic rights that we all have simply because we are human, regardless of who we are, where we live or what we do. Human Rights represent all the things that are important to us as human beings, such as being able to choose how to live our lives whilst being treated with dignity and respect. We have Human Rights from the moment we are born until the moment we die.
Health inequalities can be wide ranging in both nature and impact. Health inequalities can be seen in many arenas of healthcare and can range from limiting patient choice and independence to misdiagnoses of health conditions and/or poor treatment or a lack of health education which can result in some protected groups not accessing services in the same way as other groups of people. The most serious breaches can reduce the opportunity of early diagnosis, impacting on the overall likelihood of recovery taking place.
Putting Human Rights at the heart of the way Trust services are designed and delivered ensures better services for everyone, with patient and staff experiences reflecting the core values of Fairness, Respect, Equality, Dignity and Autonomy.

2.2 Employment

The purpose of this policy is to provide a set of minimum standards that everyone who has dealings with the Trust must adhere to. We must also ensure that all aspects of Trust business are non-discriminatory and are carried out in a fair and consistent manner. The Trust is committed to providing services and employment environments that promote Equality, Diversity and Human Rights and will make every effort not to discriminate against service users, relatives, carers, Trust staff, potential Trust staff, bank workers, agency workers, volunteers, students, contractors or anyone that deals with the Trust in any way.

Bullying, harassment and discrimination in the workplace can be described as '***any unwanted behaviour that makes someone feel intimidated, degraded, humiliated or offended'***. It is not necessarily always obvious or apparent to others. It can be insidious and can happen in the workplace without an employer's awareness. Bullying, harassment, discrimination or victimisation can be between two individuals or it may involve groups of people or teams.
It is sometimes obvious and witnessed by other people or it can be insidious and hidden from others. It can be persistent (over days, months or years) or an isolated incident. It can occur in written communications, by phone, text or email and not just face-to-face. It is

physical, psychological and emotional abuse, it damages mental health and wellbeing and will not be tolerated by the Trust. Further information about the impact of a negative culture in an organisation can be found in section 5.2.

3 Legislation - The Human Rights Act 1998

The Human Rights Act is a foundation law, meaning that all other laws must be compatible with it. When there are abuses of Human Rights people have the right to challenge, speak up or to request an investigation. The Act has three duties which all staff and those acting on behalf of the Trust must abide by at all times. The three duties are;

- **Respect**; this means to **not** violate rights
- **Protect**; to take action to prevent a violation (by whistleblowing, raising concerns etc.)
- **Fulfil**; to provide investigation and review when violations occur (procedural duty)

The Human Rights Act is an enabling foundation law that aims to promote the rights of human beings, whatever their circumstances. It is not possible for a person not to have rights; a person always has human rights.

In particular circumstances Human Rights can be limited or restricted, but rights can never be taken away completely. Human Rights provide a set of minimum standards and are a vital safety net for the treatment we can all expect from our services, including;

- **Better services and outcomes**: can help drive up quality and improve outcomes
- **Not reinventing the wheel**: Not about completely changing what you do, human rights are a practical framework to help you improve how you do it
- **Familiar shared values**: dignity, respect, fairness, autonomy, equality and choice – upholding these values under challenging circumstances
- **Power not pity**: human rights provides a powerful language
- **About the day-to-day practice**: not theory

3.1 Key Human Rights for mental health and learning disability services

There are five key Human Rights for mental health and learning disability services, these are:

Article 2 - **The right to life** includes a duty not to take away anyone's life, a positive duty to take reasonable steps to protect life and a procedural duty to investigate deaths where public officials may be implicated / involved.

Article 3 - **The right to be free from torture, inhuman and degrading treatment**. This is an absolute right. It covers three types of treatment: Torture, Inhuman treatment, degrading treatment

It imposes three types of obligations on public officials:

- A negative duty **not** to torture or treat someone in an inhuman and degrading way
- A positive duty to take reasonable steps to protect people known to be at risk of such treatment

- A procedural duty to investigate where torture, inhuman or degrading treatment has occurred

Article 5 - **The right to liberty** is a non-absolute right. In specific circumstances liberty can be limited, e.g. detention under Mental Health Act or prison. The right to liberty is not a right to be free to do whatever you want. It is a right not have extreme restrictions placed on a person's movement. It includes procedural safeguards such as review mechanisms and time limits etc.

Article 8 – **The right to respect for private and family life, home and correspondence**. This right protects four interests: private life, family life, home and correspondence

This right is non-absolute and can be restricted. It has to be balanced against the rights of others and the needs of society. This right involves three types of obligations on public officials:

- A negative duty **not** to interfere with people's family life, private life, home and correspondence
- A positive duty to take reasonable steps to protect people known to be at risk of having their rights violated, especially in relation to mental and physical well-being
- A procedural duty to ensure fair decision-making processes

Article 14 – **The right to non-discrimination**. This right can only be used in conjunction with another right or rights. The definition of discrimination is broader than that of the Equality Act and a person can bring a case of discrimination for any reason.

4 Legislation - The Equality Act 2010

The Trust focuses on Equality, Diversity and Human Rights from two perspectives that are intertwined with each other.

- **Service Delivery** – Equality, Diversity and Human Rights in healthcare for service users and their carers
- **Employment** – Equality, Diversity and Human Rights for our staff

The Equality Act 2010 makes it unlawful to discriminate against someone because of one or more protected characteristics. The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
Section 149(1) of the Equality Act 2010 states – A public authority must, in the exercise of its functions, have due regard (take seriously) to the need to –

- **Eliminate** unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- **Advance** equality of opportunity between people who share a protected characteristic and those who do not
- **Foster** good relations between people who share a protected characteristic and those who do not

These are more commonly known as the three aims of the Act.

The Act requires that the Trust demonstrates 'due regard' this means the Trust **MUST** demonstrate that it has reasonably considered its impact on equality. This is an ongoing requirement (continuous duty) and it is essential that this is done in a proactive and

anticipatory way, rather than in a reactive way which is ineffective and does not evidence or demonstrate 'due regard' (reasonable consideration) of the requirements of the Act.

Section 149(2) of the Equality Act 2010 states
A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).

Section 149(2) relates to Trust staff and anyone else who provides or delivers services to the public such as council workers, the police, teachers etc. All NHS staff and anyone else who carries out a function or functions on, or on behalf of the Trust must take their responsibility seriously and in accordance with the Act, acting in compliance with section 149(1) of the Act at all times. Further information on how to access the Equality Act 2010 can be found on page 15.

5 Policy

This policy lays down the Trusts expected standards in relation to Equality, Diversity and Human Rights in employment and service delivery. This policy applies to anyone who has dealings with the Trust. It is hoped that by taking a unified approach the Trust can promote a message that is clear and well understood by all parties.

1. The Trust will respect and protect the Human Rights of all service users, staff and anyone else who has a relationship to the Trust.
2. Any restriction/s placed on the rights of service users, for example a decision to detain a person under the Mental Health Act will be lawful, justifiable and proportionate, will have a legitimate aim and will be the least restrictive option in the circumstance
3. The Trust takes breaches of policy very seriously, particularly those that when breached have a harmful effect on other people. Victimisation, harassment, discrimination (or an attempt to do so) and bullying will not be tolerated and will, where substantiated lead to disciplinary action
4. Staff who identify with protected groups have the right to be treated in a fairly and with dignity and respect and without the fear of unlawful discrimination, harassment, victimisation or bullying
5. Service users who identify with protected groups, their relatives and their carers have the right to be treated in a fair, reasonable and consistent way with dignity, respect and compassion and without the fear of unlawful discrimination, harassment, victimisation or bullying
6. The Trust will work to reduce health inequalities for all service users
7. The Trust is committed to the ongoing development of staff awareness and knowledge of Equality, Diversity and Human Rights. Staff development begins on employment and continues throughout an individual's career until they leave the Trust

8. The Trust is committed to monitoring, evaluating and reporting on issues of Equality, Diversity and Human Rights in employment and service provision
9. The Trust will work towards best practice standards of Equality, Diversity and Human Rights and not merely comply with legislation
10. The Trust will promote equality, foster good relations and take an anti-discriminatory approach in all areas of employment and service delivery
11. The Trust will ensure that barriers to accessing services and employment are identified and removed so that no person is treated less favourably because they identify with a protected group/s
12. The Trust recognises the importance of this policy in the employment relationship it has with its staff and in provision of services for service users, and will reflect this commitment in all Trust policies, procedures and practices etc.
13. Anyone that deals with the Trust will receive equitable treatment whether they are receiving a service, providing a service, tendering for a contract or in any other relationship with the Trust
14. This policy extends outside the workplace and Trust staff should be aware that work place behaviour includes time when they are not physically at work but are participating in activities where work is a factor, i.e. team nights out, shopping trips with colleagues etc.
15. Abusive, discriminatory and / or unethical behaviour outside of work could still affect the relationship between the Trust and its employees, particularly if it is deemed to be so serious that it would warrant disciplinary action or allegations of gross misconduct, as would be the case if the individual or group concerned were at work
16. Staff with a professional registration may also find that discriminatory and or unethical practices outside work may lead to complaints to their professional body and possible action by them
17. This policy is a key policy and as such should be read by all staff regardless of role, grade or position.

5.1 Associated Benefits

The Trust recognises the benefits which will arise from implementation of the Human Rights, Equality and Diversity Policy including:

1. Right respecting clinical practice provides the very best opportunity for recovery. Services take a positive and inclusive approach to minimising distress and harm
2. The provision of accessible, flexible and adaptable services that are delivered by highly capable staff that meet the needs of service users', resulting in equitable levels of patient satisfaction regardless of which protected group/s they identify with
3. Equality, Diversity and Human Rights enhance opportunity, inclusivity, creativity and innovation leading to better working and patient care environments

4. Employing staff from different protected groups and cultural backgrounds enables a better understanding of the needs of all service users, and results in a workforce with increased levels of empathy and compassion
5. A diverse workforce and inclusive working environments increase the reputation of the Trust in different communities. In turn this encourages people from these communities such as BAME and LGB&T people, and people with disabilities to apply for positions within the Trusts as its reputation grows as an employer of choice
6. A diverse organisation has higher levels of emotional intelligence and empathy than less diverse organisations. Diversity also drives innovation and creativity which is a key element in developing inclusive working practices and service provision. Staff that share similar values on issues such as respect, compassion, equality and fairness are more likely to get on and more likely to be part of an effective and successful team

5.2 Associated Risks

There are a number of risks associated with not implementing this policy. Including:

- Low staff morale
- Reduced team performance due to bullying
- Higher than average sickness levels in teams where there are issues
- High turnover of staff
- Nepotism
- Litigation and associated financial costs and penalties
- Investigation of individual, team, service, Trust etc.
- CQC and EHRC warnings and fines
- Unwanted (negative) media attention
- Loss of public confidence
- Loss of future business
- Poor patient reported outcome measures
- Reduction in Staff Survey outcome measures

The associated risks stated in 3.2 are more likely to occur when the following takes place.

1. **Discrimination arising from disability:** Discrimination for any reason connected to the person's disability that is not covered by other forms of discrimination. For example, people with disabilities having to walk on the road because the pavements at a hospital are not suitable for people who use wheelchairs or people who are registered blind
2. **Failure to make reasonable adjustments in relation to disability:** Where a physical feature, provision, criterion or practice puts a disabled person at a substantial disadvantage, the service provider has a duty to take reasonable steps to alter, remove or avoid that disadvantage. E.g. providing aids and equipment, changes to working arrangements and ensuring services are accessible and inclusive to people who have a range of disabilities
3. **Harassment:** unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual
4. **Bullying:** Unwanted conduct, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual

5. **Equality, Diversity and Human Rights Breaches:** Human Rights breaches, failure to provide and deliver services or provide employment that is appropriate and meet the needs of the individual service user or member of staff
6. **Direct discrimination:** when someone is treated less favourably than another person because of a protected characteristic they have. Includes, age, disability, gender reassignment, race, religion or belief, sex (gender) and sexual orientation. Note – the protected characteristics of marriage and civil partnership and pregnancy and maternity are not covered by perceptive discrimination or associative discrimination
7. **Perceptive discrimination:** Discrimination by perception happens when a person is discriminated against because they are thought to have a particular protected characteristic. People are protected even if they do not have the protected characteristic, and they are protected if they do. E.g. Tim finds homophobic abuse written on his locker. He reports it to his manager. Tim is protected whatever his sexual orientation because even if Tim is heterosexual he is still receiving homophobic abuse
8. **Associative Discrimination:** Discrimination by association occurs when a person is treated less favourably because of their association with a person who has a protected characteristic. It could be that they are being treated less favourably than others because of the protected characteristic of spouse, partner, parent or another person with whom they are associated
9. **Indirect discrimination:** a rule, policy or practice which is applied to all but has a disproportionately adverse effect on particular groups of people and it cannot be objectively justified
10. **Victimisation:** treating a person worse because they have made, or people think they have made, a complaint about discrimination, harassment, bullying or have given or about to give evidence in an investigation or discrimination case – victimisation is unlawful

6 Equality Analysis

The Trust will use Equality Analysis (EA) to ensure that the Trust reasonably considers its impact on equality. Equality Analysis Policy and Guidance, defines the requirements of the Trust and its staff in more detail. The Trust has identified some additional priorities and these are identified in sections 5 to 6.8.

Valuing staff and ensuring that they feel they have been treated fairly results in staff feeling engaged, improves morale, motivation, loyalty and job satisfaction. It also reduces staff turnover meaning that the Trust is more likely to retain staff with the right values, attitudes and skills

7 Interpreting and Translation

Trust staff will refer to the Interpreting and Translation Policy and Guidance when providing care for people who speak using a language other than English or who communicate using

British Sign Language. Patient care cannot take place if the service user is unable to understand the clinician or any member of staff involved in their care and treatment.

8 How this policy will be embedded

Equality, Diversity and Human Rights will be embedded into every aspect of Trust business. This section highlights some of the key areas and themes that have been identified within the Trust.

8.1 Recruitment, Selection and Employment

- All recruitment processes, conditions of service, job requirements and learning and development opportunities, must fit with the needs of the service and those who work in it. The trust will comply with the legal requirements of the Equality Act 2010 and the Human Rights Act 1998
- The Trust will strive to provide a positive working environment in which people want to work and be a leader in good employment practices and effective communication
- Under representation, where it exists, will be identified and addressed by removing barriers. People will have equal access to career advancement and other opportunities within the organisation
- Taking positive action, where appropriate, to ensure applicants and employees can participate in, and have opportunity work for the Trust, further ensuring that Trust services meet the needs of its communities
- The Trust is also committed to enabling every member of staff to achieve their full potential in an environment characterised by opportunity, dignity and mutual respect

8.2 Learning and Development

- All staff must undertake Equality and Diversity training as they start working for the Trust. Additionally staff are required to undertake regular refresher training in accordance with the mandatory training needs analysis which is part of the staff development policy
- All employees should have an annual individual appraisal including a personal development plan. This should completed in accordance with the staff development policy On an annual basis the Trust will produce a Training Needs Analysis to outline how the Trust priorities for development will be achieved
- Information on training and development opportunities is widely publicised and all employees will be encouraged to undertake appropriate training and development, which will enable them to meet the requirements of their role in meeting service needs

8.3 Performance Management

- Performance assessments should be based on employee's performance against

their actual objectives and the Knowledge and Skills Framework profile linked to their job description

- All managers with responsibility for appraisal should be able to show evidence of competence in Appraisal and Equality and Diversity Awareness

- Concerns over discriminatory or inappropriate behaviour picked up through supervision, whether clinical, professional or managerial, should be dealt with promptly by the manager

- In relation to disability, the Trust will make every effort to make reasonable adjustments for Trust staff that have or develop a disability whilst employed by the Trust. This could include people who can continue to work but the reasonable adjustments can't be accommodated in that particular role. Under the Trusts capability or sickness procedures there would be opportunity for staff to enter redeployment to explore whether adjustments could be accommodated in another job in a different area

- If an individual is so unwell or the condition is so severe/life-threatening that they cannot continue working then Occupational Health advice would be sought and the Trust would follow the Sickness Absence Management Procedure (Stage 4)

- Reasonable adjustments and other support procedures will be put in place to support and enable staff with disabilities to meet the requirements of their role, but on very rare occasions it will be not be possible to make reasonable adjustments or redeploy staff. This may be because the nature of the person's disability will be such that it inhibits the person's ability to work at all. When this happens the Trust will follow the End of Employment Procedure.

- If you believe that you have been subjected to bullying, harassment, discrimination or victimisation, you can raise a grievance using the Trust's Grievance Procedure. The Trust will not tolerate harassment, discrimination, victimisation or bullying of staff because of a protected characteristic(s) or for any other reason. Any member of staff committing such actions will be subject to the Trusts Disciplinary Procedure and it could result in dismissal

- **If you witness someone being subjected to bullying, harassment, discrimination or victimisation and don't feel you can raise it with your line manager then you should use the Trust's** Whistleblowing Procedure and Raising Serious Concerns Procedure **to raise the issue.**

8.4 Partnership Agreement

The Trust has an agreement with staff side representatives which reinforces the importance of partnership working with all parties sharing a commitment to the business and service needs of the Trust.
The agreement encourages managers to spread the benefits of partnership working by ensuring that staff and staff side representatives are systematically and routinely involved in shaping the service and involved in the decision making process. This reinforces an environment where the right balance is reached between the needs of the service and the needs of its employees, ultimately improving the working environment for staff which has a positive knock on effect which can be seen in the quality of patient care. Further information on Joint Staff Side work can be found here.

8.5 Trust Services – Planning Services

- The Trust will ensure that its priorities are informed by the health needs of the communities it serves. When health inequalities are recognised steps will be taken to remove them by engaging and seeking the views of the communities, including those represented by protected groups and by working with commissioners
- Equality, Diversity and Human Rights will be considered throughout the planning stages of all Trust services

8.6 Trust Services – Service Design

- Equality analysis and/or demographic equality data will be used to consider Equality, Diversity and Human Rights and the needs of service users and carers at every stage of the service design process
- Trust staff will take a positive and proactive approach to Equality, Diversity and Human Rights by raising their own awareness and knowledge levels to accomplish this aim. The Trust (the equality and diversity team) will support staff to do this

8.7 Trust Services – Access to Services

- All Trust services will proactively endeavour to anticipate and meet the needs of people that identify with protected groups. When a protected group is underrepresented in a service the Trust will investigate the reasons for this and where necessary will take action to remove barriers that impact on services being accessed in an equitable way
- The Trust will ensure that its services are accessible to people with disabilities

8.8 Trust Services – Service Delivery

- Trust services will be delivered in a respectful, dignified, compassionate and professional way with the needs of the service user taking priority
- Trust services and the staff involved in the delivery of services will maintain a flexible and adaptable approach to delivering care, if concerns or issues arise around working with protected groups or in how to meet the human rights of service users, staff will seek advice from the Equality and Diversity Team in the first instance
- Trust services will ensure that patients are involved in discussions about their care and treatment and that their culture and ethnicity are respected and supported. The Care Programme Approach and Standard Care
- The Trust will gather feedback on patients' experiences at appropriate times. Quality Strategy 2017- 2020

The Trust requests that staff display **moral courage**, actively challenging and reporting abusive behaviour of any kind. If you are unsure of what this is, you can seek further advice and guidance from the Equality, Diversity and Human Rights

9 Roles and responsibilities

Role	Responsibility
Chief Executive and the Trust Board of Directors	• The Chief Executive is responsible for providing leadership to the Trust in the promotion of Equality, Diversity and Human Rights in both service delivery and employment matters • Members of the Trust Board collectively and individually are responsible for supporting the Chief Executive in this objective • The Trust must conform to current legislative requirements of the Human Rights Act 1998 and the Equality Act 2010. • The Trust seeks to ensure equitability of access in the provision of its services, which meets the needs of service users • As a provider of mental health, learning disability and substance misuse services, the Trust is committed to meaningful engagement with all parts of its communities and commissioners • The Trust seeks to dismantle barriers that prevent equality of access to employment, promotion, training and development opportunities for all protected groups
Director of HR&OD	• The Director of HR&OD has operational responsibility for Equality, Diversity and Human Rights throughout the Trust in both Employment and Service Delivery
The Equality and Diversity Lead - Services	• The Equality, Diversity and Human Rights Lead role is to support the Director of HR&OD to be able to make informed decisions in all matters relating to Equality, Diversity and Human Rights. The EDHR Lead reports to the Director of HR&OD monthly and to the Quality and Assurance Committee (QUAC) three times a year, submitting an annual report of progress made as part of the reporting cycle. Further to this the EDHR Lead reports to the Executive Management Team (EMT) and Workforce Development Group as and when necessary and in accordance with Trust requirements
Equality, Diversity and Human Rights Officer	• The Equality, Diversity and Human Rights Officer reports to the Equality and Diversity Lead and has an active role in supporting the Equality, Diversity and Human Rights Lead, supporting Trust staff to embed Equality, Diversity and Human Rights within employment and services
Managers	• Managers understand that unlawful discrimination, harassment, bullying and victimisation are unacceptable practices and have no place in Trust services, departments

	or teams. • Managers are expected to foster positive working environments where mutual respect for Equality, Diversity and Human Rights are central to their role as manager, leading by example, and actively challenging abusive behaviour of any kind to maintain good staff morale, wellbeing and good patient care • Making staff aware of the Trust policy on Equality, Diversity and Human Rights and the supporting policies in relation to employment and service delivery • Promoting Equality, Diversity and Human Rights by their behaviour and actions • Ensuring that complaints are dealt with in a fair and consistent manner • Ensuring that contractors working within the Trust adhere to the principles of the Equality, Diversity and Human Rights Policy
Staff, including agency workers, bank workers and students	• Are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision • Must not discriminate e.g. This includes any person who is responsible for selection decisions in recruitment, promotion, transfer, training etc. or those responsible for the provision and delivery of services • Not acting, persuading, attempting to persuade or instructing other employees, unions or Management to practice unlawful discrimination, harassment, bullying, victimisation or any act that would result in a breach of the Human Rights Act 1998 • Not harassing, bullying or intimidating other employees, including their peers, subordinates or seniors. This includes amongst others: sexual, racial and homophobic harassment • Not victimising or attempting to victimise individuals on the grounds that they have made complaints or provided information on discriminatory practice. • Informing management if they suspect or are aware that an act or acts of discrimination or inhumane treatment of any kind is or have taken place
Contractors	• All contractors must comply with the requirements of the Equality Act 2010 and the Human Rights Act 1998 whilst providing or delivering goods, services and facilities to Trust staff, service users, their relatives, carers and anyone else

	who has links with the Trust. • Not complying with the above means that the contractor is in direct breach of the 'Terms and Conditions of its contract with the Trust and the contract will be terminated.
Service users, their relatives and carers	• Service users, their relatives, friends and carers can expect to be treated with respect and courtesy whilst accessing or engaging with Trust services. We encourage service users, their carers and relatives to contact the Trust using the PALS service if they experience unfair or unequal treatment or feel that Trust services do not meet their needs. • Service users, their relatives, friends and carers are expected to treat Trust staff with respect and courtesy whilst receiving Trust services. The Trust will not tolerate racist, sexist or homophobic abuse etc., towards its staff, other service users, their relatives or carers. The Trust will provide support and/or signposting to staff or anyone else who feels that they have been harassed, discriminated against or victimised whilst they have been delivering services or receiving care.
Trust Governors and Volunteers	• Trust Governors and Volunteers are expected to treat each other and anyone else they come into contact with whilst carrying out their duties with respect and courtesy • Trust Governors and Volunteers can expect to be treated with respect and courtesy whilst performing duties, with or on behalf of the Trust
Hospital Managers	• Hospital Managers have a statutory role under the Mental Health Act 1983 which requires them to attend review meetings to ensure the lawful criteria for detention under the Act is met. This role is also pivotal in that it addresses the Human Rights of service users. It is expected that they will be non-biased and that their decisions will be made without prejudice. It is expected that individuals who are selected to act on behalf of the Trust as Hospital Managers will uphold the principles of this policy, in that the Trust expects high standards in relation to Equality, Diversity and Human Rights from Hospital Managers. The Trust will take action to remove Hospital Managers who do not meet the Trusts expected standards.

10 Glossary

Term	Definition
CQC	Care Quality Commission
Diversity (difference)	The Trust recognises that everyone has a unique contribution to make and that a person's personal attributes contribute significantly in achieving the Trusts goals. Diversity is a strength and it should be visible at all levels of the organisation. Valuing Diversity is integral to valuing people. When we value Diversity we promote a positive, supportive and innovative working environment. When we value the Diversity of our service users we are more likely to meet their needs and support them on their journey to recovery.
EHRC	Equality and Human Rights Commission
Equality	Equality in the UK is about fostering and promoting the right to be different, to be free from discrimination, and to have equal choices, opportunities being valued as an individual.
HR&OD	Human Resources and Organisational Development
Human Rights	The rights that we all have and share, simply because we are human
BAME	Black, Asian and Minority Ethnic
LGB&T	Lesbian, Gay, Bisexual and Transgender

11 Related documents

To provide context the Trust has a number of closely associated policies, procedures, guidance and other documents that support the aims of this central policy, they include:

- Disciplinary Policy and Procedure, Whistle Blowing and Raising Serious Concerns, Incident Reporting and Investigating Policy, Security Procedure, Equality Analysis Policy and Guidance, Interpreting and Translation Policy and Guidance, Staff Development Policy, Dress Code Policy, Special Leave and Flexible Working Policy, Health and Wellbeing Strategy, Recruitment & Selection Policy, End of Employment Policy and Procedure, Grievance Policy and Procedure (including bullying and harassment), Job Evaluation Policy and Procedure, Organisational Change Policy, Retirement and Long Service Policy, Information Governance and Information Security and Risk Policy, End of Employment Procedure and Capability Procedure

12 How this policy will be promoted

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.
- Where additional training needs for staff are identified they will be taken forward using

existing Trust processes by the Equality and Diversity Lead and the Workforce Lead

13 How this policy will be monitored

The Director of Human Resources and Organisational Development will ensure this policy is reviewed with respect to changes in legislation and/or at any time where it can be shown the needs staff, service users or any other group are not being met

1. Publish equality information as required by the Equality Act 2010 and by the Mental Health Act Code of Practice 2015 (para.3.15)
2. Publish 'Equality Objectives' every four years which will be supported by an annual work plan which will be reviewed annually. The work plan is aimed at meeting the requirements of the 'Public Sector Equality. Regular progress reports will be made to the Trust Board via the Equality, Diversity and Human Rights Steering Group, the Equality and Diversity Lead and Work Force Lead.

The Equality, Diversity and Human Rights Steering Group will monitor and evaluate progress made on delivering the Trusts equality objectives including:

3. Develop and performance manage the systems to monitor and improve Equality, Diversity and Human Rights within the Trust with particular reference to ensuring the Trust meets its responsibilities under the Equality Act 2010 and the Human Rights Act 1998

4. Develop an annual work plan to progress the delivery of Equality, Diversity and Human Rights and to ensure the Trust meets its legal responsibilities under the Acts

5. Ensure that systems are in place to provide assurance that demonstrates compliance with all legislative and quality requirements

6. Monitor incidents and breaches of Equality, Diversity and Human Rights legislation and monitor and audit the dissemination of learning lessons and feedback from actions

7. Oversee any relevant procedural and policy development and review

8. Ensure that systems are in place to provide evidence of the Trust's compliance with the expectations of any external regulatory bodies and their standards

The Trust will monitor and where appropriate:

9. Report incidents towards service users, carers and staff. If incidents such as racial, sexist, and homophobic or any other abuse occurs while on Trust premises or whilst staff are representing the Trust, these will be challenged and dealt with in line with the Trust security policy and/or disciplinary policy and procedure and the grievance policy and procedure (including bullying and harassment).

The Trust:

10. Recognises an individual's right to privacy, under European Human Rights Regulations and the provisions laid out in the Data Protection Act 1998. Information

will therefore be stored in accordance with the Information Governance and Information Security and Risk Policy

In order to assess the effectiveness of its Human Rights, Equality and Diversity policy in employment matters the Trust will review and maintain the following information in relation to staff identifying with protected groups, including:

11. Statistical information about the composition of the workforce. This will be used for measuring the achievement of the Trust's annual work plan in relation to employment, including:

    - Job applicants
    - Short-listed candidates
    - Existing and new employees deployment and managerial/leadership level within the Trust and the protected characteristics identified.
    - Details of selections decisions for recruitment, redeployment, promotion, transfer and training and reasons for these decisions
    - Exit interviews
    - Grievances
    - Disciplinary decisions

Where information is collated in line with the Human Rights, Equality and Diversity Policy, it will be published using established communication mechanisms and in line with the NHS confidentiality code of practice.

14 Contact Details and Further Information

The Equality and Diversity Team can be contacted on 0191 3336267/6542 if you have concerns or would like advice about **any issue relating to services and employment**.
Sarah Jay – Equality, Diversity and Human Rights Lead
Email: sarahjay@nhs.net

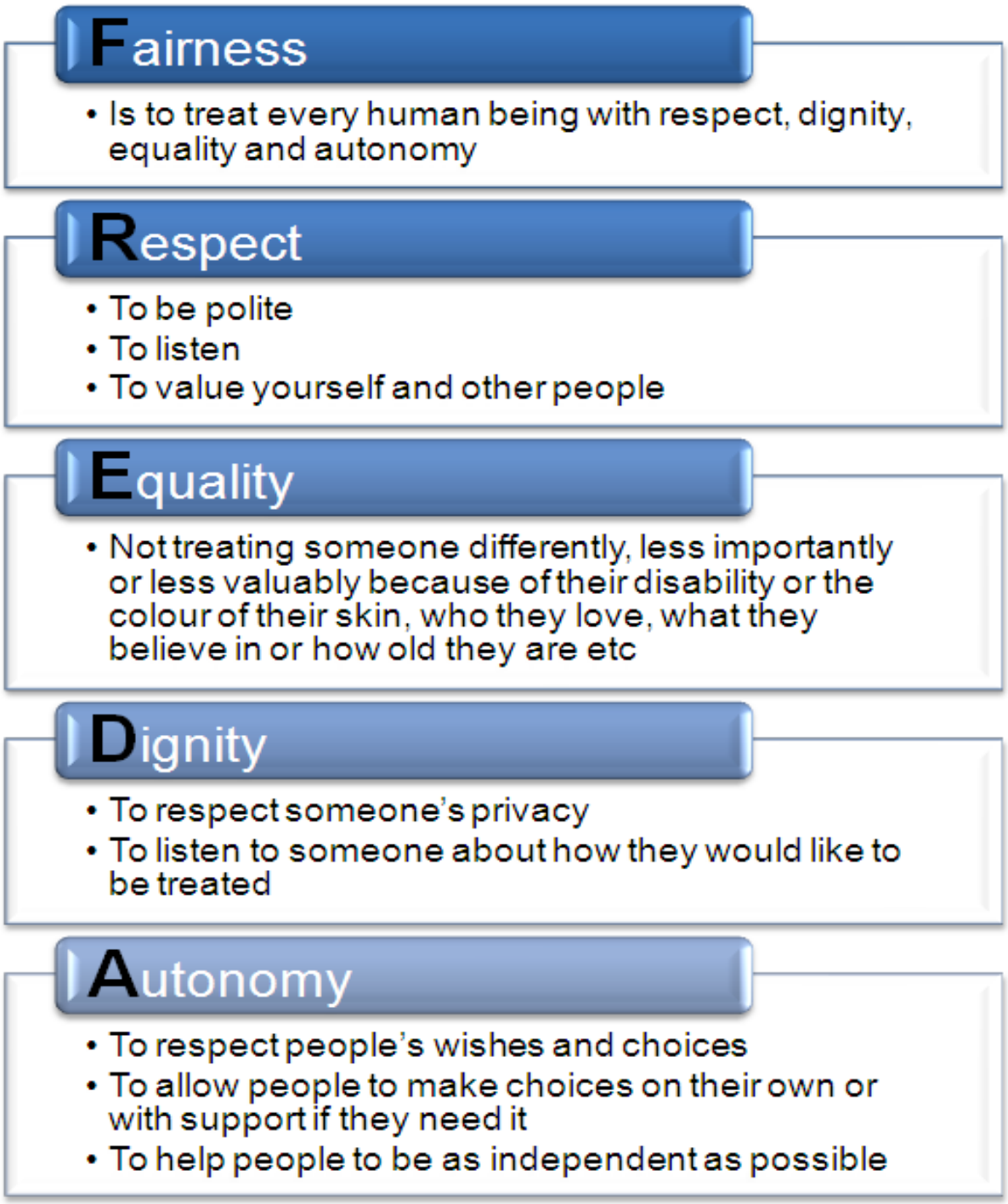
The Equality and Human Rights Commission
The Equality Advisory and Support Service (EASS) provide bespoke advice and in-depth support to individuals with discrimination problems and can be contacted on the following number: 0808 800 0082 (or textphone 0808 800 0084).
The Equality and Human Rights Commission have advice on their website regarding all forms of discrimination as well as a useful glossary of terms which can be found here

Press ctrl +click on these links in order to access further information.
The Human Rights Act 1998
The Equality Act 2010
The Health and Social Care Act 2008 (regulated activities) Regulations 2009
The Health and Safety at Work Act 1974
The Care Quality Commissions – Essential Standards of Quality and Safety and Equality and Human Rights in Outcomes
FREDA and Human Rights in Health Care - Mersey Care NHS Trust
Mental Health Act 1983: Code of Practice

15 Document control

Date of approval:	01 February 2017	
Next review date:	01 February 2018 (Annual review required by MHA CoP para.3.15)	
This document replaces:	HR-0013-v6	
Lead:	Name	Title
	Sarah Jay	Human Rights Equality and Diversity Lead
Members of working party:	Name	Title
	Policy Working Group	
This document has been agreed and accepted by: (Director)	Name	Title
	David Levy	Director of Human Resources and OD
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	01 February 2017
An equality analysis was completed on this document on:	January 2017	

16 Appendix 1 – F.R.E.D.A Human Rights in Health Care



FREDA courtesy of
Mersey Care NHS Trust

17 Appendix 2 – The Human Rights Act 1998

The UK Human Rights Act 1998 contains sixteen basic rights. They fall into two categories

1. Absolute – Rights that are absolute cannot be taken away

- (N A) Non Absolute Rights can be restricted or limited in certain circumstances, e.g. to protect a person or when a person's actions are likely to impact on the person or to protect the wider community from harm

    - (A2)Right to life (A)
    - (A3)Right not to be tortured or treated in an inhuman or degrading way (A)
    - (A4)Right to be free from slavery or forced labour (A)
    - (A5)Right to liberty (N A)
    - (A6)Right to a fair trial (N A)
    - (A7)Right to no punishment without law (A)
    - (A8)Right to respect for private, family life, home and correspondence (N A)
    - (A9)Right to freedom of thought, conscience and religion (N A)
    - (A10)Right to freedom of expression (N A)
    - (A11)Right to freedom of assembly and association (N A)
    - (A12)Right to marry and found a family (N A)
    - (A14)Right not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention (is used in conjunction with other article or protocol)
    - (A1 P1)Right to peaceful enjoyment of possessions (N A)
    - (A2 P1)Right to education (N A)
    - (A3 P1)Right to free elections (N A)
    - (A1 P13) Abolition of death penalty (A)

For further information on The Human Rights Act 1998 press ctrl + click on this link

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 11

FOR GENERAL RELEASE

Board of Directors

DATE:	**30 January 2018**
TITLE:	**Trust IAPT Services, current position and issues**
REPORT OF:	**Tim Cate, Acting Director of Operations for North Yorkshire and Ruth Hill, Director of Operations**
REPORT FOR:	

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 a summary of the current issues for the three Improving Access to Psychological Therapies services (IAPT) that the trust provides (or provides jointly) in Durham and Darlington, North Yorkshire and York and Selby. The report highlights the key issues impacting each service including highlighting the Intensive Support Team's input to all 3 services over the last period.

There are significant commissioning issues across each locality which will require close working with our commissioners to address and resolve.

Recommendations:

To consider the report on the Trust's position, including trends for each CCG area, and action being taken to improve performance on the IAPT recovery indicator.

MEETING OF:	**Board of Directors**
DATE:	**30 January 2018**
TITLE:	**Trust IAPT Services, current position and issues**

1. INTRODUCTION & PURPOSE:

1.1 The report highlights the current status and issues of the 3 IAPT services within the trust, Durham and Darlington, North Yorkshire and York and Selby. The main themes relate to the Intensive Support Team (IST) recommendations for each service, performance, funding and recruitment, retention and training of staff. The future sustainability of the workforce and funding remain critical issues for services.

1.2 Following the Five Year Forward View (5YFV) plan the visibility and profile of IAPT services remains high and there are local commissioning challenges which may impact on the operational delivery in each locality.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Trust Board has requested an update on the position of each of the 3 IAPT services in the trust following information received via the Trust Dashboard and the Single Oversight Framework Reports which identified issues with meeting the recovery targets both at a Trust and individual CCG level. This paper outlines the key issues for consideration.

2.2. The Intensive Support Team (IST) are a group of service experts, led by NHS Improvement, who have reviewed each of the IAPT services and made a number of recommendations. Over 2017/18 their reviews and assessments have led to action plans across all 3 services being implemented.

3. KEY ISSUES:

The IAPT service configuration varies in each locality and Appendix 1 outlines the key organisational elements. The relevant service factors are outlined by service.

3.1 County Durham and Darlington Talking Changes IAPT Service

At the beginning of 2017, the service was subject to a contract performance notice (PIN) in relation to recovery which was consistently below 45%. NHS Improvement's Intensive Support Team visited in May 2017 and then again in September 2017. The key driver for the visit was the challenging recovery position.

3.1.1 What action was undertaken in light of the IST recommendations?

Intensive work was focused on recovery - Learning from other services, national benchmarks and the implementation of a weekly recovery/strategy working group has seen a marked improvement in this indicator. All three CCGs were above 50% for the first time in October 2017. The contract performance notice has now been stood down.

For commissioners, there was a clear recommendation that the commissioning of primary care counselling services (and reporting of activity within the IAPT dataset) was no longer acceptable. It was recommended that commissioners and providers agree a timeline for a phased transition to a single point of access for primary care counselling. This is a key driver for the development of a revised service model as above.

The IST calculated that investment was sufficient to achieve 16.8% prevalence; however, therapist productivity was at 8-10 positive clinical contact hours against a national recommendation of 18-20 hours. In response to this, the service has introduced products from the Trust's Purposeful and Productive Community Services series, including daily management.

There was recognition that recruitment was challenging which has been mitigated by:

- The development of Band 4 Therapy Support Workers – many of whom go on to the formal training programme (and who achieve comparable recovery rates).
- The service has given honorary contracts to self-funded PWP trainees with both Newcastle and Teesside University, with the expectation that these individuals would gain subsequent employment as qualified PWPs with the service.
- Recent positive recruitment (including some staff who have left have returned)
- Investment in both CPD and formal training programmes to support workforce development.

3.1.2 Ongoing Issues

There is uncertainty around the future commissioning arrangements for the locality. Discussions with commissioners have indicated that there will be a revised model for IAPT and primary care and the geographical footprint may extend into Hartlepool and Stockton on Tees.

The increase in referrals and access in order to meet the prevalence targets has begun to lead to lengthening wait times for second treatment appointments (the service continues to meet an internal 3-day target for initial assessment and treatment appointments).

3.2 North Yorkshire IAPT

The service was also subject to IST visits in 2017. Its review highlighted an efficient and high performing service but that there were a number of issues for the Trust and commissioners to address. There were still a number of recommendations to implement e.g. self referral.

3.2.1 What action was undertaken in light of the IST recommendations?

Detailed discussions with commissioners on the funding model and investment have been initiated. The service has undertaken capacity and demand modelling to quantify backlogs to be cleared for first appointments and all subsequent appointments. This has also enabled the service to review its reference costs and understand the expenditure elements. This has informed the funding discussions with CCGs.

Further recovery improvement work has been undertaken and the focus is now concentrating on attempting to rebalance the disproportionately high number of 'severely unwell' patients entering the service, particularly in Scarborough.

There has been a review of IAPT modalities to ensure that they are NICE compliant and offer full choice for the population needs. In collaboration with Primary Care Colleagues and the CCGs there is ongoing work to increase self-referral rates.

Workforce has been a risk which was compounded due to high levels of maternity leave. The service have recruited trainee PWPs and have been successful in gaining funded Health Education England (HEE) training places. The Harrogate IAPT team was also successful in recruiting to the Long Term Conditions pilot project which included a small number of training places, however the funding for this was non-recurrent and commissioners have confirmed that it will end on 31 March 2018.

The service has met, via the short term recruitment, the 17/18 access target.

3.2.2 Ongoing Issues

There continues to be concern about meeting future capacity increases to meet the 25% access standard by 2020/21. Discussions are ongoing with the CCGs in terms of how additional resources for IAPT services can be identified for 2018/19.

The successful bidding for IAPT trainees has led to some unintended consequences. Firstly, the service has become much more dependent on the output of trainees to support the core service KPI's. It is anticipated that the cohorts will start to leave the service for permanent post qualifying work from January 2018. This will have an impact on service capacity in the future especially in the context of further planned increases in access targets. The second unintended consequence of an over reliance on trainees is the cyclical nature of their productivity.

Once the current trainees depart from the service, along with temporary staff from the Harrogate LTC pilot, the service stands to lose a total of 17.6 wte clinical staff. This is the equivalent of 38% of the current workforce. This clearly has the ability to destabilise the service and put at risk the ability to meet the current and future KPI standards.

3.3 York and Selby IAPT

Historically, IAPT services within the locality have been challenged and have been a national outlier in terms of KPIs. In February 2017, the CCG issued a performance improvement notice in relation to ongoing issues with the service around meeting its

KPIs. In parallel, NHS England's intensive support team carried out a service review and they made a number of recommendations. They have continued to support the service around the implementation of the action plan.

3.3.1 What action was undertaken in light of the IST recommendations?

A detailed joint action plan was agreed between the Trust and CCG to meet the PIN and IST recommendations.

The initial service focus has been on clearing the backlog of patients rather than achieving access standards until such a time the service is in a sustainable position. An interim pathway has been implemented which was agreed by IST and CCG. It was acknowledged that there would be a consequent impact on recovery rates whilst this arrangement was in place.

Further service redesign has been undertaken to address the substantive pathways and following the Rapid Process Improvement Workshop (RPIW), a revised Step 2 pathway has been implemented with a new Wellbeing Course.

Additional capacity from Mental Health Matters has supported gaps in current workforce and has been targeted to address long waits at Step 3. Recent recruitment has been successful but there remain some underlying difficult to fill posts. Clinical leadership has also been enhanced.

There has been intensive work to address a number of issues, including admin processes, addressing data quality, developing an IAPT trained workforce (where there were gaps), provision of relevant analytical support and reports to enable staff to understand their outcomes and productivity.

Throughout this period, the staff team have had support from organisational development; consisting of individual interviews, discovery days and a series of facilitated time out days. This has proved beneficial with positive feedback from organisational development about cultural shift within the service.

Capacity and demand work is in progress, which will enable a fuller assessment of the potential additional workforce requirements and financial risk (or funding gap). The service anticipates that it will meet 15% prevalence at the end of March 2018.

3.3.2 Ongoing Issues

The contract arrangement with VOY CCG means that the activity and performance risks to meet 15% prevalence remains with the locality (TEWV risk). Discussions are ongoing with the CCG on the need to identify additional funding to increase this position in line with 5YFV. The outcome of the capacity and demand work will be an important part of the investment discussions.

There has been significant service redesign and a number of the new pathways are still in the early stages of implementation and review. There will need to be careful

monitoring of the outcomes and, in particular, any build-up of waiting times across the pathways.

The localities reliance on trainee workforce will need to be carefully reviewed. The service has taken on a larger number of trainees than usual over the last year to future develop capacity. 50 % of the current PWP and CBT workforce are newly qualified or in training resulting in a more inexperienced staffing group.

3.4 Performance & Recovery Position

The performance targets by each IAPT service is outlined within Appendix 2.

3.4.1 The table below outlines the recovery position for the IAPT services

PHQ 13_6 The proportion of people that complete treatment who are moving to recovery				
Year	**2014/15**	**2015/16**	**2016/17**	**Apr 17 - Dec 17**
Operating Framework Target	**50.00%**	**50.00%**	**50.00%**	**50.00%**
Durham & Darlington	**48.8%**	**45.9%**	**47.1%**	**52.9%**
North Yorkshire	**45.8%**	**46.7%**	**50.7%**	**49.3%**
York & Selby	**35.9%**	**44.6%**	**46.7%**	**43.0%**
Trustwide	**48.1%**	**46.2%**	**48.3%**	**50.2%**

Each service has had variable achievement around the recovery position but there has been recent improvement in performance, with the exception of York & Selby. The IST recommendations have led to focused work on recovery for the services. Within N Yorkshire (notably Scarborough and Ryedale CCG) there have been challenges with the level of complexity of patients who have been referred to the service (with subsequent impact on recovery rates). Its focus on self referral and close monitoring by practitioner is helping to improve this position. The implementation of the York & Selby interim pathway (to address the historical backlog and long waiters), is acknowledged by commissioners and IST, to have a detrimental impact on recovery rates. Once the interim pathway work is completed, by the end of March 2018, it is expected that there will be revised focus on recovery.

3.4.2 As part of the 5YFV there is an increasing trajectory for the prevalence target (the proportion of people who enter treatment against the level of need in the general population). In 2016/17 the target was 15% and 2017/18 is 16.8%. N Yorkshire service has met this position but through the use of trainee PWP posts and has highlighted that this is not a sustainable position. In Durham & Darlington the service was commissioned to deliver 12.8 % which has been revised to 16.8%. The service is working to meeting this target by end March 2018, by increasing its practitioner productivity. In York & Selby the service has agreed with both the CCG and IST that it will work towards reaching 15% compliance by the year end.

3.4.3 However, meeting the prevalence target does have potential impacts on waiting times which are also closely monitored by KPIs. IST reports investigate all parts of the pathway to ensure that there are no significant waits within the different steps of treatment. York & Selby have had historic long waits and much of the recent work has been focused on redesigning the pathways, putting in place interim pathways to address this. N Yorkshire have indicated to commissioners that meeting the prevalence and waiting time KPIs will be challenging given the known changes in the workforce and lack of certainty around commissioner investment plans.

3.4.4 In addition, any recruitment issues may impact on the service confidence to meet future KPIs. For example, within the Durham and Darlington service, future re-procurement plans will create further service uncertainty. For York and Selby, there continue to be recruitment and retention challenges and this may impact on the overall KPIs performance.

3.4.5 There is close monitoring of the various targets for IAPT services – a Trust-wide group has been introduced with a focus to support the ongoing learning from each service. There is a level of scrutiny around the productivity of IAPT services and the reporting to commissioners and IST on the action plans will be an ongoing focus.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** The funding for both the North Yorkshire and York and Selby services is below what is recommended as indicated by the IST reports. The potential recommissioning of services in Co Durham and Darlington (and wider geography) may be a further factor to consider dependant on the contractual arrangements that the CCGs apply. In parallel, payment by results is a small but emerging component of the IAPT contract delivery, which as yet has not been applied by CCGs locally.

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

4.4 **Equality and Diversity:** None.

4.5 **Other implications:** Consideration of reputational implications given that 2 services have been served performance notices in the last 12 months. Key IAPT measures (including recovery rates) form part of our regulatory framework with NHS Improvement.

5. RISKS:

5.1 For Durham and Darlington there is a risk that the service could be served notice by the end of January 2018 which will provide both challenges and opportunities for the joint venture arrangements. The viability of the North Yorkshire service in meeting old and new targets without the required investment, and its associated impact on future recruitment is of concern. Within York and Selby IAPT

service there are a number of challenges which will require continued oversight to address and are flagged within the locality risk register.

6. CONCLUSIONS:

6.1 All 3 IAPT services for the trust have had positive IST input over the last 12 months which has led to improvement in all 3 services and engagement with commissioners. The Durham and Darlington service seems to be the most stable currently although may be served notice by the end of January 2018. North Yorkshire IAPT service medium to long term future is of concern if there is no increase in funding from commissioners. York and Selby service has undergone a fundamental transition in service delivery and in spite of recruitment and retention issues it is now beginning to perform as required, with fidelity to the IAPT model.

6.2 There will be further work with commissioners to consider FYFV trajectories and associated investment requirements. In parallel, there will be continued focus around ongoing productivity, service redesign and workforce capacity. Additional opportunities to work in partnership with other providers may enable some of the workforce challenges to be met.

6.3 If Board members require additional papers and associated information this can be made available.

7. RECOMMENDATIONS:

Board is requested to note work to date to meet the performance position and consider the service redesign which has been undertaken following IST reports.

Author: Tim Cate, Acting Director of Operations for North Yorkshire and Ruth Hill, Director of Operations York and Selby
Title: Trust IAPT Services, current position and issues.

Background Papers:
N/A

Appendix 1 Service Overview

County Durham and Darlington Talking Changes IAPT Service

Service Overview

Talking Changes is accountable to a joint venture board chaired by the Operational Director for the Durham and Darlington locality. The North Durham; Durham Dales, Easington and Sedgefield; and, Darlington CCGs currently commission this service for a three year period 1 April 2016 to 31 March 2019. However, the future commissioning plans are uncertain, and a revised service model with a new geographical footprint may emerge. This presents both an opportunity and challenge for the current joint venture.

The TEWV element of the contract consists of approx. 38 WTE (ex Admin staff).

North Yorkshire IAPT

Service Overview

The NY IAPT Service is a single managed service with a Service Manager, Clinical Lead and Team managers located in the four main teams in North Yorkshire, namely Harrogate, Northallerton, Whitby and Catterick Garrison. It provides IAPT services to three main Clinical Commissioning Groups (CCG's) in North Yorkshire; Harrogate and Rural District, Hambleton Richmondshire and Whitby and Scarborough & Ryedale. IAPT services are also provided to four GP surgeries in the top of the Vale of York CCG area.

The TEWV staffing is approx. 36.8 WTE (ex Admin staff).

York and Selby IAPT

The York and Selby IAPT service is an integrated Step 2, Step 3 and counselling service covering York, Selby, Easingwold and Tadcaster geographical areas. The service will from February 2018 also be providing a service to the Pocklington area when the current Humber contract ends.

Historically, IAPT services within the locality have been challenged and have been a national outlier in terms of KPIs.

The TEWV staffing is approx. 24.5 WTE (ex Admin staff).

Appendix 2 – Trust wide IAPT Performance against KPIs.

PHQ 13_5 The proportion of people that enter treatment against the level of need in the general population				
Year	**2014/15**	**2015/16**	**2016/17**	**Apr 17 - Dec 17**
Operating Framework Target	**15%**	**15%**	**16.80%**	**16.80%**
Durham & Darlington	**11.84%**	**12.75%**	**13.19%**	**13.73%**
North Yorkshire	**7.26%**	**15.12%**	**16.03%**	**16.49%**
York & Selby	**3.91%**	**8.83%**	**11.07%**	**9.69%**
Trustwide	**9.97%**	**13.57%**	**13.57%**	**13.68%**
PHQ 13_6 The proportion of people that complete treatment who are moving to recovery				
Year	**2014/15**	**2015/16**	**2016/17**	**Apr 17 - Dec 17**
Operating Framework Target	**50.00%**	**50.00%**	**50.00%**	**50.00%**
Durham & Darlington	**48.8%**	**45.9%**	**47.1%**	**52.9%**
North Yorkshire	**45.8%**	**46.7%**	**50.7%**	**49.3%**
York & Selby	**35.9%**	**44.6%**	**46.7%**	**43.0%**
Trustwide	**48.1%**	**46.2%**	**48.3%**	**50.2%**
E.H.1_B1: The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment				
Year	**2014/15**	**2015/16**	**2016/17**	**Apr 17 - Dec 17**
Operating Framework Target		**75.00%**	**75.00%**	**75.00%**
Durham & Darlington		**98.46%**	**99.48%**	**99.56%**
North Yorkshire		**92.90%**	**99.21%**	**98.78%**
York & Selby		**95.24%**	**92.93%**	**68.23%**
Trustwide		**96.10%**	**98.21%**	**94.42%**
E.H.2_B2: The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment				
Year	**2014/15**	**2015/16**	**2016/17**	**Apr 17 - Dec 17**
Operating Framework Target		**95.00%**	**95.00%**	**95.00%**
Durham & Darlington		**99.82%**	**99.86%**	**99.97%**

North Yorkshire		**96.54%**	**100.00%**	**99.84%**
York & Selby		**97.62%**	**99.21%**	**99.54%**
Trustwide		**98.42%**	**99.79%**	**99.86%**

E.H.1_A1: The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment

Year	2014/15	2015/16	2016/17	Apr 17 - Dec 17
Operating Framework Target		**75.00%**	**75.00%**	**75.00%**
Durham & Darlington		**98.52%**	**99.36%**	**99.50%**
North Yorkshire		**77.24%**	**97.97%**	**98.89%**
York & Selby		**62.96%**	**77.53%**	**82.31%**
Trustwide		**90.16%**	**96.08%**	**96.53%**

E.H.2_A2: The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment

Year	2014/15	2015/16	2016/17	Apr 17 - Dec 17
Operating Framework Target		**95.00%**	**95.00%**	**95.00%**
Durham & Darlington		**99.85%**	**99.97%**	**99.95%**
North Yorkshire		**93.04%**	**99.40%**	**99.89%**
York & Selby		**91.36%**	**96.73%**	**98.88%**
Trustwide		**97.20%**	**99.36%**	**99.76%**

Item 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30 January 2018**
TITLE:	**Finance Report for Period 1 April 2017 to 31 December 2017**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 December 2017 is a surplus of £7,750k, representing 3.1% of the Trust's turnover and is £120k ahead of plan.

Identified Cash Releasing Efficiency Savings at 31 December 2017 are £1,749k behind plan for the year to date. The deterioration is due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 December 2017 and is behind plan due to the I&E margin and agency expenditure being marginally behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year, which is behind plan.

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.
- The Board of Directors is requested to approve the submission of the NHS Improvement quarter 3 return in accordance with the results detailed in this report.

MEETING OF:	**Board of Directors**
DATE:	**30 January 2018**
TITLE:	**Finance Report for Period 1 April 2017 to 31 December 2017**

1. INTRODUCTION & PURPOSE

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

2. BACKGROUND INFORMATION

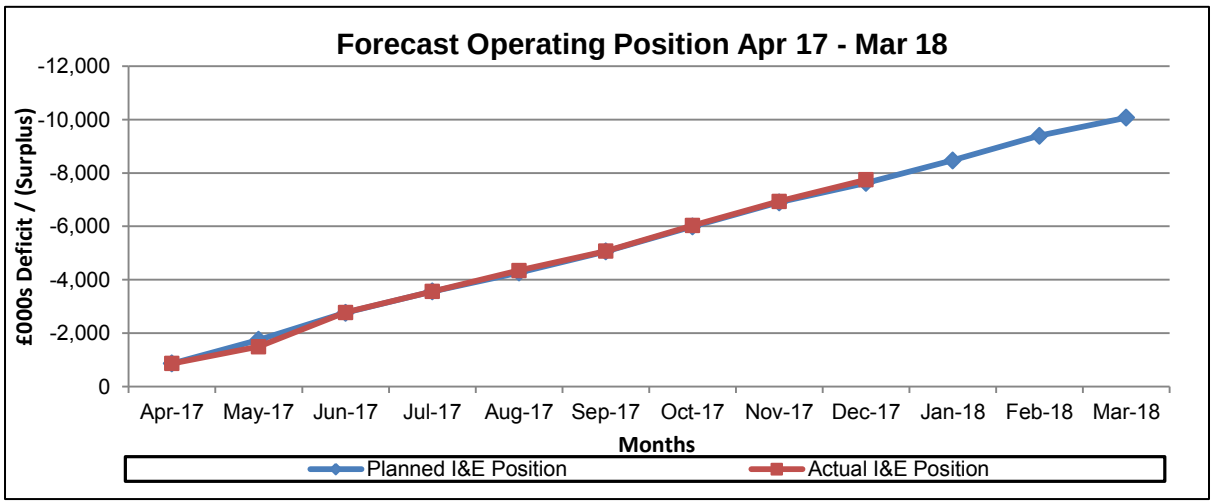
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 December 2017 is a surplus of £7,750k, representing 3.1% of the Trust's turnover and is £120k ahead of plan.

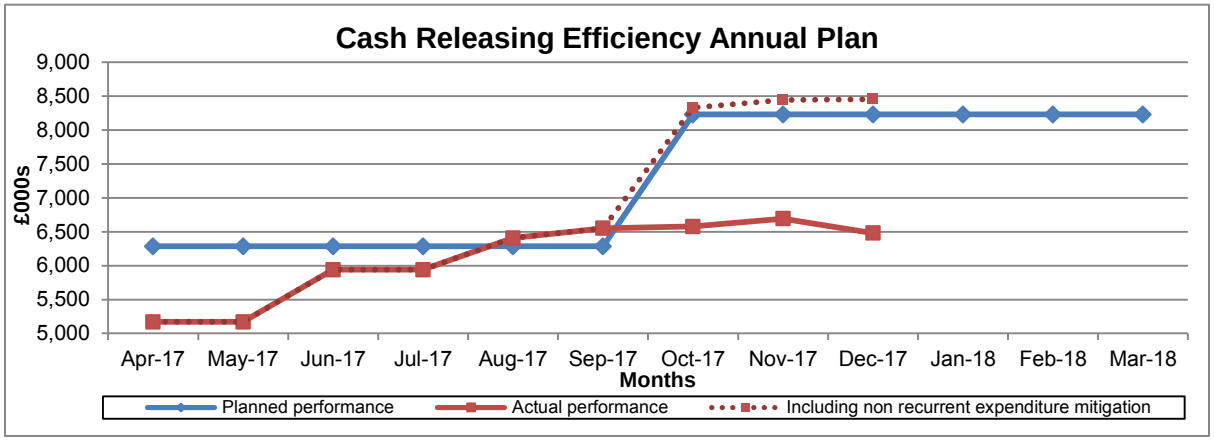
The graph below shows the Trust's planned operating surplus against actual performance.



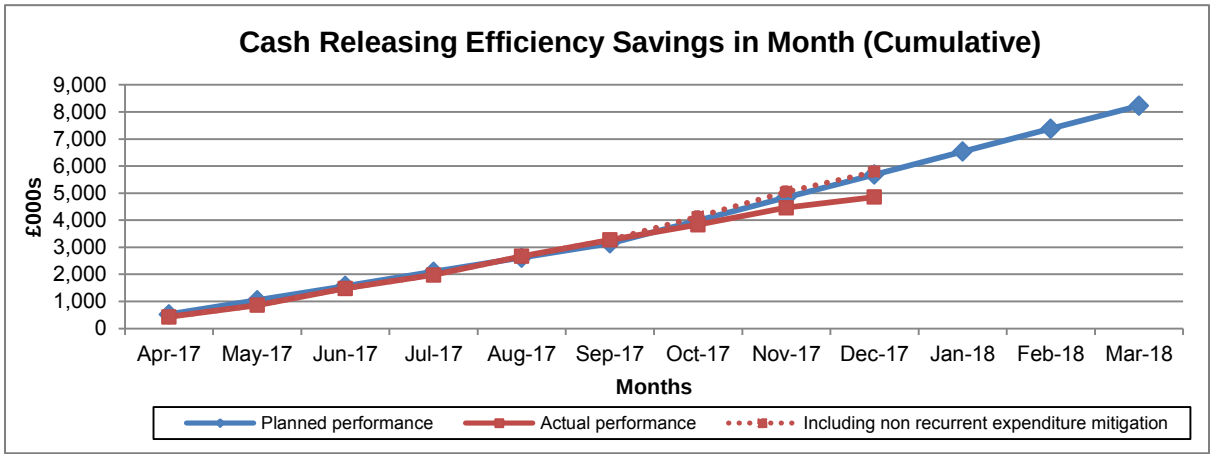
3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 December 2017 is £6,481k and is £1,749k behind plan for the year to date. The deterioration is due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future

years, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

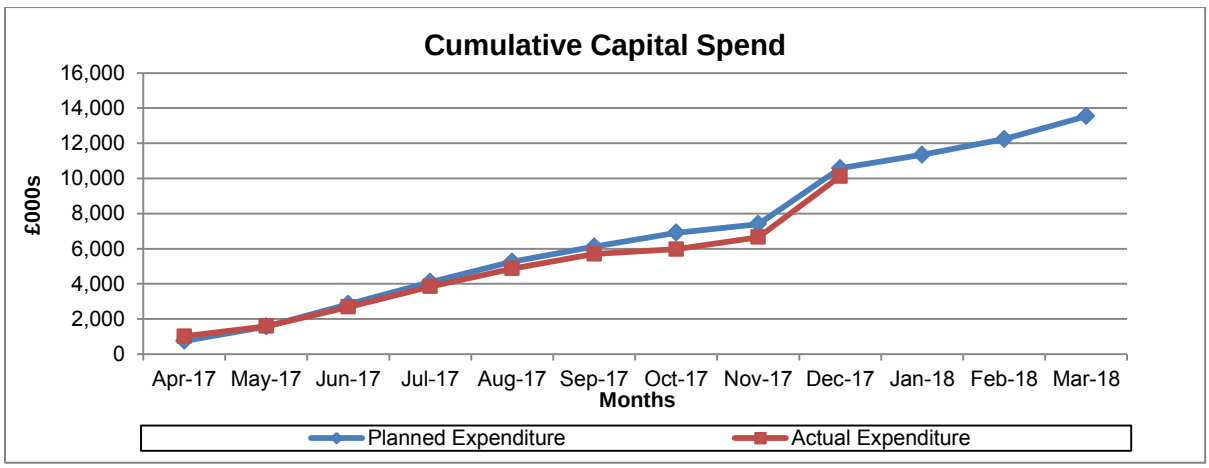


The monthly profile for CRES identified by Localities is shown below.



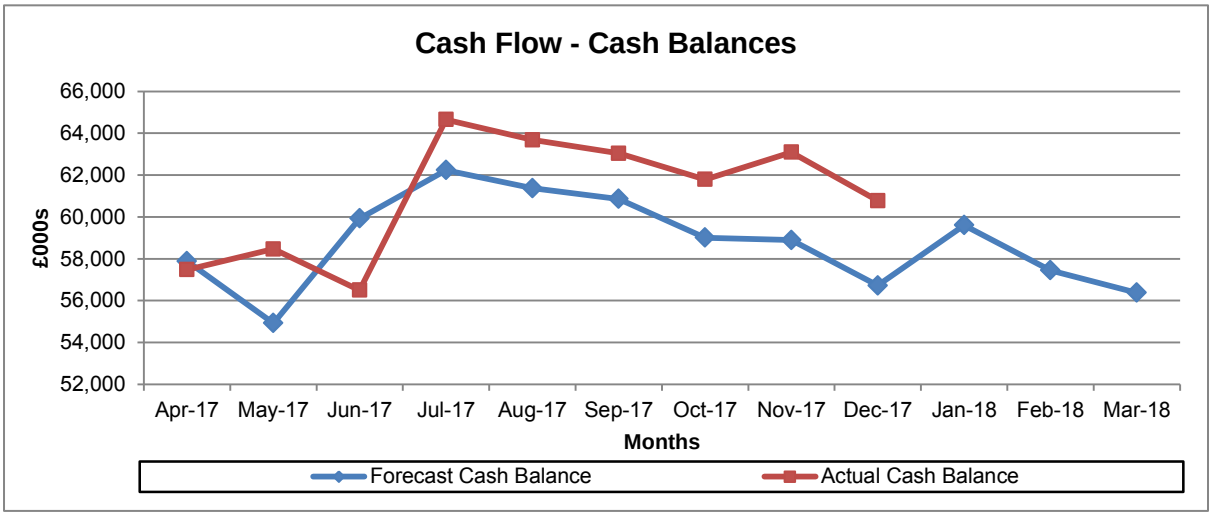
3.3 Capital Programme

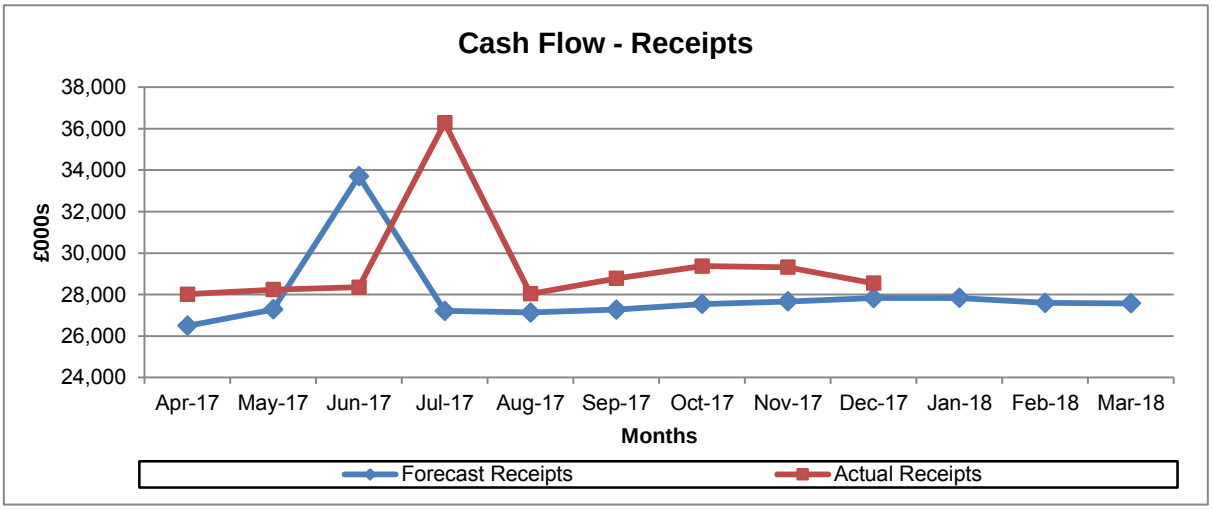
Capital expenditure to 31 December 2017 is £10,123k and is £455k behind plan due to delays against identified developments. The year end forecast is £15,492k; which is £1,958k in excess of plan and is due to additional expenditure previously anticipated in 2018/19 financial year.

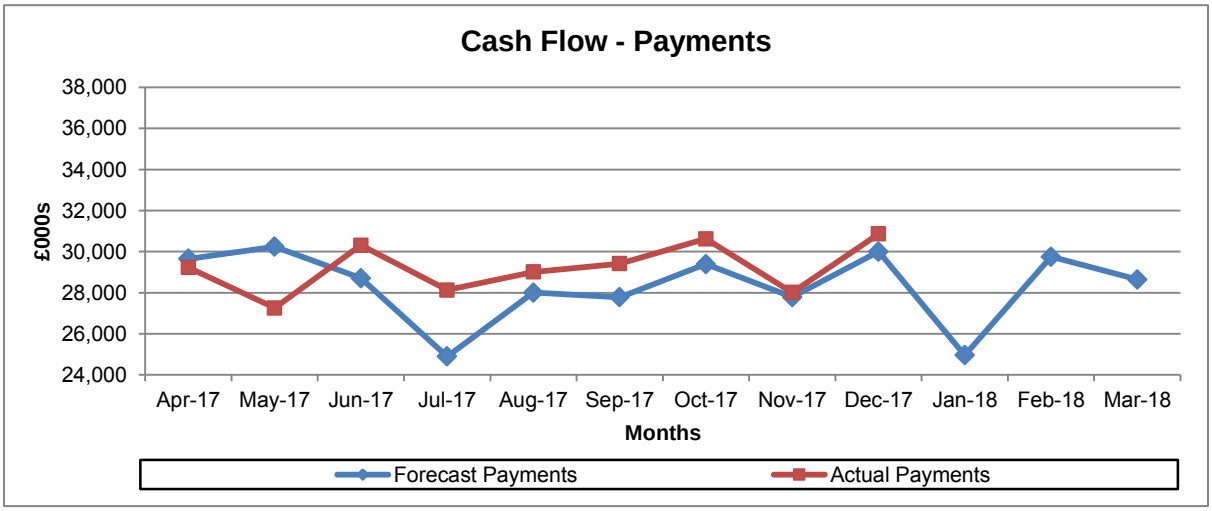


3.4 Cash Flow

Total cash at 31 December 2017 is £60,776k, and is £4,050k ahead of plan largely due to working capital variations.



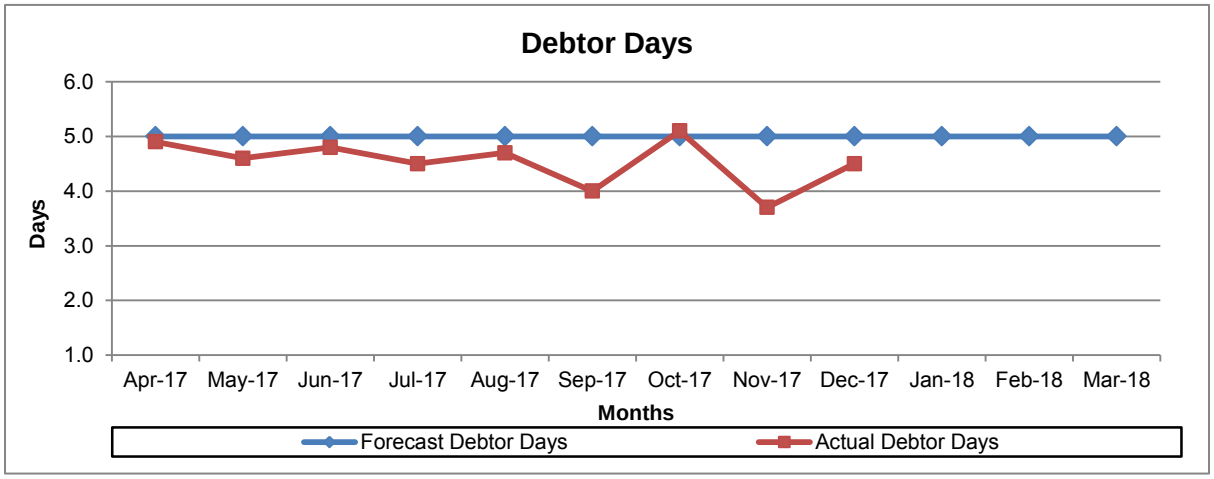




The receipts profile fluctuates over the year for Sustainability and Transformation Fund incentive scheme receipt. The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

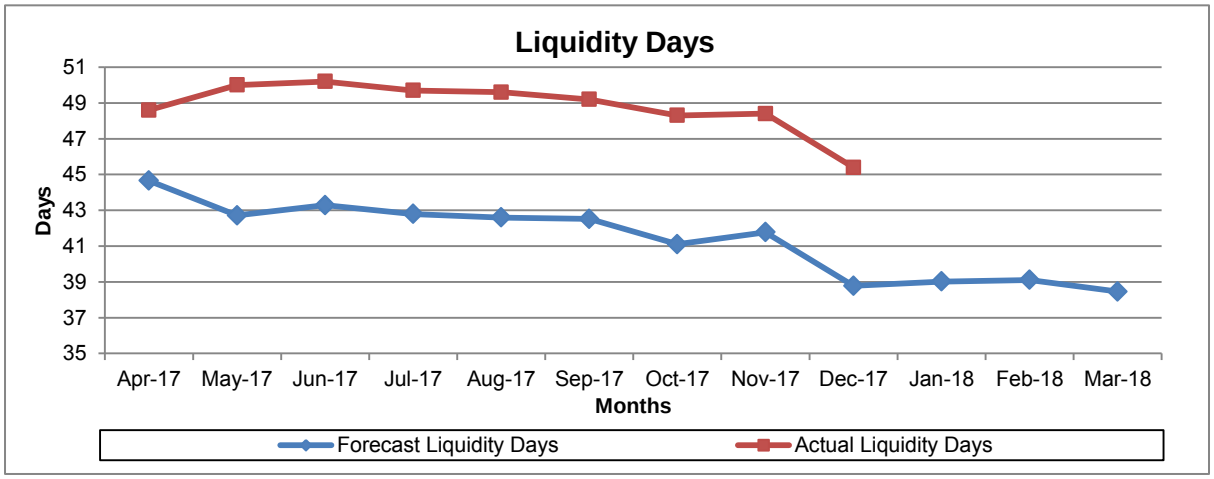
Working Capital ratios for period to 31 December 2017 are:

- Debtor Days of 4.5 days
- Liquidity of 45.4 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 50.92%
  Non NHS 30 Days – 96.92%



The Trust has a debtors' target of 5.0 days, and actual performance of 4.5 days at 31 December 2017, which is ahead of plan.

The liquidity days graph below reflects the metric within NHS Improvement's single oversight framework. The Trust's liquidity day's ratio is ahead of plan due to higher than planned net current assets.



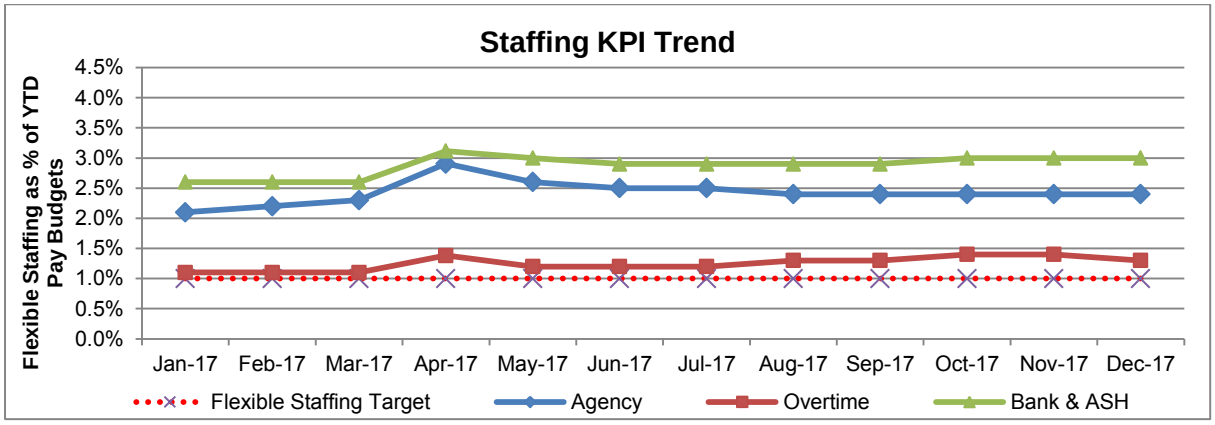
3.5 Financial Drivers

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

Tolerance	Jul	Aug	Sept	Oct	Nov	Dec
Agency (1%)	2.5%	2.4%	2.4%	2.4%	2.4%	2.4%
Overtime (1%)	1.2%	1.3%	1.3%	1.4%	1.4%	1.3%
Bank & ASH (flexed against establishment)	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%
Establishment (90%-95%)	93.1%	93.1%	93.1%	94.3%	94.5%	94.5%
Total	**99.7%**	**99.7%**	**99.7%**	**101.1%**	**101.3%**	**101.2%**

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 December 2017 the tolerance for Bank and ASH is 3.5% of pay budgets.

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



Additional staffing expenditure is 6.7% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (48%), enhanced observations (21%), service need (11%) and sickness (10%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 December 2017 and is behind plan due to the I&E margin and agency expenditure being marginally behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year, which is behind plan.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.52x (can cover debt payments due 1.52 times), which is ahead of plan and rated as a 3.

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 45.4 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 I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan is -0.1% and is 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 marginally higher than the cap and is rated as a 2.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £2,670k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £38,887k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £5,207k is required.
- I&E margin distance from plan – to improve to a 1 an operating surplus increase of £347k is required.
- Agency Cap rating – to improve to a 1 a reduction in agency expenditure of £63k is required.

Use of Resource Rating at 31 December 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%
I&E margin distance from plan	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.52x	3	1.46x	3	
Liquidity	45.4 days	1	38.8 days	1	
I&E margin	3.1%	1	3.2%	1	
I&E margin distance from plan	-0.1%	2	0.0%	1	
Agency expenditure	£4,689k	2	£4,626k	1	
Overall Use of Resource Rating		**2**		**1**	

3.6.7 5.58% of total receivables (£267k) are over 90 days past their due date; this is marginally above the 5% finance risk tolerance. The Trust has received confirmation of payment for the majority of this debt and therefore does not give cause for concern.

3.6.8 4.9% of total payables invoices (£506k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance.

3.6.9 The cash balance at 31 December 2017 is £60,776k and represents 70.6 days of annualised operating expenses.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 December 2017 is a surplus of £7,750k, representing 3.1% of the Trust's turnover and is £120k ahead of plan.

6.2 Identified Cash Releasing Efficiency Savings at 31 December 2017 are £1,749k behind plan for the year to date. The deterioration is due to slippage on CRES schemes which were due to commence 1 October 2017. The Trust has, and continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

6.3 The Use of Resources Rating for the Trust is assessed as 2 for the period ending 31 December 2017 and is behind plan due to the I&E margin and agency expenditure being marginally behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year, which is behind plan.

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to:

7.11 receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

7.12 approve the submission of the NHS Improvement quarter 3 return in accordance with the results detailed in this report.

Drew Kendall
Interim Director of Finance and Information

ITEM:13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th January 2018**
TITLE:	**Board Dashboard as at 31st December 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:

As at the end of December 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red. This is an improvement on the 6 that was reported as at the end of November 2017. Only one of these indicators is showing an improving position over the previous 3 months. It should be noted that the 4 reds are split across all 4 domains.

There are a further 4 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is one less than the number reported as at the end of November).

In terms of the year to date position there are 6 indicators that are reporting red.

In respect of performance against the key NHSI operational indicators for Quarter 3 the Trust met all of the required targets. However in December the Trust did not achieve the IAPT recovery rate target at 46.2% which is the lowest level of performance in the year to date. As has been outlined previously the achievement of this target does remain a concern and a detailed report on the issues being faced by the three IAPT services and action being taken is included in a separate Board of Directors agenda item.

There remain a number of risks around achievement of the targets within the Dashboard and these are described in Section 2.3 of the report.

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

MEETING OF:	**Board of Directors**
DATE:	**30th January 2018**
TITLE:	**Board Dashboard as at 31st December 2017**

1. INTRODUCTION & PURPOSE:

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

2. KEY ISSUES:

2.1 Performance Issues

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

- As at the end of December 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red. This is an improvement on the 6 that was reported as at the end of November 2017. Only one of these indicators is showing an improving position over the previous 3 months.

  It should be noted that the 4 reds are split across all 4 domains.

  There are a further 4 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is one less than the number reported as at the end of November). Please note that the bed occupancy figure is under reported in the dashboard and is in fact achieving target and therefore should be green.

  In terms of the year to date position there are 6 indicators that are reporting red.

- In respect of performance against the key NHSI operational indicators for Quarter 3 the Trust met all of the required targets. However in December the Trust did not achieve the IAPT recovery rate target at 46.2% which is the lowest level of performance in the year to date. The recovery rate of 50% was only in achieved in December in one CCG (North Durham) and was lowest in Harrogate and Rural District CCG and Vale of York CCG. As has been outlined previously the achievement of this target does remain a concern and a detailed report on the issues being faced by the three IAPT services and action being taken is included in a separate Board of Directors agenda item.

  Please note that following the receipt of additional guidance in the revised Single Oversight Framework (SOF), we are now monitoring the 6 and 18 week IAPT waits, as those who have waited for treatment and not those who have waited for treatment and have completed their course of treatment.

There have been other changes to the SOF following the publication of a revised framework and these are outlined in the separate report on the SOF on the Board agenda.

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

2.2 Data Quality Assessment.

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

2.3 Key Risks

- Referrals (KPI1) – The number of referrals received in December has decreased further compared to November and is now at the lowest level since April 2017. This decrease does follow the usual seasonal trend that occurs in December. In terms of the year to date position the actual number of referrals received is significantly above the expected number. It will be important to monitor the position in January to see if there is a 'bounce' back of referral rates following the December reduction or if the reduction seen since October continues.
- Bed Occupancy (KPI 3) – whilst the position (corrected) in terms of Bed Occupancy in December is meeting target at 86.75% it should be noted that the position of KPI4 (Number of patient occupying a bed with a length of stay >90 days) and KPI5 (Percentage of patient readmitted within 30 days) have both increased in December and therefore there is a risk that the bed occupancy figures start to increase again in January 2018.
- Percentage of patients surveyed reporting their overall experience as excellent or good (KPI10) – the position reported in December has deteriorate and is one of the lowest positions in the year to date. The Patient Experience Sub Group has commenced a piece of work to understand this further and will report further once this is completed.
- Number of Unexpected Deaths classed as a serious incident (KPI 11)- There has been an increase in the number reported in December to the highest position since 2015. Further work is taking place to establish if there are any themes arising from the incidents reported in October to December.
- Sickness (KPI 18) – There has been a deterioration in the performance reported in December and the position is still significantly worse than the target. It is anticipated that this position will worsen further during December. An event was held in November to look at how we can better understand the reasons for the increase in sickness absence we have seen this year and broadly focused on health and well-being within the organisation. The event was productive and identified a number of areas to explore. Further events are planned for January and February to continue the discussions.
- CRES Delivery (KPI 20) – the delivery of the CRES is behind plan for the month of December and year to date. The deterioration in month is due to

slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future years, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

3. RECOMMENDATIONS:

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

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Activity

	December 2017				April 2017 To December 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,793.00	7,890.00			69,133.00	78,467.00		91,759.00
2) Caseload Turnover	1.99%	1.08%			1.99%	1.08%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	84.61%			85.00%	86.18%		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	70.00			75.00	70.00		75.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	9.90%			10.00%	8.89%		10.00%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	21.00	25.00			179.00	230.33		237.00

Quality

	December 2017				April 2017 To December 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%	92.14%			90.00%	91.02%		90.00%
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	7.74%			10.00%	8.57%		10.00%
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	12.36%			20.00%	13.48%		20.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	90.23%			92.45%	91.63%		92.45%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	2.15			9.00	11.30		12.00

Trust Dashboard Summary for TRUST

Workforce

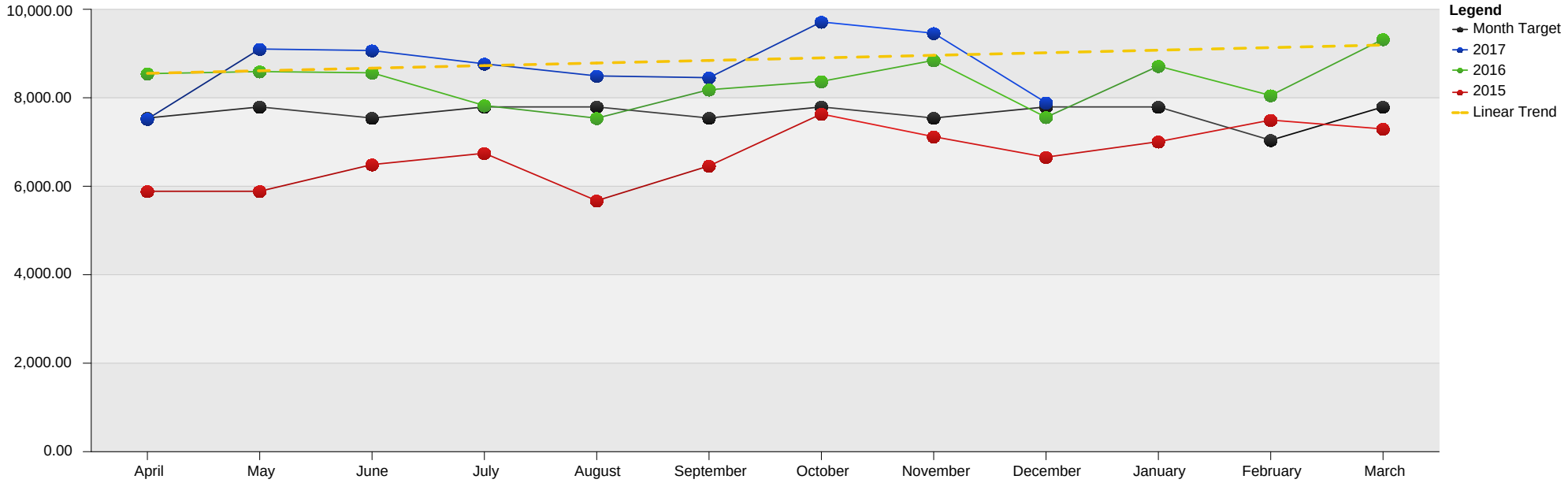
	December 2017				April 2017 To December 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	94.47%			100.00%	94.47%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	13.79%			15.00%	19.04%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.75%			95.00%	92.75%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	88.75%			90.00%	88.75%		90.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.40%			4.50%	5.02%		4.50%

Money

	December 2017				April 2017 To December 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-727,000.00	-814,000.00			-7,630,000.00	-7,750,000.00		-10,076,000.00
20) CRES delivery	848,000.00	397,577.00			5,686,080.00	4,860,397.93		8,230,080.00
21) Cash against plan	56,726,000.00	60,776,000.00			56,726,000.00	60,776,000.00		56,376,000.00

Trust Dashboard Graphs for TRUST

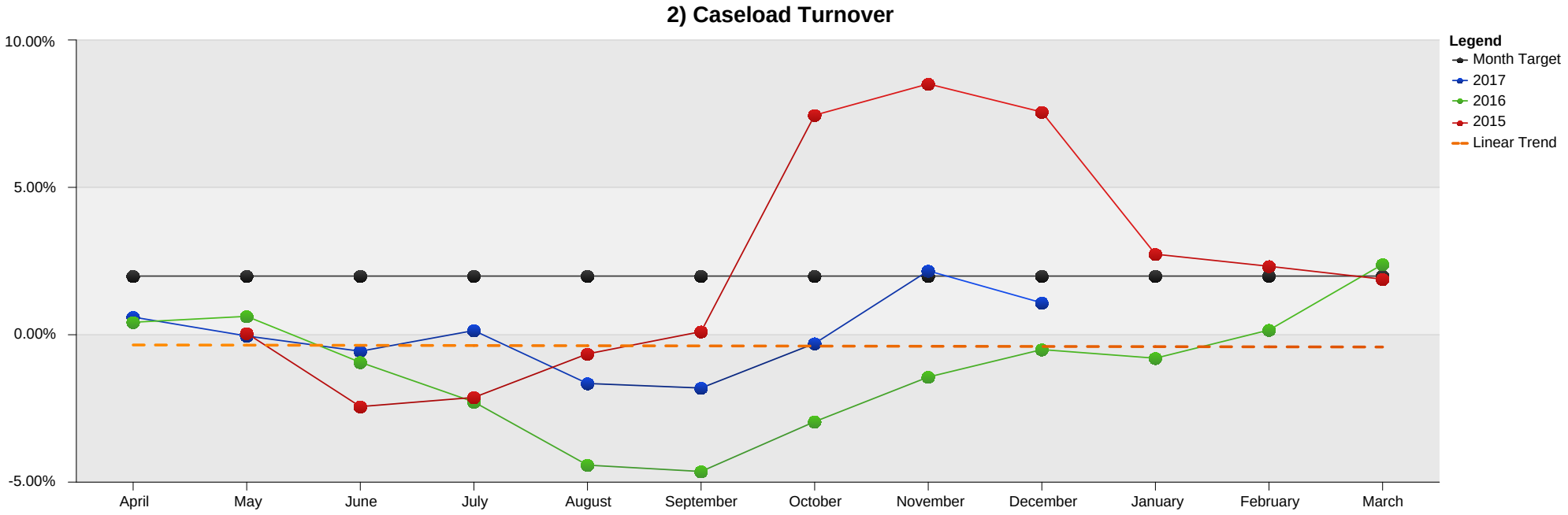
1) Total number of External Referrals into Trust Services



	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	7,890.00	78,467.00	1,846.00	18,154.00	2,454.00	23,388.00	1,756.00	18,740.00	627.00	5,679.00	1,207.00	12,503.00		

Narrative
The Trust position for December 2017 is 7,890 which is within the Trust target of 7,793. This is a decrease on the number of referrals received in November 2017, which follows a seasonal trend where referrals decrease over the Christmas period. This is the third consecutive month where a decrease in referrals has been seen, however the position in December 2017 is an increase to that reported in December 2016.Durham and Darlington and North Yorkshire are the only localities meeting target.Based on current trends it is anticipated that we will exceed the annual target of 91,759

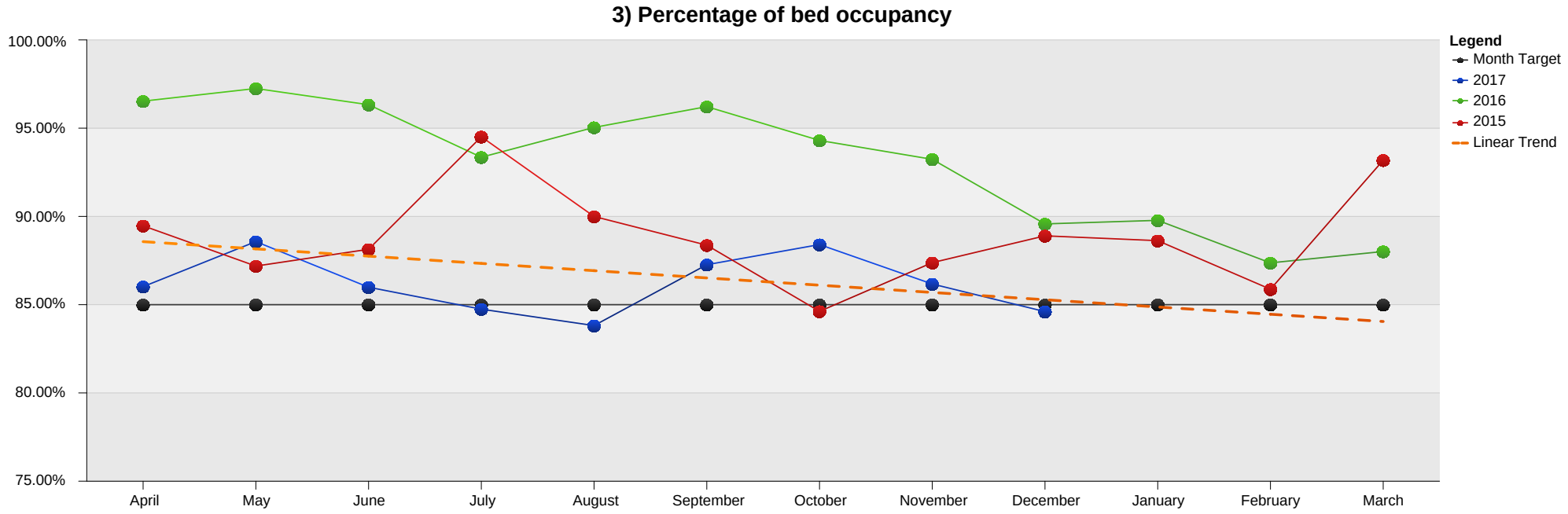
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Caseload Turnover	1.08%	1.08%	2.46%	2.46%	3.56%	3.56%	-0.88%	-0.88%	NA	NA	-4.55%	-4.55%		

Narrative
The Trust position for December 2017 is 1.08% which is meeting the Trust target of 1.99%. This is an improvement to both that reported in November 2017 and on the deteriorating trend seen since September 2017. North Yorkshire and York and Selby are meeting target. Under performance in Durham and Darlington is within CAMHS services and this is due to an increase in the number of referrals received. Further investigation is required to understand the underperformance in Tees.Based on current trends it is anticipated that we will meet the annual target of 1.99%

Trust Dashboard Graphs for TRUST

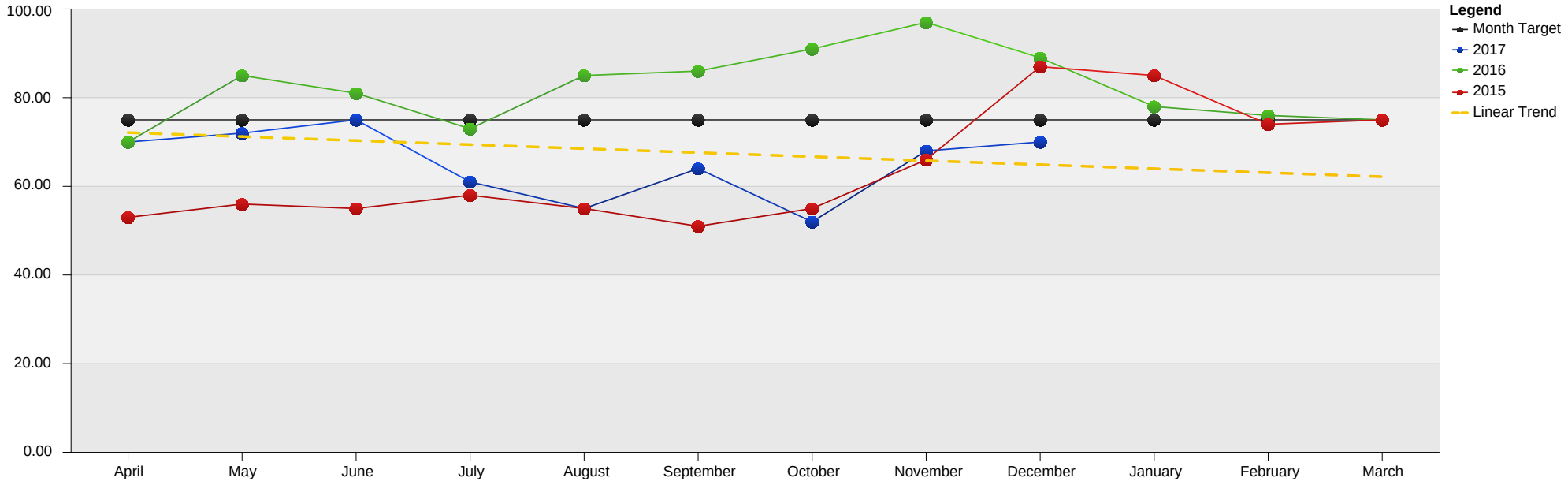


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	84.61%	86.18%	91.45%	88.24%	77.63%	84.96%	85.55%	90.62%	NA	NA	80.78%	78.33%		

Narrative
The Trust position for December 2017 is 84.61% which is under reported due to a delay in amending PARIS to reflect the changes at Sandwell Park and the adjusted position is 86.75% which is meeting target and an improvement on the position recorded in November 2017.Tees report the lowest bed occupancy at 77.63% which is due to the above and this is artificially reducing the bed occupancy rate. This has been resolved on the system and the correct position will be shown in next months reports. The adjusted position for Tees is 85.72%.Durham and Darlington reports the highest bed occupancy at 91.45%. Key pressures are seen in adult services , an RPIW has been held to improve patient flow and improvements in performance are expected. Particular pressure has been seen in male beds, there is dedicated focus on this issue in the huddle to proactively address delays and improve links with the Local Authority via the TEWV Accommodation Officer.North Yorkshire have seen an improvement.

Trust Dashboard Graphs for TRUST

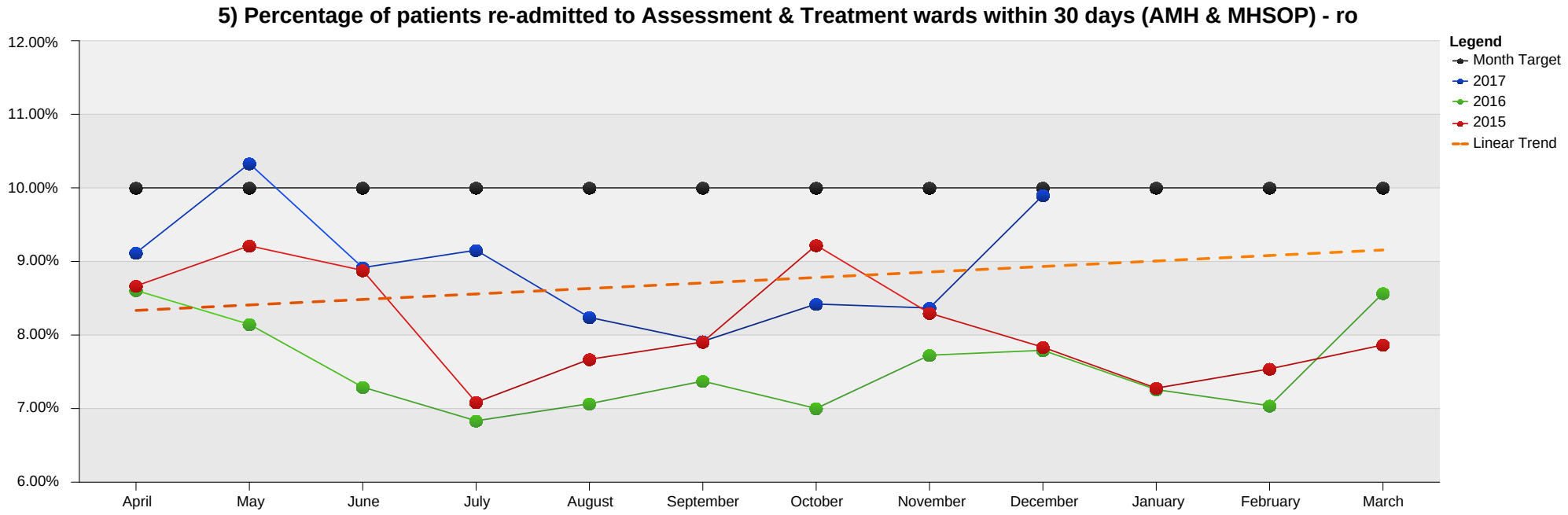
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH



	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)	70.00	70.00	17.00	17.00	16.00	16.00	22.00	22.00			14.00	14.00		

Narrative
The Trust position for December 2017 is 70 which is meeting the target of 75 but a deterioration compared to that reported in November 2017 and the third consecutive month where a deterioration has been seen. Tees and Durham and Darlington are not achieving target. Of the 70 patients occupying a bed with a LoS greater than 90 days:• 18 (26%) were within Durham and Darlington (6 MHSOP and 12 ADULTS) • 14 (20%) were within York & Selby (14 MHSOP) • 16 (23%) were within Teesside (14 MHSOP and 2 ADULTS) • 22 (31%) were within North Yorkshire (6 MHSOP and 16 ADULTS) The majority of patients in Tees are due for discharge in January and their length of admission is appropriate. However 2 are delayed discharges, one being due to the confirmation of social care placement and the other due to the completion of building works to support discharge to their home. A focused piece of work is also to be completed in Tees to improve understanding of this issue. Patients within Durham and Darlington are under constant review and the appropriateness of the patients length of stay is under investigation and will be confirmed.Based on current trends it is expected that we will meet the annual target of 75.

Trust Dashboard Graphs for TRUST

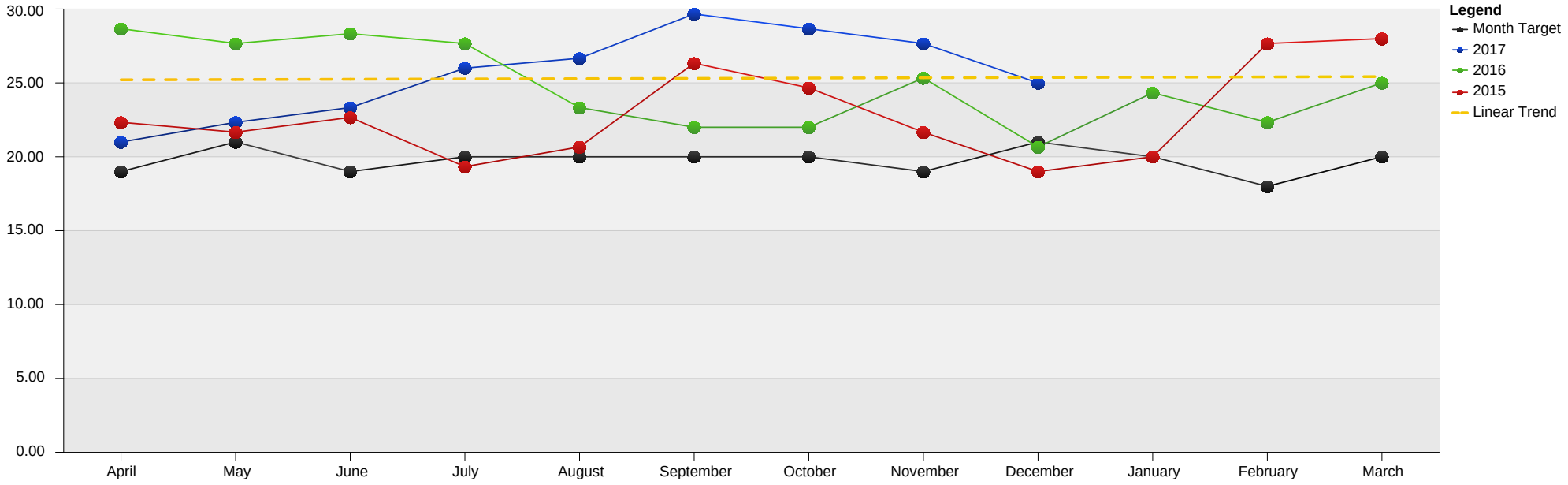


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	9.90%	8.89%	8.33%	8.07%	8.47%	8.79%	12.24%	8.32%			12.50%	11.14%		

Narrative
The Trust rolling 3 month position ending December 2017 is 9.90%, which relates to 22.66 patients out of 229 that were readmitted within 30 days. This is meeting the target of 10% however a deterioration on the position recorded in November 2017 and that recorded in December 2016.Of the 22.66 patients re-admitted:• 6.33 (28%) were within Durham & Darlington (5.33 AMH and 0.99 MHSOP) • 4.99 (22%) were within York and Selby (3.33 AMH 1.66 MHSOP)• 5.99 (26%) were within North Yorkshire (4.66 AMH and 1.33 MHSOP) • 5.33 (24%) were within Teesside (5.33 AMH)(*Please note data is displayed in decimal points due to the rolling position being calculated.)North Yorkshire and York and Selby are not meeting target for this indicator, this is under investigation and an update will be provided.

Trust Dashboard Graphs for TRUST

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

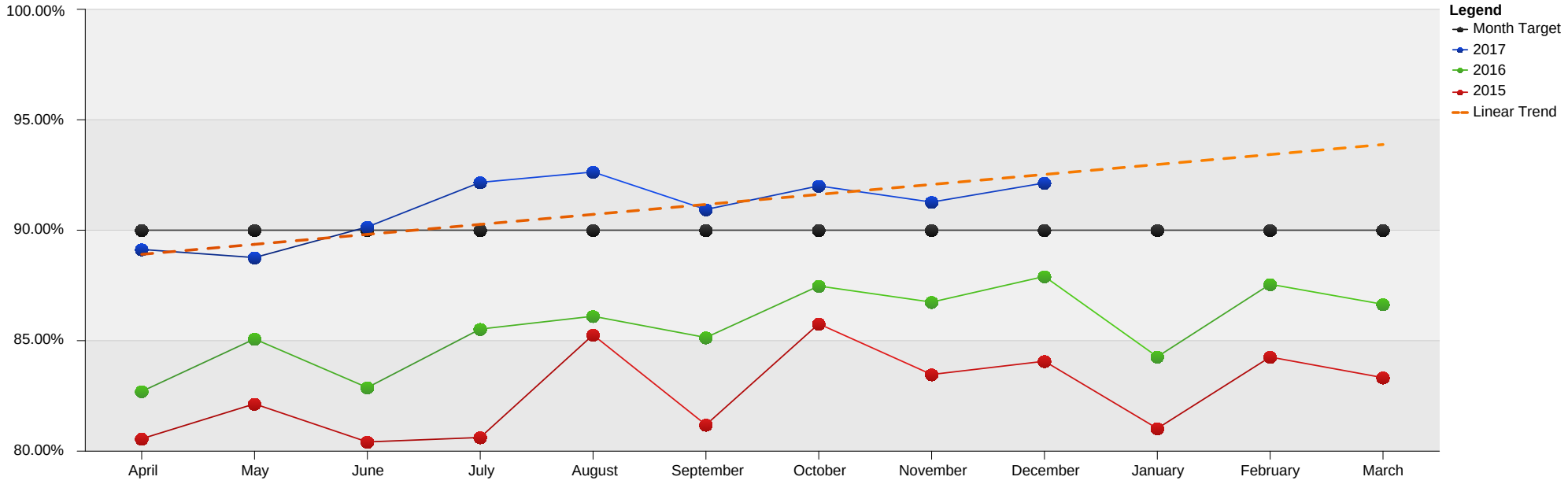


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	25.00	230.33	7.00	83.33	4.33	47.33	5.33	43.67			7.00	44.33		

Narrative
The Trust rolling 3 month position ending December 2017 is 25 which is 4 worse than the target of 21 but an improvement compared to the position reported in November 2017. An improving trend is seen from September to December.Only North Yorkshire and Tees are achieving target. Of the 25 or more readmissions:• 7.66 (30%) were within Durham & Darlington (7.33 AMH and 0.33 MHSOP)• 6.33 (25%) were within Tees (3.99 AMH 0.66 MHSOP)• 5.66 (22%) were within North Yorkshire (4.99 AMH 0.66 AMH)• 6.99 (27%) were within York and Selby (6.33 AMH 0.66 MHSOP)In York and Selby a deep dive has been completed to review patients admitted on three or more occasions and all have been appropriate. However further work is to be completed to provide reassurance that all issues have been addressed.In Durham and Darlington a focused piece of work is ongoing to improve understanding of this issue led by the Director of Operations.(*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)

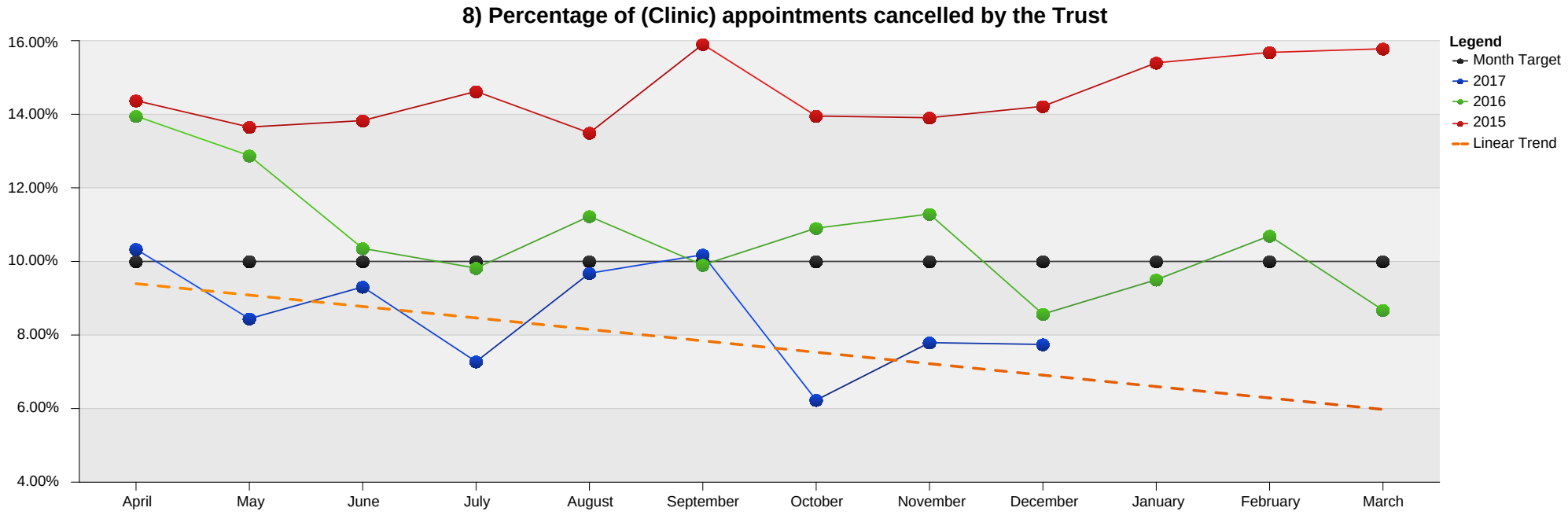


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	92.14%	91.02%	92.91%	89.67%	98.44%	98.45%	85.29%	84.37%	100.00%	99.76%	75.20%	74.68%		

Narrative

The position for December 2017 is 92.14% 91.17%, relating to 423 patients out of 5381 who waited longer than 4 weeks. This is meeting target and an improvement on the November 2017 position.Areas of concern:• York and Selby Adults at 64% (100 out of 279 patients). This is an improvement on the November position. Focus continues on clearing the backlog and it is anticipated that this will be complete in February. An action plan is in place to address areas of concern and the trajectory for the target to be met is February 2018.• York and Selby MHSOP, Memory Service at 78% (49 out of 229 patients). A review of the service has taken place which has identified the need for additional staff in order to meet demand. This is being managed by the management of change process which will see additional staff placed in the Memory Service Team.• North Yorkshire MHSOP at 78% (54 out of 359 patients) This is an improvement on the November position. A deep dive was completed in November to review capacity and staffing and the action plan is ongoing. An update as to when trajectories are expected to be met will be provided.• Durham and Darlington Adults at 80.97%. (86 out of 452 patients) This is an improvement on the November position and work continues to progress the ongoing action plan. An update as to when trajectories are expected to be met will be provided.

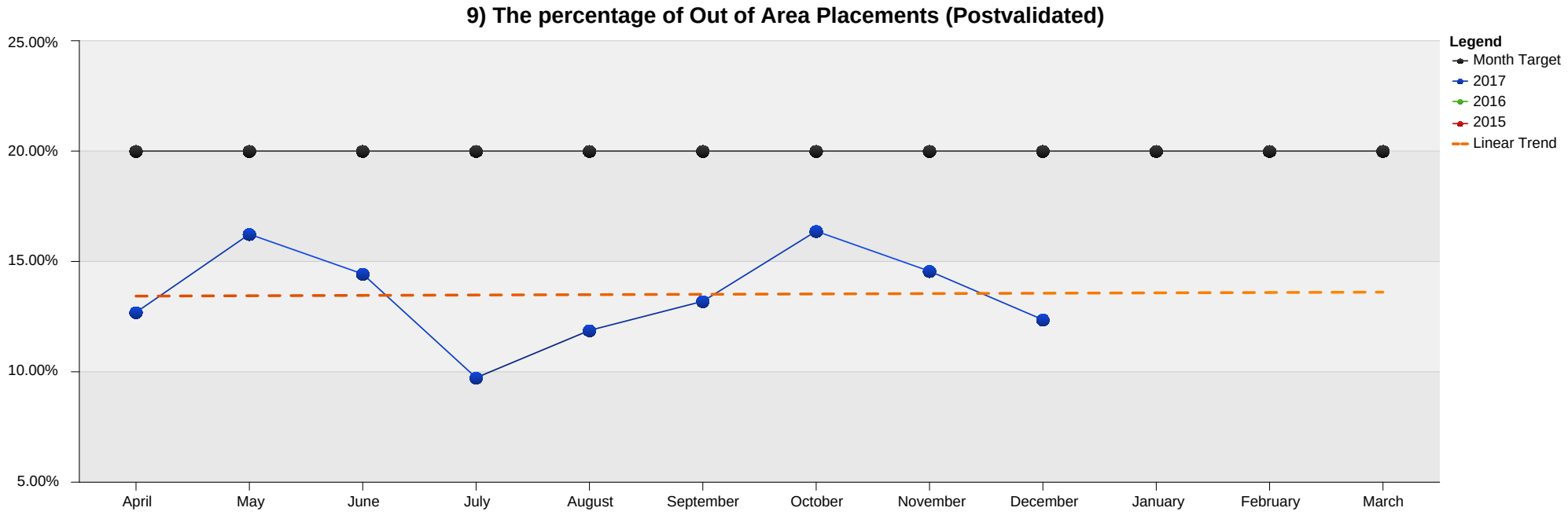
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of (Clinic) appointments cancelled by the Trust	7.74%	8.57%	8.67%	10.68%	6.23%	5.70%	11.00%	11.20%			2.52%	4.68%		

Narrative
The Trust position for December 2017 is 7.74% which relates to 210 clinic appointments out of 2712 that have been cancelled. This is meeting the target of 10% and similar to the position in November 2017.North Yorkshire is the only locality not meeting target. This is due to continued difficulties being experienced by staff in using the PARIS system in relation to the re scheduling of appointments. Support was provided from the information department to resolve this issue and improvements in performance have been seen

Trust Dashboard Graphs for TRUST

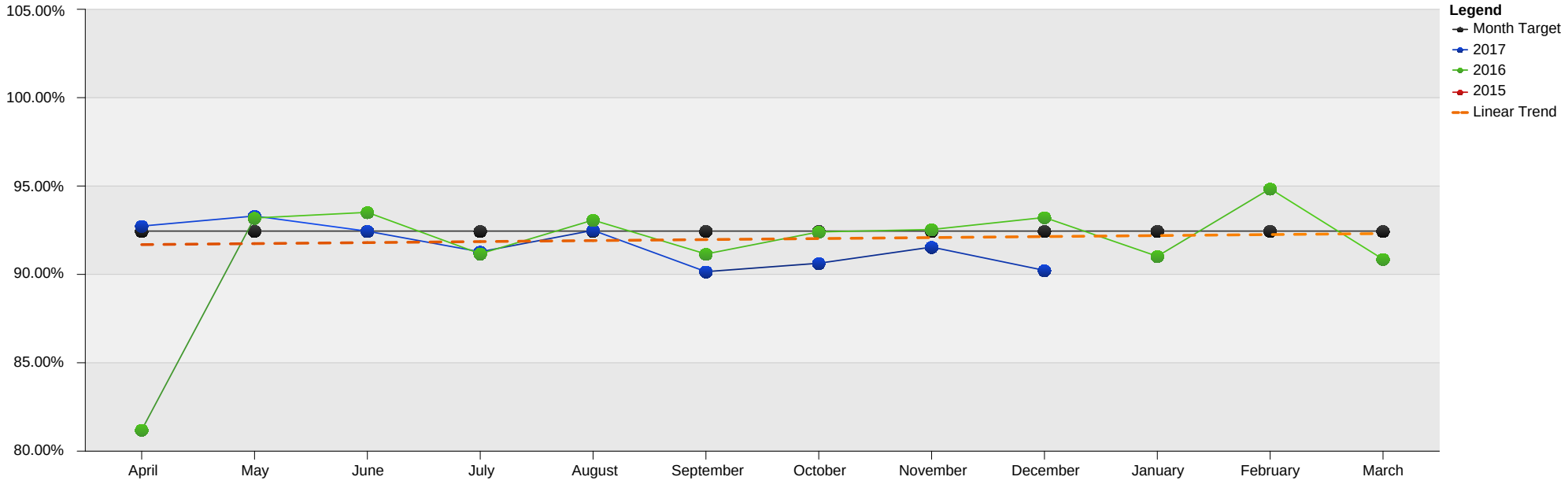


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Area Placements (Postvalidated)	12.36%	13.48%	5.45%	5.58%	5.00%	4.67%	45.24%	37.69%			8.82%	21.59%		

Narrative
The Trust position for December 2017 is 12.36% which relates to 33 admissions out of 267 that were inappropriately admitted out of area. This is better than the target of 20% and an improving trend is seen from October 2017.All localities are meeting target with the exception of North Yorkshire, where the key pressure is in adult services and the high level of bed occupancy within adults is impacting on this position. Of the 33 patients (AMH 24, MHSOP 9) all were due to a lack of bed availability.

Trust Dashboard Graphs for TRUST

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

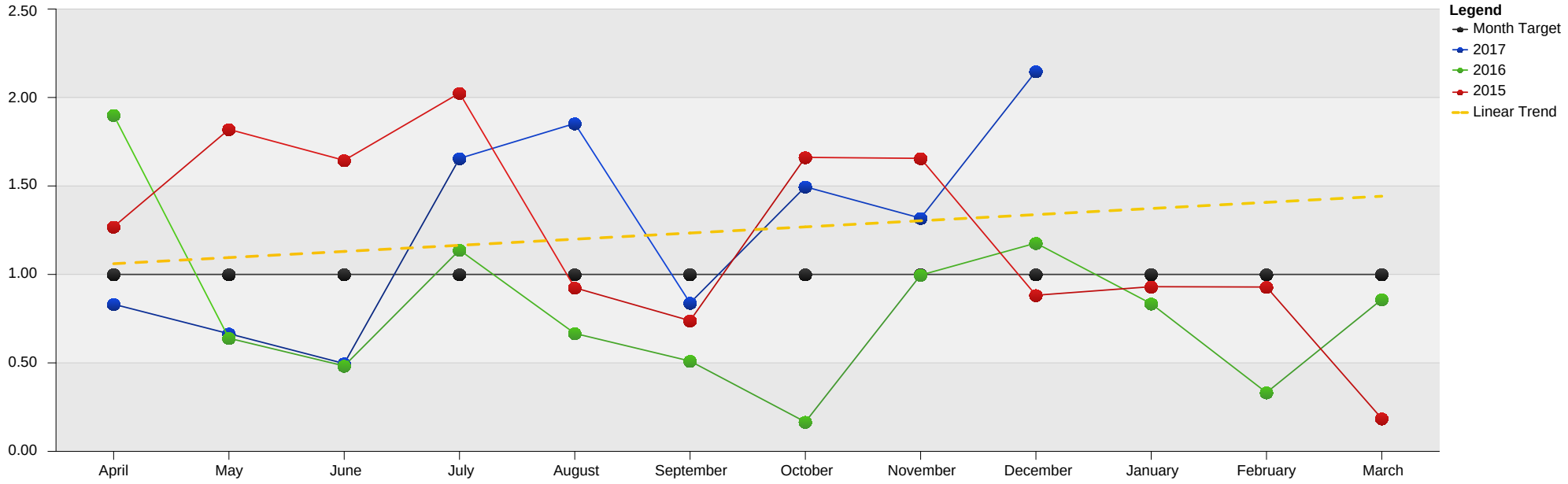


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	90.23%	91.63%	92.91%	92.64%	90.97%	92.92%	88.95%	91.58%	78.08%	79.86%	88.89%	90.68%		

Narrative
The Trust position reported in December relates to November's performance. The Trust position for November 2017 is 90.23% which is not meeting the target of 92.45% and a deterioration on both the position in October 2017 and that in October 2016. Durham and Darlington are meeting target for this indicator with Forensic Services reporting the poorest performance at 78.08%The Patient Experience Group has commenced a piece of work to improve understanding of this issue and an update on this will be provided.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



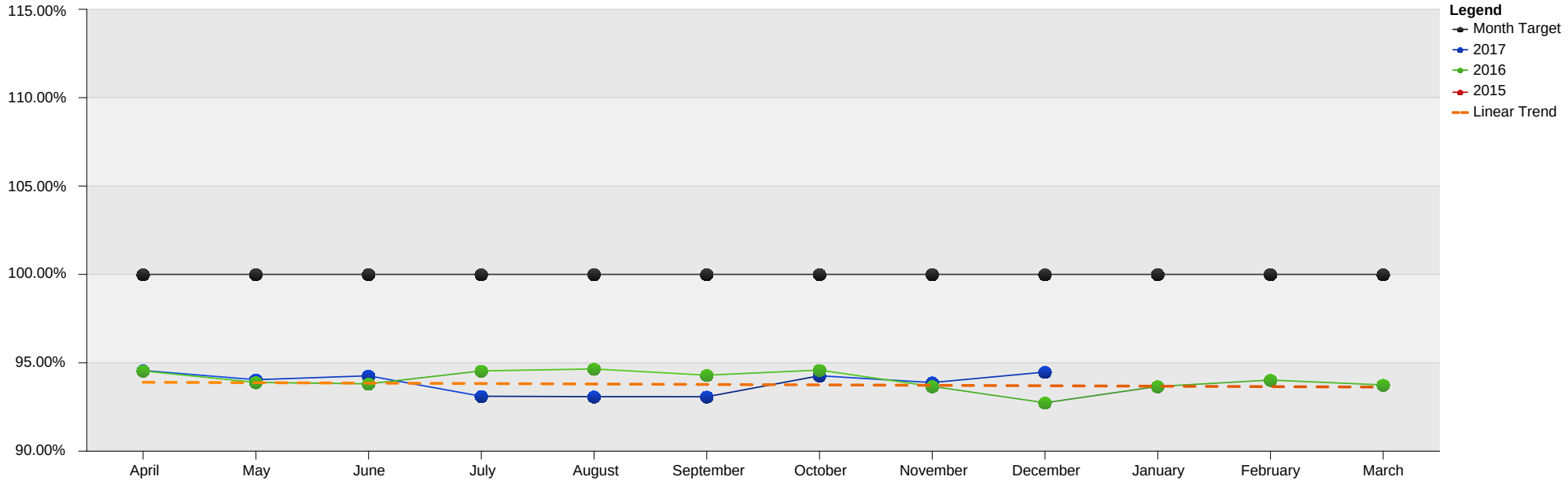
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	2.15	11.30	1.93	10.15	1.17	8.44	4.51	17.00	0.00	67.94	2.55	9.48		

Narrative

The Trust position for December 2017 is 2.15, which is not meeting the expected number of 1.00. This rate relates to 13 unexpected deaths which occurred in December. This is a significant increase on the 8 unexpected deaths reported in November and the highest number recorded since 15/16.Of the 13 unexpected deaths the details below shows a breakdown by locality:• 5 x North Yorkshire• 4 x Durham and Darlington• 2 x Tees• 2 x North YorkshireOf the unexpected deaths that occurred in December 10 occurred in adult services. A piece of work is to be completed in January that will review the information from October to December 2017 to establish if there are any themes over a longer time period.

Trust Dashboard Graphs for TRUST

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

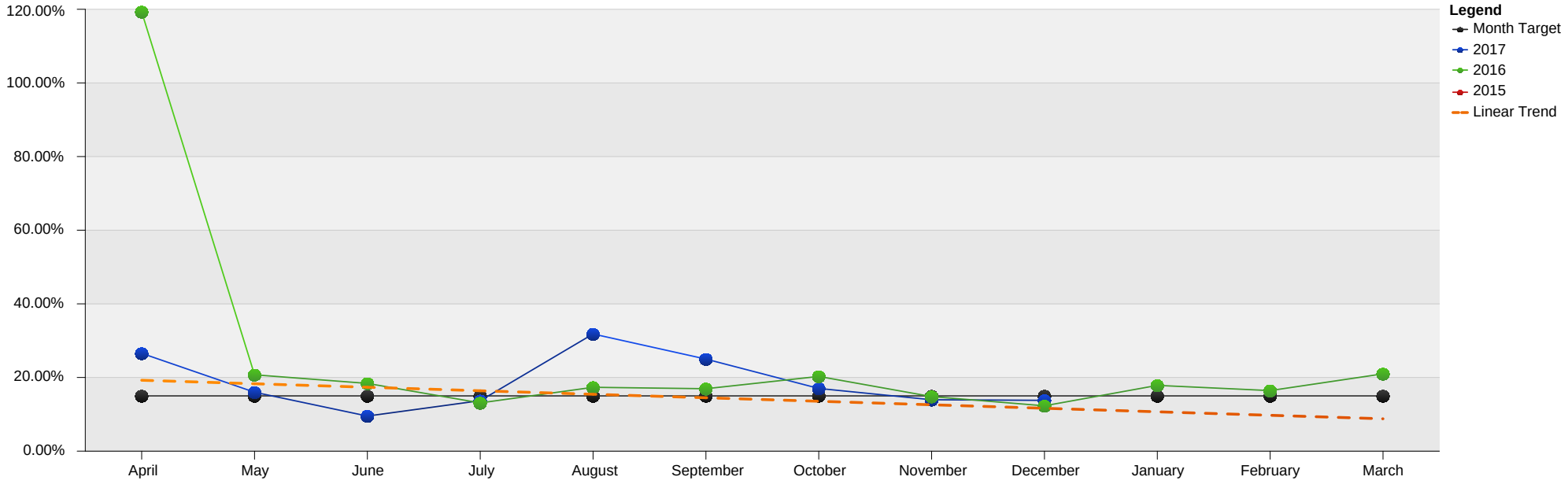


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	94.47%	94.47%	95.97%	95.97%	97.85%	97.85%	93.59%	93.59%	93.23%	93.23%	89.66%	89.66%		

Narrative
The Trust position for 31 December 2017 is 94.47% which is below the targeted establishment level of 95-100%, however a slight improvement on that reported in the previous month. A task and finish group within HR will meet January to agree further recruitment events.

Trust Dashboard Graphs for TRUST

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

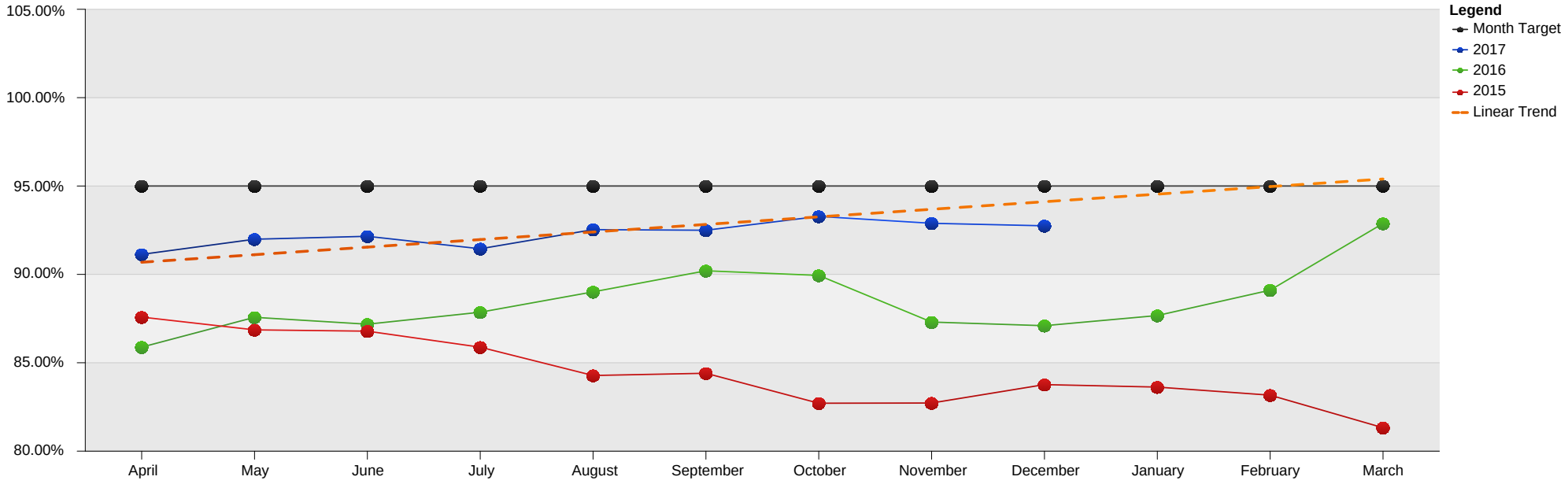


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	13.79%	19.04%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The Trust position for December 2017 is 13.79% which is meeting the target of 15.00%, and is an improvement on the previous month's position. There were 3 non medical posts re-advertised in December out of a total of 25 posts advertised The posts proving difficult to fill are a Psychological Wellbeing Practitioner in Harrogate, a Home Treatment Worker also in Harrogate and an Applied Psychologist in Tees.Further work is to be completed by HR to understand the key areas of concern and themes and this work is planned to be completed in January 2018.Data only started to be reported for 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)

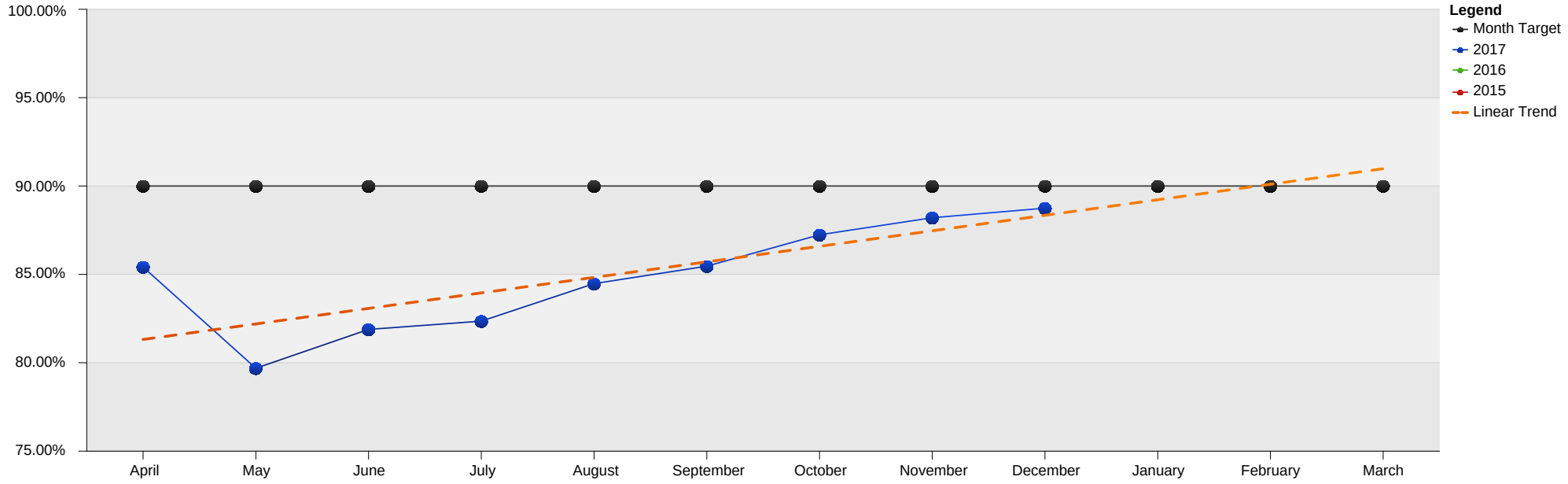


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	92.75%	92.75%	92.99%	92.99%	94.26%	94.26%	91.48%	91.48%	95.92%	95.92%	89.35%	89.35%		

Narrative
The Trust position for December 2017 is 92.75% which relates to 411 members of staff out of 5668 that do not have a current appraisal. This is not meeting the target of 95% and a slight deterioration on the figure reported in November. It is however one of the best positions reported since 2015/16 to date.Forensic services are the only locality meeting target and North Yorkshire report the poorest performance at 89.35%.The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels.

Trust Dashboard Graphs for TRUST

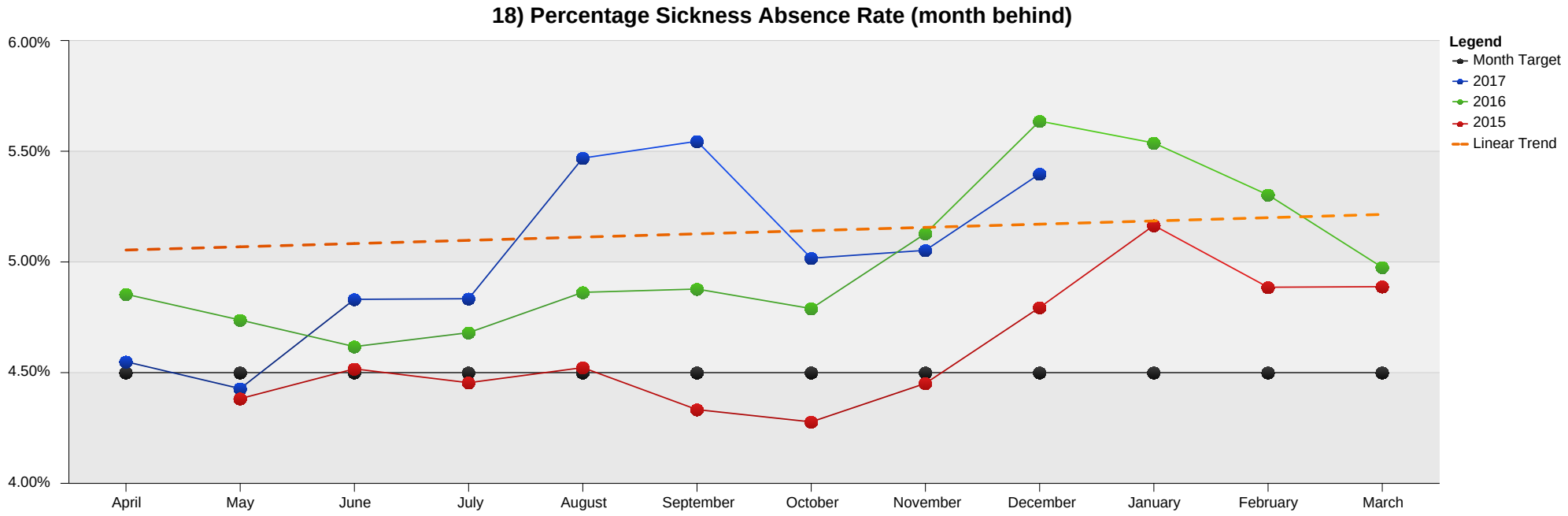
17) Percentage compliance with ALL mandatory and statutory training (snapshot)



	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)	88.75%	88.75%	86.64%	86.64%	89.54%	89.54%	88.22%	88.22%	89.79%	89.79%	88.97%	88.97%		

Narrative
The position for December 2017 is 88.75%, which is 1.25% lower than the target of 90%. This figure represents a continuing improvement in compliance since April 2017. The key performance indicator has changed to measure compliance against all mandatory training rather than the Core 7. The availability of face to face training is impacting on compliance levels and this is being addressed to ensure attendance is maximised at available training courses .It is planned to review the Trusts approach to recording mandatory and statutory training to identify any system improvements to drive efficiencies in the process. This KPI was discussed at the Performance Improvement Group in January 2018 where a number of actions were agreed to address areas of concern.The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh allows a timelier update of accurate performance information to managers.

Trust Dashboard Graphs for TRUST

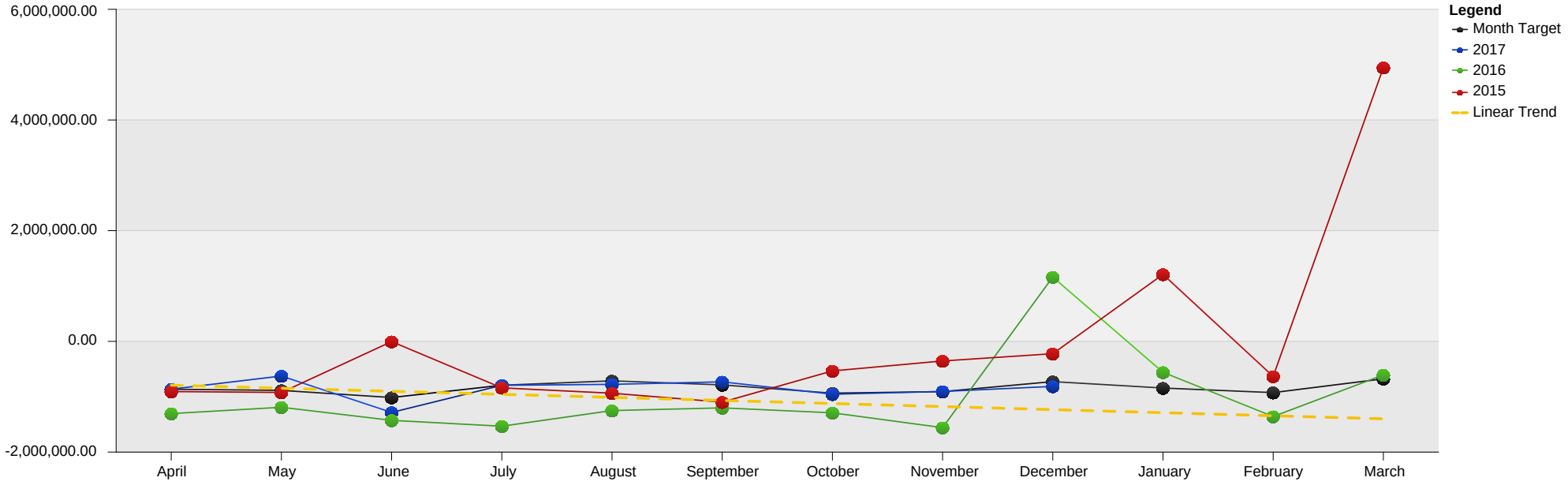


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	5.40%	5.02%	6.49%	5.45%	5.43%	5.62%	4.16%	4.38%	5.76%	5.03%	5.82%	5.51%		

Narrative
The Trust position reported in December relates to the November sickness level. The Trust position reported in November 2017 is 5.40% which is not meeting target of 4.50% and is a deterioration on that reported in October 2017, but an improvement compared to that reported in November 2016. An event was held in November to look at how we can better understand the reasons for the increase in sickness absence we have seen this year and broadly focused on health and well-being within the organisation. The event was productive and identified a number of areas to explore. Further events are planned for January and February to continue the discussions. North Yorkshire is the only locality meeting target with Durham and Darlington reporting the poorest position at 6.49%. 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

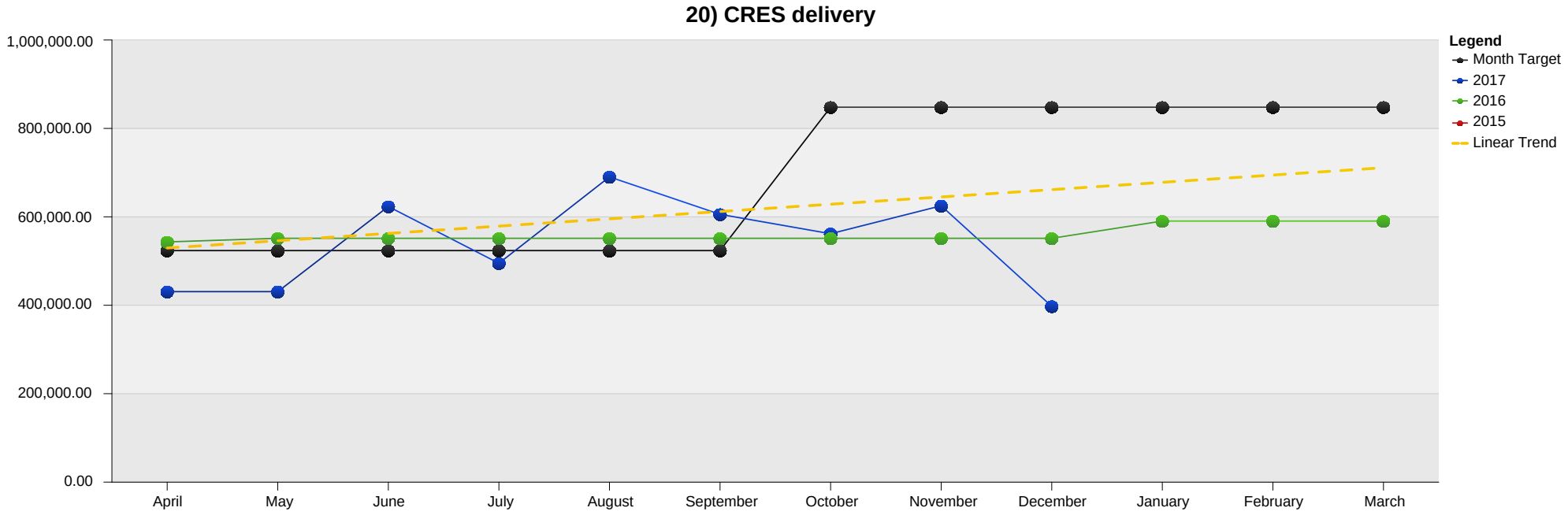
19) Delivery of our financial plan (I and E)



	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)	-814,000.00	-7,750,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The comprehensive income outturn for the period ending 31 December 2017 is a surplus of £7,750k, representing 3.1% of the Trust's turnover and is £120k ahead of plan.

Trust Dashboard Graphs for TRUST

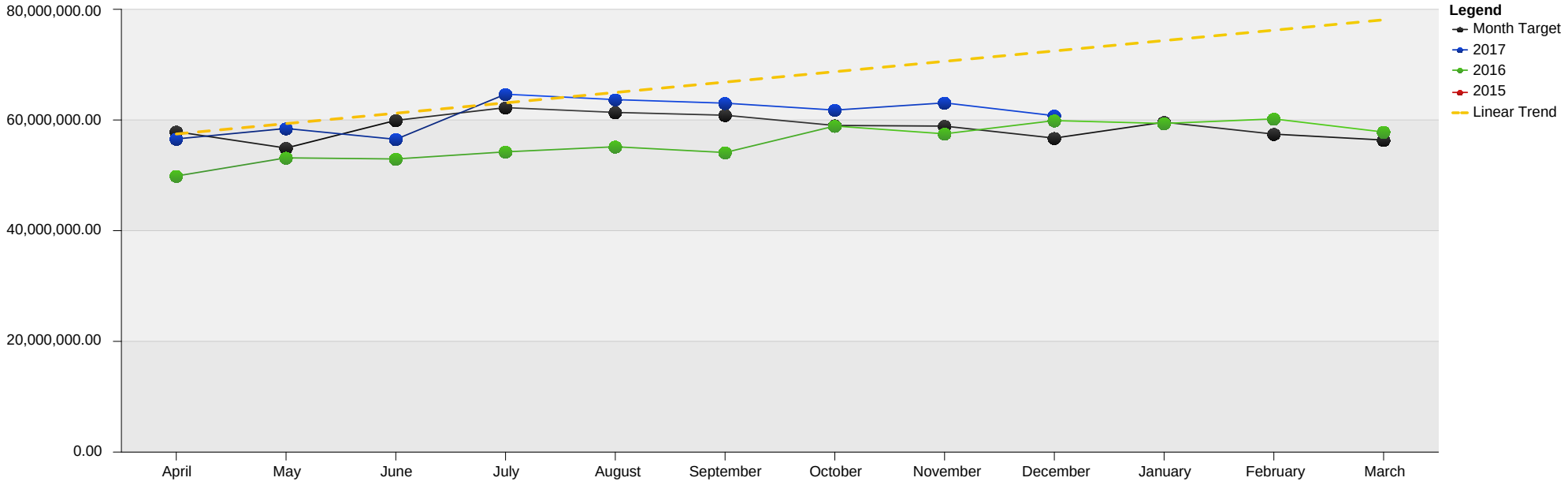


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	397,577.00	4,860,397.93	73,141.00	1,136,472.91	92,113.00	1,633,014.08	32,242.00	290,180.92	16,504.00	148,537.66	60,756.00	546,805.34		

Narrative
Total CRES identified at 31 December 2017 is £6,481k and is £1,749k behind plan for the year to date. The deterioration is due to slippage on CRES schemes due to commence 1 October 2017. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future years, and has non-recurrent expenditure mitigations in place to manage this position in 2017/18.

Trust Dashboard Graphs for TRUST

21) Cash against plan



	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	60,776,000.00	60,776,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 December 2017 is £60,776k and is £4,050k ahead of plan largely due to working capital variations.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	December 2017														April 2017 To December 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Total number of External Referrals into Trust Services	7,793.00	7,890.00	1,885.00	1,846.00	1,916.00	2,454.00	1,848.00	1,756.00	585.00	627.00	1,559.00	1,207.00			69,133.00	78,467.00	16,721.00	18,154.00	16,996.00	23,388.00	16,396.00	18,740.00	5,193.00	5,679.00	13,827.00	12,503.00		
2) Caseload Turnover	1.99%	1.08%	1.99%	2.46%	1.99%	3.56%	1.99%	-0.88%	NA	NA	1.99%	-4.55%			1.99%	1.08%	1.99%	2.46%	1.99%	3.56%	1.99%	-0.88%	NA	NA	1.99%	-4.55%		
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	84.61%	85.00%	91.45%	85.00%	77.63%	85.00%	85.55%	85.00%	NA	85.00%	80.78%			85.00%	86.18%	85.00%	88.24%	85.00%	84.96%	85.00%	90.62%	85.00%	NA	85.00%	78.33%		
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	70.00	16.00	17.00	11.00	16.00	22.00	22.00			24.00	14.00			75.00	70.00	16.00	17.00	11.00	16.00	22.00	22.00			24.00	14.00		
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	9.90%	10.00%	8.33%	10.00%	8.47%	10.00%	12.24%			10.00%	12.50%	10.00%		10.00%	8.89%	10.00%	8.07%	10.00%	8.79%	10.00%	8.32%			10.00%	11.14%	10.00%	
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	21.00	25.00	6.00	7.00	6.00	4.33	7.00	5.33			2.00	7.00			179.00	230.33	49.00	83.33	49.00	47.33	60.00	43.67			21.00	44.33		

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	December 2017														April 2017 To December 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%	92.14%	90.00%	92.91%	90.00%	98.44%	90.00%	85.29%	90.00%	100.00%	90.00%	75.20%			90.00%	91.02%	90.00%	89.67%	90.00%	98.45%	90.00%	84.37%	90.00%	99.76%	90.00%	74.68%		
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	7.74%	10.00%	8.67%	10.00%	6.23%	10.00%	11.00%	10.00%		10.00%	2.52%			10.00%	8.57%	10.00%	10.68%	10.00%	5.70%	10.00%	11.20%	10.00%		10.00%	4.68%		
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	12.36%	20.00%	5.45%	20.00%	5.00%	20.00%	45.24%			20.00%	8.82%			20.00%	13.48%	20.00%	5.58%	20.00%	4.67%	20.00%	37.69%			20.00%	21.59%		
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	90.23%	92.45%	92.91%	92.45%	90.97%	92.45%	88.95%	92.45%	78.08%	92.45%	88.89%			92.45%	91.63%	92.45%	92.64%	92.45%	92.92%	92.45%	91.58%	92.45%	79.86%	92.45%	90.68%		
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	2.15	1.00	1.93	1.00	1.17	1.00	4.51	1.00	0.00	1.00	2.55			9.00	11.30	9.00	10.15	9.00	8.44	9.00	17.00	9.00	67.94	9.00	9.48		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	December 2017														April 2017 To December 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%	94.47%	100.00%	95.97%	100.00%	97.85%	100.00%	93.59%	100.00%	93.23%	100.00%	89.66%			100.00%	94.47%	100.00%	95.97%	100.00%	97.85%	100.00%	93.59%	100.00%	93.23%	100.00%	89.66%		
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	13.79%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA			15.00%	19.04%	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%	92.75%	95.00%	92.99%	95.00%	94.26%	95.00%	91.48%	95.00%	95.92%	95.00%	89.35%			95.00%	92.75%	95.00%	92.99%	95.00%	94.26%	95.00%	91.48%	95.00%	95.92%	95.00%	89.35%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	88.75%	90.00%	86.64%	90.00%	89.54%	90.00%	88.22%	90.00%	89.79%	90.00%	88.97%			90.00%	88.75%	90.00%	86.64%	90.00%	89.54%	90.00%	88.22%	90.00%	89.79%	90.00%	88.97%		
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.40%	4.50%	6.49%	4.50%	5.43%	4.50%	4.16%	4.50%	5.76%	4.50%	5.82%			4.50%	5.02%	4.50%	5.45%	4.50%	5.62%	4.50%	4.38%	4.50%	5.03%	4.50%	5.51%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	December 2017														April 2017 To December 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)	-727,000.00	-814,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			-7,630,000.00	-7,750,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
20) CRES delivery	848,000.00	397,577.00	107,322.17	73,141.00	198,536.25	92,113.00	148,049.17	32,242.00	124,378.00	16,504.00	59,416.00	60,756.00			5,686,080.00	4,860,397.93	965,899.50	1,138,472.91	1,786,826.25	1,633,014.08	1,332,442.50	290,180.92	1,119,402.00	148,537.66	534,744.00	546,805.34		
21) Cash against plan	56,726,000.00	60,776,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			56,726,000.00	60,776,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

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

	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	Durham & Darlington	Teesside	North Yorkshire	Forensics	York	Durham & Darlington	Teesside	North Yorkshire	Forensics	York	Durham & Darlington	Teesside	North Yorkshire	Forensics	York	
Accidental death																					
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Natural causes																					
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hanging																	17/17912(Jul)				
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1

Suicides																					
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Open																					
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Drug related death																					
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Drowning																					
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Misadventure																					

Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Awaiting verdict	17/14612(May)	17/9769(Apr)	17/10022(Apr)	17/17337(Jul)	17/10645(Apr)	2017/24226 (Oct)	2017/20399 (Aug)										17/13705(May)		17/19071(Jul)	2017/26250 (Oct)	2017/19594 (Aug)	
	2017/21616 (Jun)	17/12205(May)	17/10026(Apr)	2017/24890 (Oct)	17/18326(Jul)		2018/51 (Dec)										2017/19680 (Aug)		2017/21390 (Aug)	2017/26443 (Oct)	2017/20872 (Aug)	
	2017/20284 (Aug)	17/12193(May)	17/17086(Jul)		2017/20401 (Aug)												2017/22972 (Sep)		2017/26720 (Oct)		2017/30109 (Jul)	
	2017/20474 (Aug)	17/17704(Jul)	17/17317(Jul)		2017/30605 (Dec)												2017/27619 (Nov)		2017/29771 (Dec)			
	2017/20299 (Aug)	2017/21469 (Aug)	2017/21909 (Aug)		2018/43 (Dec)												2017/30296 (Sep)		2017/30782 (Dec)			
	2017/23197 (Jun)	2017/23963 (Sep)	2017/24241 (Sep)														2017/31197 (Dec)					
	2017/24589 (Jul)	2017/28639 (Oct)	2017/25765 (Oct)														2017/31316 (Dec)					
	2017/23360 (Sep)	2017/28240 (Nov)	2017/25993 (Oct)																			
	2017/24976 (Jul)	2017/29200 (Nov)	2017/26709 (Oct)																			
	2017/28731 (Jul)	2017/31106 (Dec)	2017/26877 (Nov)																			
	2017/28161 (Nov)		2017/28196 (Nov)																			
	2017/28182 (Nov)		2017/29681 (Dec)																			
	2017/29034 (Nov)		2017/29831 (Dec)																			
	2017/30665 (Dec)		2017/31603 (Dec)																			
	2017/31694 (Dec)																					
Total	**15**	**10**	**14**	**2**	**5**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7**	**0**	**5**	**2**	**3**	**66**

Grand Total	15	10	14	2	5	1	2	0	0	0	0	0	0	0	0	0	7	1	5	2	3	67

Number of unexpected deaths reported as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	4	3	10	11	5	9	8	13			

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
1	Total number of external referrals into trust (same)services	5					5					5					15	**100%**	**100%**	
2	Caseload Turnover (same)	5					5					5					15	**100%**	**100%**	
3	Bed occupancy (AMH & MHSOP A&T wards) (same)	5					5					5					15	**100%**	**100%**	
4	Number of patients occupying a bed with a length of stay (from admission) over 90 days (AMH & MHSOP A&T wards)	5					5					5					15	**100%**	**100%**	This KPI has been amended to include patients currently occupying a bed, rather than those subject to discharge. This allows for more pro active monitoring of patients with a longer length of stay to enable a review of the appropriateness of the length of impatient spell and this is monitored in the report out process. The change to this KPI does not impact on the score previously applied, which remains unchanged.
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						5				5					15	**93%**	**100%**	Historic data for York and Selby prior to 1st April 2016 was not on Trust systems and this impacted on the reliability score applied to this KPI. However due to the new reporting year this concern no longers applies. T and therefore the scoring of this KPI has improved from 93% to 100%
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						5				5					15	**93%**	**100%**	The previous comments about the lack of historic data on the system with regards to York and Selby data no longer applies and therefore the scoring of this KPI has improved from 93% to 100%
7	Percentage of patients who have not waited longer than 4 weeks following an external referral	5						4				5					14	**93%**	**93%**	Data reliability is remains at 4 due to issues over the recording of DNA's. Although this continues to improve issues are still reported, particularly in the North Yorkshire locality and these are being addressed through the report out process

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	**% as at October 2016**	**% as at July 17**	**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				
8	Percentage of clinic appointments cancelled by the Trust	5					5					5					15	**87%**	**100%**	This KPI has been changed to clinic appointments as the previous use of community contacts was unreliable as you could not future date appointments, and therefore clinicians were likely to record these inaccurately. This KPI now uses the outpatients module on PARIS and there are no concerns of the reliability of this data. The use of a drop down menu to clearly state cancellation reasons provides a high degree of confidence in data quality.
9	The percentage of Out of Area Placements (post validated)		4				5								5		14	**N/A**	**93%**	Data is imported back into the IIC following manual validation. This increases reliability however introduces a manual element into the process. Validation for all breaches must be completed within the timeframe to support a national return, which prevents concerns about some breaches being inappropriately discounted. Therefore the data reliability has been amended from 4 to 5. A change to PARIS with the inclusion of drop downs to eradicate the manual element of the process is planned.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	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				
10	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					12	**80%**	**80%**	Questionnaires continue to be are a mix of paper and electronic. All inpatient wards are electronic data collection, however there is also a number of kiosks in a range of services which complement the paper collection. A new provider (Optimum Health Technology) is in place and data collection commenced on 1st April 2017 . Paper surveys are sent to the new provider and entered into their Meridian system. There is a manual upload of the data accessed from Meridian into the IIC (this was the case for the most recent data by the Data Quality Team) but work is ongoing to integrate this data with the IIC.
11	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					14	**93%**	**93%**	Data continues to be directly extracted from Datix into the IIC; however, this process is not fully embedded. IAPT caseload is a manual upload.
16	Percentage Sickness Absence Rate (month behind)	5						4				5					14	**93%**	**93%**	Sickness absence data for inpatient services is taken directly from the rostering system which helps to eliminate inaccuracies, the remainder of the Trust continue to input directly into ESR and there continues to be examples where managers are failing to end sickness in a timely manner or inaccurately recording information onto the system. These issues are picked up and monitored through sickness absence audits that the Operational HR team undertake.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	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				
14	Actual number of workforce in month		4				5					5					14	**93%**	**93%**	Data continues to be extracted electronically but processed manually
15	Percentage of registered health care professional jobs that are advertised two or more times				2			4				5					11	**73%**	**73%**	The form to capture this information 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.
19	Are we delivering our financial plan (I and E)		4				5					5					14	**93%**	**93%**	Information is extracted from and electronic system but is then subject to a manual process.
16	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 continue to improve - there appears to be greater confidence in the data being reported and operational clinical services have incorporated the monitoring of compliance into the daily lean management process. Performance has improved and the Trust compliance rate has consistently been above 90%
17	Percentage compliance with mandatory and statutory training – snapshot **	5						4				5					14	**93%**	**93%**	The key issue that impacts on the reliability of the data is that staff do not follow the correct procedures to ensure training is recorded accurately on the source system as being completed and this is being addressed. In terms of training requirements there have been issues with Resus and PAT training and work is underway to resolve these issues
20	Delivery of CRES against plan				2		5					5					12	**80%**	**80%**	Data continues to be 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%**	**93%**	An extract continues to be taken from the system then processed manually to obtain actual performance.

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th January 2018**
TITLE:	**Single Oversight Framework**
REPORT OF:	**Phil Bellas, Trust Secretary & Sharon Pickering, Director of Planning, Performance and Communications**
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:

The Single Oversight Framework (SOF) sets out NHS Improvement's approach to identifying the potential support needs of providers as they emerge.

The purpose of this report is to examine the Trust's position against the requirements of the revised SOF at the end of Quarter 3, 2017/18.

Overall, the report provides assurance, to the extent that information is available, that the Trust's segment 1 (maximum autonomy) rating should be maintained.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**30th January 2018**
TITLE:	**Single Oversight Framework**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to examine the Trust's position against NHS Improvement's (NHSI) Single Oversight Framework (SOF) at the end of Quarter 3, 2017/18.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The SOF sets out NHSI's approach to overseeing NHS Trusts/Foundation Trusts and seeks to enable the regulator to identify where providers may benefit from, or require, improvement support.

2.2 NHSI uses a range of information across the following five themes: quality of care; finance and use of resources; operational performance; strategic change; and leadership and improvement capability.

2.3 Providers are placed in segments ranging from 1 (maximum autonomy) to 4 (special measures) based on NHSI's judgement of the seriousness and complexity of the issues they face.

2.4 The Trust has been placed in segment 1 since the introduction of the SOF.

2.5 In previous reports the Board has noted that:

(a) The Trust's position is a significant achievement in comparison to other local mental health providers.

(b) Although the Trust undertakes internal monitoring against the quality of care and operational performance metrics this is hampered by a number of issues principally related to the regulator's use of national data sources.

2.6 In November 2017 NHSI published a revised version of the SOF. A summary of the key changes is provided in Annex 1 to this report for information. In reviewing the SOF dashboards (Annexes 2 – 4 to this report) the Board is asked to note that work to update internal monitoring processes, to reflect the amendments, is ongoing.

2.7 The next Quarterly Review Meeting with NHSI is due to be held on 25th January 2018. Any material issues raised by the regulator will be reported verbally at the meeting.

3. KEY ISSUES:

3.1 The following sections explore the Trust's position against the triggers used by NHSI for determining support to be provided under the SOF and seek to highlight any risks to the maintenance of the segment 1 position.

3.2 The Board is asked to note that changes to the segmentation of providers are not automatic if a trigger occurs. NHSI takes into account a provider's circumstances in determining the nature and extent of any support required.

Quality of Care

Triggers
▪ CQC 'inadequate' or 'requires improvement' assessment in overall rating, or against any of the safe, effective, caring or responsive key question ▪ CQC warning notices ▪ Other material concerns identified or relevant to CQC monitoring processes e.g. civil or criminal cases raised, whistleblowers etc. ▪ Concerns arising from trends in quality indicators ▪ Delivery against an agreed trajectory for the four priority standards for 7-day hospital services ▪ *(New) Any other material concerns about a provider's quality of care arising from intelligence gathered by or provided to NHSI*

3.3 The Trust's position on the quality indicators, where available, is provided in Annex 2 to this report.

3.4 The Board is asked to note that:

(a) The Trust's segmentation reflects its "good" CQC rating.

(b) The implementation of the CQC Action Plan continues to be broadly on track; however:

- Some issues have been identified with training compliance. These are being addressed and are expected to be resolved by 31st March 2018.
- Further assurance of improvements to the personalisation of care plans is being sought.

(c) There are no trends on the quality indicators which raise concerns at the present time; however, potential data quality issues in relation to the metric "% CPA clients in settled accommodation" have been identified and are being examined by the Information Department.

(d) No CQC warning notices have been received since the last report.

(e) Plans to extend relevant services to meet 24/7 requirements are included in the Trust's Business Plan.

(f) There are no known exceptions to bring to the Board's attention.

Finance and Use of Resources

3.5 The Trust's position on the SOF requirements in relation to finance and use of resources is set out in the Finance Report (agenda item 12).

Operational Performance

Triggers
▪ Failure to meet the trajectory for a metric for at least two consecutive months (quarterly for quarterly metrics) ▪ *(New) Other factors (eg a significant deterioration in a single month or multiple potential support needs across standards and/or other themes) indicate NHSI needs to get involved before two months have elapsed*

▪ *(New) Any other material concerns about a providers' operational performance arising from intelligence gathered by or provided to NHS Improvement*

3.6 The Trust's position on the operational performance metrics, where available, is provided in Annex 3 to this report.

3.7 The Board will recall that a risk was identified at Quarter 2 in relation to performance on the IAPT recovery indicator. As shown in Annex 3 the Trust achieved the target on this metric at Quarter 3. Further information on this matter is provided under agenda items 11 and 13.

3.8 There are no known exceptions to bring to the Board's attention.

Strategic Change

Triggers
Material concerns with a provider's delivery against the *local* transformation agenda, including new care models and devolution

3.9 Whilst there is a lack of clarity in the SOF on the assessment and application of the triggers under this theme, the Board will be aware that the Trust continues to engage positively with the local transformation agenda.

Leadership and Improvement Capability (Well-led)

Triggers
▪ CQC 'inadequate' or 'requires improvement' assessment against 'well-led'. ▪ (New) Concerns arising from trends in the organisational health indicators ▪ (New) Other material concerns about a provider's governance, leadership and improvement capability, arising from third-party reports, developmental well-led reviews or other relevant sources

3.10 The Trust's position on the leadership and improvement capability metrics is provided in Annex 4 to this report.

3.11 The Board is asked to note:

(a) That, following the CQC inspection in January 2017, the Trust was rated "good" in the well-led domain.

(b) That no material issues were identified during the external governance review in 2017.

(c) The positions on the sickness absence and temporary staffing metrics. Neither of these issues is considered to be material; however, further information is provided in the Performance Dashboard report (agenda item 13) and the Finance Report (agenda item 12) respectively.

(d) That, at this time, there is no known third party information (e.g. GMC, PHSO, Healthwatch, HSE, complaints, whistleblowers, medical royal colleges) which suggests governance concerns in the Trust.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** There are no direct CQC implications arising from this report; however NHSI's aim is to help providers attain and maintain CQC ratings of "good" or "outstanding".

4.2 **Financial/Value for Money:** Assessments of the Trust's position against the SOF's theme of finance and use of resources are provided in the Finance Reports.

4.3 **Legal and Constitutional (including the NHS Constitution):** The legal basis for enforcement action in relation to NHS Foundation Trusts remains unchanged. This means that, for example, a Foundation Trust will only be in segments 3 or 4 where it has been found to have been in breach or suspected breach of its licence.

4.4 **Equality and Diversity:** Information on delivering Workforce Race Equality Standards (WRES) will be used as part of assessments under the Leadership and improvement capability theme; however, no further information on this matter is included in the SOF.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks arising from the Trust not being able to accurately assess its position against the requirements of the SOF in view of the lack of information on the construction of metrics; information not being available from the national sources identified; and/or data quality issues.

6. CONCLUSIONS:

6.1 Overall, the Trust should expect to maintain its segment 1 position for Quarter 3; however, close monitoring by NHSI is expected to continue.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary
Victoria Reed and Ashleigh Lyons, Corporate Performance Managers

Background Papers:
Single Oversight Framework published by NHS Improvement in November 2017

Annex 1

Summary of Changes made to the Single Oversight Framework (November 2017)

1 **General:**

NHSI has reinstated the requirement (previously included in its Risk Assessment Framework) for Trusts to notify it of any actual or prospective changes in performance or risks that fall outside the routine SOF monitoring, where these are material to the provider's ability to deliver safe and sustainable services.

2 **Quality of Care:**

Metric	Change
Occurrence of a Never Event	Frequency changed from monthly to monthly (six month rolling)
Patient safety alerts not completed by deadline	Previously "outstanding patient safety alerts"
CQC community mental health survey	Previously inpatient/mental health and community survey
Care programme approach (CPA) follow-up – proportion of discharges from hospital followed up within 7 days	No change at present but NHSI is developing metrics to measure 48 hour follow up
Executive team turnover	Removed
Aggressive cost reduction plans	Removed as a quality indicator

3 **Finance and Use of Resources:**

NHSI will be using assessments under its use of resources (UoR) framework to inform its consideration of support needs.

At present these assessments have only been introduced for specialist acute trusts. Pending a UoR assessment the regulator will, therefore, be using the finance score, alongside other evidence, to identify potential support needs.

4 **Operational Performance:**

Metric	Change
People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral	Frequency changed from quarterly to quarterly (three month rolling)
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: ▪ Inpatient wards ▪ Early intervention in psychosis services ▪ Community mental health services (people on care programme approach)	Frequency changed from quarterly to annual (via audit)

Improving Access to Psychological Therapies (IAPT)/talking therapies: ▪ Waiting times	Frequency changed from quarterly to three month rolling
Patients requiring acute care who received a gatekeeping assessment by a crisis resolution & home treatment team	Removed
Inappropriate adult mental health out of area placements. Total number of bed days patients have spent out of area in the last quarter.	New metric Progress to be in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021
Data Quality Maturity Index (DQMI) – Mental Health Services Data Set (MHSDS) Data Score	Replaces the previous standards for submitting 'priority' and 'identifier' metrics to MHSDS The initial focus (until April 2018) will be ensuring providers understand their current score and, where the standard is not being reached, have a clear plan for improving data quality. During 2018/19, failure to meet the standard will trigger consideration of a provider's support needs in this area.

5 **Strategic Change:**

NHSI will review the assessment of system-wide leadership in relevant sustainability and transformation partnership (STP) ratings when considering providers' performance under this theme.

6 **Leadership and Improvement Capability:**

The SOF now references the new NHSI &CQC joint well-led framework and guidance on developmental reviews.

Metric	**Change**
Staff Sickness	Frequency changed from monthly/quarterly to monthly
Staff turnover	Frequency changed from monthly/quarterly to monthly
NHS Staff survey	Frequency changed from monthly/quarterly to monthly
Proportion of temporary staff	Frequency changed from quarterly to monthly

SINGLE OVERSIGHT SCORECARD - QUALITY INDICATORS - 2017/18

All Providers																	
Quality Indicators	**SOF Source**	**Other known source**	**Freq.**		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Written compliants - rate	NHS Digital	n/a	Q		9.7			9.7									Last published data is September 2017
Staff and Friends and Family test % recommended - care	NHSE	n/a	Q		83%			81%			No Staff FFT in Q3						
		Strategic Direction Perf. Report	Q		84%			81%			No Staff FFT in Q3						
Occurrence of Never Event	NHS Improvement	Governance	M		0	0	0	0	0	0	0	0	-	-	-	-	Data published up to November 2017
NHS England/NHS Improvement Patient Safety Alerts outstanding	NHS Improvement	Governance	M		0	0	0	0	0	0	0	0	0	-	-	-	Data published up to December 2017
Mental Health Providers																	
Quality Indicators	**SOF Source**	**Other known source**	**Freq.**		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
CQC inpatient/mental health and community survey	CQC	n/a	A		About the Same' as other Trusts												Trusts are no longer provided with an overall score and are rated as Better, About the Same or Worse on a range of questions in ten categories. Our Trust scored 'About the Same' in every category.
Mental Health scores from Friends and Family Test - % positive	NHSE	n/a	M		88.63%	88.10%	86.97%	89.12%	86.04%	87.15%	88.07%	85.26%	-	-	-	-	Latest published data November 2017
Admissions to adult faciliites of patients who are under 16 years old	NHS Digital	n/a	M											-	-	-	No public data available
		PARIS	M		0	0	0	1	0	0	0	0	0				Data from Paris
Quality Indicators	**SOF Source**	**Other known source**	**Freq.**	**Standard**	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
CPA follow up - proportion of discharges from hospital followed up within 7 days (all discharges treated as being on CPA)		UNIFY			96.42%			95.15%									Data states the source is UNIFY (data submitted quarterly) -submission for Q3 2017/18 due 15th January, will be published 9th February Post validated position stated is from our intenal files which are used to provide the UNIFY submission.
		pre validated IIC		95%	**92.63%**	**95.12%**	**97.93%**	**94.25%**	**94.96%**	**92.54%**	**96.19%**	**96.31%**	**92.96%**				
		post validated IIC			**94.74%**	**95.53%**	**98.34%**	**97.31%**	**96.22%**	**93.86%**	**98.72%**	**97.24%**	**95.26%**				
% clients in settled accommodation	NHS Digital	n/a	M		79.05%	77.88%	80.83%	81.50%	82.27%	82.70%	-	-	-				Latest published data September 2017
		IIC	M		83.43%	82.24%	80.88%	79.03%	78.07%	76.31%	73.34%	71.33%	69.76%				Percentage of people on CPA in settled accommodation
% clients in employment	NHS Digital	n/a	M		13.36%	13.50%	13.63%	13.56%	13.42%	13.27%	-	-					Latest published data September 2017
		IIC	M		12.85%	13.09%	12.99%	13.21%	13.17%	12.91%	13.23%	12.44%	12.78%				Percentage of people on CPA in employment
Potential under-reporting of patient safety incidents	NHS England Dashboard	n/a	M											-	-	-	No public data available

SINGLE OVERSIGHT SCORECARD - OPERATIONAL PERFORMANCE METRICS - 2017/18

Mental Health Providers																				
Operational Performance Metrics	**SOF Identified source**	**Other Identiifed Source**	Freq.	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Q1**	**Q2**	**Q3**	**Comments**
People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral	UNIFY2 and MHSDS	n/a	**Q**	**50%**	**69.70%**	**78.26%**	**70.18%**	**77.55%**	**65.96%**	**71.43%**	**91.67%**	**76.36%**	**72.73%**				**72.79%**	**71.77%**	**80.27%**	This data is currently published from the Unify submissions that are made monthly
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **inpatient wards**	Board declaration but can be triangulated with results of CQUIN audit	pre validated PARIS	**Q**	**90%**	-	-	-	-	-	-	-	-	-							
		post validated PARIS			-	-	-	-	-	-	-	-	-							Data has been collected and submitted to National Clinical Audit of Pschosis (NCAP) at the end of December 17 and results are expected May 2018.
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **early intervention in psychosis services**		pre validated PARIS	**Q**	**90%**	-	-	-	-	-	-	-	-	-							
		post validated PARIS			-	-	-	-	-	-	-	-	-							Data has been collected and will be submitted to College Centre for Quality Improvement(CCQI) by 31st January, it is expected results will be available in May 2018
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **community mental health services (people on CPA)**		pre validated PARIS	**Q**	**65%**	-	-	-	-	-	-	-	-	-							
		post validated PARIS			-	-	-	-	-	-	-	-	-							Data has been collected and submitted to NCAP at the end of December 17 and results are expected May 2018.
IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	IAPT minimum dataset	n/a	**Q**	**50%**	**45.94%**	**47.14%**	**49.36%**	**48.35%**	**45.59%**	**45.66%**	**49.30%**						**47.53%**	**46.50%**	**49.30%**	Data only available until October on IAPT minimum dataset
		Internal Reports		**50%**	**49.49%**	**50.58%**	**52.86%**	**50.95%**	**48.55%**	**49.01%**	**52.12%**	**51.22%**	**46.10%**				**51.04%**	**49.47%**	**50.00%**	
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 6 weeks**	IAPT minimum dataset	n/a		**75%**							**98.27%**								**98.27%**	
		internal IAPT reports		**75%**							**98.26%**	**96.50%**	**95.40%**						**96.78%**	Following realease of additional guidance in November 17, it is now clear that the IAPT indicator relates wait for treatment and is not linked ot the course of treatment being finished. This indicator has been backd to October so that we can provide a Q3 position.
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 18 weeks**	IAPT minimum dataset	n/a	**Q**	**95%**							########								**100.00%**	IAPT minimum dataset data is only available until October.
		internal IAPT reports		**95%**							**99.94%**	**99.83%**	**99.85%**						**99.87%**	

SINGLE OVERSIGHT SCORECARD - QUALITY INDICATORS - 2017/18

All Providers																	
Quality Indicators	**SOF Source**	**Other known source**	Freq.		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Staff Sickness	NHS Digital	n/a	M & Q		4.41%	4.79%	4.79%	5.42%	5.53%	-	-	-	-				ESR Data Warehouse - last published data August 17
		Finance Return	M & Q			4.40%	4.80%	4.79%	4.83%	4.93%	4.66%	5.03%	5.04%				Finance Return to NHS Improvement - not required to report in April. All other figures are a month behind
		Trust Dashboard (month behind)	M & Q		4.54%	4.39%	4.80%	4.81%	5.44%	5.52%	5.02%	5.05%	5.40%				IIC reporting a month behind
Staff turnover (Finance Return)	NHS Digital	Finance Return	M & Q			0.50%	0.60%	0.76%	1.10%	0.90%	0.82%	0.68%	0.76%				Finance Return to NHS Improvement - not required to report in April. All other figures are a month behind
NHS Staff survey	CQC	n/a	A														Staff survey not yet undertaken
Proportion of temporary staff	Provider Return	n/a	Q		1.49%			1.47%			1.83%						Finance Return to NHS Improvement

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th January 2018**
TITLE:	**Organisational Risk Management Policy**
REPORT OF:	**Phil Bellas, Trust Secretary**
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 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 the report is to seek the Board's approval of the revised Organisational Risk Management Policy which has been developed in response to recommendations arising from a review undertaken by Internal Audit in 2017 (assignment ref. 18/17).

Recommendations:

The Board is asked to approve the revised Organisational Risk Management Policy (attached as Annex 1 to this report) to come into force on 1st April 2018.

MEETING OF:	**Board of Directors**
DATE:	**30th January 2018**
TITLE:	**Organisational Risk Management Policy**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek the approval of the revised Organisational Risk Management Policy.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 An Internal Audit review of the Trust's risk management arrangements (final report ref 18/17 published on 16th August 2017) provided only "reasonable" assurance.

2.2 One of the recommendations made by the Internal Auditors was that the Trust should develop "a comprehensive Risk Management Policy in the new Trust format that clearly articulates the organisational approach to risk management, including the operation of the Board Assurance Framework (BAF)."

2.3 The Internal Auditors also recommended that:

(a) The development and operation of the Policy should be consistent with the requirements of the Trust Policy on Policies and would, therefore require, consultation, clearly identify responsibilities and training needs and explain how the policy will be implemented and monitored.

(b) It should clarify how DATIX is to be used, and ensure that there is some central oversight and reporting of the information in DATIX.

(c) It should state what the Trust's risk appetite is and include reference to (or include within the document) the escalation framework for key risks.

(d) The document should outline what the requirements of the BAF are and articulate how it is going to be designed, maintained and which group/Committee is responsible for the oversight of each corporate objective and the associated risks/assurances.

3. KEY ISSUES:

3.1 The draft revised Organisational Risk Management Policy is attached as Annex 1 to this report.

3.2 The approach taken to the development of the Policy has been to build on existing arrangements (as set out in the Integrated Governance Framework) whilst also seeking to address the Internal Auditors' recommendations. The Board's discussions on the findings of the External Governance review in July 2017 have also been taken into account.

3.3 In summary, the key changes made to the Trust's risk management arrangements, as set out in to the draft Policy, include:

(a) Clarification of roles and responsibilities including those of the Director of Quality Governance.
(b) The introduction of the Corporate (EMT) risk register as previously approved by the EMT.
(c) The removal of the concept of the "Integrated Assurance Framework and Risk Register" and the introduction of the Board Assurance Framework in order to provide greater focus on the strategic risks facing the Trust.
(d) The articulation of the Trust's risk appetite.

3.4 The draft Policy has been developed with the support of the Director of Internal Audit at Audit One and consultation has been undertaken with the Audit Committee and the Executive Management Team.

3.5 Additional resources will need to be provided within the Nursing and Governance Directorate to support the implementation and operation of the Policy. It is, therefore, recommended that the Policy should come into force on 1st April 2018 to enable the recruitment of a member of staff.

3.6 The approval of the Policy is a matter reserved to the Board in accordance with the Trust's scheme of delegation (included in Annex 8 to the Constitution).

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The Trust's risk management arrangements are assessed under the "well-led" domain and contribute to the overall CQC rating.

4.2 **Financial/Value for Money:** The provision of additional staffing resources in the Nursing and Governance Directorate is supported by the EMT.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust is required to apply those principles, systems and standards of good corporate governance (including risk management) appropriate for a supplier of health care services to the NHS (Licence Condition FT 4).

4.4 **Equality and Diversity:** The draft policy has been subject to equality analysis screening.

4.5 **Other implications:** The Organisational Risk Management Policy supports the Annual Governance Statement and will contribute to the annual opinion of the Head of Internal Audit on the robustness of the Trust's controls environment.

5. RISKS:

5.1 Failure to have robust risk management arrangements in place potentially undermines the future sustainability of the Trust.

6. CONCLUSIONS:

6.1 The draft Organisational Risk Management Policy has been prepared in response to the deficiencies identified by the Internal Auditors.

7. RECOMMENDATIONS:

7.1 The Board is asked to approve the revised Organisational Risk Management Policy (attached as Annex 1 to this report) to come into force on 1st April 2018.

Phil Bellas, Trust Secretary

Background Papers:
Internal Audit Report ref. 18/17

Tees, Esk and Wear Valleys
NHS Foundation Trust

Organisational Risk Management Policy

Ref (TBC)

Status: Draft
Document type: Policy

1 Introduction

The Trust exists in an uncertain and challenging environment. It can only achieve its aims, providing high quality services and positive outcomes for patients, by managing, often competing, risks.

How risks are managed is, therefore, vital in making the Trust a safe, sustainable and successful organisation.

This document sets out a structured approach to identifying, assessing, evaluating and responding to risks.

It also seeks to inform business planning and all decision making by articulating the levels and types of risk which the Trust is prepared to accept in pursuance of its objectives (its "risk appetite").

(Note: This policy does not cover the assessment and management of clinical risks relating to individual service users. This is set out in the Harm Minimisation Policy).

2 Why we need this policy

2.1 Purpose

The purpose of this document is to describe and detail the arrangements for organisational risk management in the Trust.

The policy:

- Provides a consistent and standardised approach to the identification, management and mitigation of risk by which future problems can be prevented.
- Supports the Board, through the Board Assurance Framework (BAF), to focus on those risks which might compromise the achievement of the Trust's strategic objectives.
- Supports ongoing compliance with statutory and regulatory requirements, both clinical and non-clinical e.g. the fundamental standards, health and safety, governance and financial oversight, etc.
- Supports decision making on the future provision and development of services and enables the challenges of different delivery models (e.g. collaboration) to be systematically assessed and controlled.
- Encourages the sharing of good practice and learning lessons across the Trust.
- Forms a key component of the Annual Governance Statement, providing the pubic and stakeholders with assurances about the effectiveness of the organisation's approach to governance, risk and control.

2.2 Definition of Risk Management

Risk management is the continuous process by which risks are identified, assessed, evaluated, controlled or accepted.

It seeks to help the Trust reduce the incidence and impact of the risks it faces.

2.3 Objectives

The objectives of this policy are to:

- Support compliance with regulatory requirements and expectations e.g. the Provider Licence.
- Embed a consistent, systematic and standardarised approach to the management of risks across the Trust.
- Support understanding of, and competence in, the anticipation, assessment and management of risks amongst all staff.
- Provide clarity on the Trust's risk appetite to support effective decision-making.

3 Scope

3.1 Who this policy applies to

This policy applies to the whole Trust and to staff employed by it.

3.2 Roles and responsibilities

3.2.1 **Organisational:**

Role	**Responsibilities**
Board of Directors	▪ Determines the Trust's approach to risk management including its risk appetite. ▪ Approves organisational risk management policies and procedures. ▪ Identifies strategic risks, principally through the Board Business Planning cycle, for inclusion in the Board Assurance Framework. ▪ Oversees the Board Assurance Framework and provides direction on action to reduce the Trust's

	exposure to strategic risks. ▪ Monitors (by exception) the management of operational risks contained in the Corporate Risk Register receiving assurance from the Executive Management Team (EMT). ▪ Approves all risk control related statements (e.g. the Annual Governance Statement) taking assurance from the Audit Committee.
Audit Committee	▪ Provides assurance to the Board (through its oversight of governance, risk management and internal control) on the effectiveness and robustness of the Trust's risk management arrangements and controls environment. ▪ Reviews the adequacy of all risk and control related statements (e.g. the Annual Governance Statement) prior to endorsement by the Board.
All Board Committees, including the Audit Committee	Within their terms of reference: ▪ Provide assurance to the Board on the effectiveness of controls. ▪ Identify gaps/weaknesses in control and ensure these are addressed/escalated as required. ▪ Identify and escalate new risks, that could impact significantly on the Trust's ability to deliver its Strategic Direction, to the Board.
Executive Management Team (EMT)	▪ Ensures the consistent application of risk management policies and processes within the Trust. ▪ Provides assurance to the Board on the delivery of mitigations to reduce exposure to the strategic risks contained in the Board Assurance Framework. ▪ Oversees operational risks contained in the corporate risk register and provides assurance (by exception) on the management of those risks to the Board. ▪ Monitors (by exception) the management of operational risks within the Locality Risk Registers receiving assurance from the Locality Management and Governance Boards. ▪ Agrees and oversees training in relation to risk management.
Specialty Development Groups (SDGs)	▪ Identify and communicate potential risks arising from national guidance, etc. ▪ Provide advice on mitigating actions for cross-locality

	clinical risks.
Locality Management and Governance Boards (LMGB)	▪ Ensure the effective operation of risk management arrangements within their Localities and provide assurance on this to the EMT. ▪ Provide assurance to the EMT on the delivery of mitigations to reduce exposure to risks contained in the Corporate Risk Register. ▪ Oversee operational risks through their Locality risk registers and provide assurance (by exception) on the management of those risks to the EMT. ▪ Monitor (by exception) the management of operational risks contained in the Clinical Directorate risk registers receiving assurance from their Quality Assurance Groups (QuAGs). ▪ Bring material risks to the quality of services to the attention of the Quality Assurance Committee.
Corporate Directorate Management Teams (DMT)	▪ Ensure the effective operation of risk management arrangements within their Directorates and provide assurance on this to the EMT. ▪ Provide assurance to the EMT on the delivery of mitigations to reduce exposure to risks contained in the Corporate Risk Register. ▪ Oversee relevant risks through their Directorate risk registers and provide assurance (by exception) on the management of those risks to the EMT.
Quality Assurance Groups (QuAGs)	▪ Ensure the effective operation of risk management arrangements within their Directorates and provide assurance on this to the LMGB. ▪ Provide assurance to the LMGB on the delivery of mitigations to reduce exposure to risks contained in the Locality Risk Register. ▪ Oversee operational risks contained in their Directorate risk registers and provide assurance (by exception) on the management of those risks to their LMGB. ▪ Identify and respond to potential risks arising from their consideration of performance information or escalated by wards/team.

(***Notes***:

(1) *Directors have the ability to tailor their Locality's/Corporate Directorate's risk management arrangements to their governance structure subject to the responsibilities set out above being maintained.*

(2) *Oversee means:*

- *Identifying new risks for inclusion in their risk register and ratifying their score/level*
- *Monitoring the implementation of agreed mitigating actions requiring corrective measures as necessary*
- *Approving material changes to existing risk profiles*
- *Escalating risks where appropriate*
- *Approving the closure or de-escalation of risks.)*

3.2.2 **Individual:**

Role	**Responsibilities**
Chief Executive	▪ As the Accounting Officer, overall responsibility for risk management in the Trust. ▪ Owner of the BAF (on behalf of the Board) and the Corporate Risk Register (on behalf of the EMT).
Non-Executive Directors	Satisfy themselves that management controls and systems of risk management and governance are sound and are used effectively.

Trust Secretary	▪ Provision of support for the Chief Executive e.g.:
	  ▪ The drafting of corporate risk management policies, procedures, etc
	  ▪ Maintenance of the BAF
	  ▪ Preparation of reports to the Board on the BAF/Corporate Risk Register.
	▪ Provision of independent advice on governance and compliance matters (including risk management) to the Board.

Director of Quality Governance	▪ Development and maintenance of the risk management system. ▪ Compilation and maintenance of the Corporate Risk Register. ▪ Reporting to the EMT on the corporate risk register. ▪ Identification and commissioning of training and

	development on risk management. ▪ Provision of best practice advice on risk management within the Trust's quality governance arrangements.
Directors	▪ Provision of assurance to the EMT on the operation of risk management arrangements within their Locality/Corporate Directorate. ▪ Owner of their Locality/Corporate Directorate Risk Registers (on behalf of their LMGB/DMT). ▪ Ensuring that staff have access to and receive appropriate training on risk management (as agreed by the EMT). ▪ Reporting on the delivery of operational risks to the Quality Assurance Committee (Directors of Operations only). ▪ Risk Managers (on appointment by the Chief Executive) for BAF level risks (Executive and Corporate Directors only). ▪ Risk managers for risks contained in the Corporate Risk Register (on appointment by the Chief Executive). ▪ Ensuring the delivery of mitigating actions assigned to them within required timescales.
Heads of Service	▪ Provision of assurance to their LMGB/DMT on the operation of risk management arrangements within their Clinical Directorate/Corporate Department. ▪ Owner of their Clinical Directorate risk register (on behalf of their QuAG) or Corporate Department risk register (if appropriate). ▪ Ensuring that staff have access to and receive appropriate training on risk management (as agreed by the EMT). ▪ Risk Managers (on appointment by the Director of Operations/Corporate Director) for risks contained in the LMGB/DMT Risk Register. ▪ Ensuring the delivery of mitigating actions assigned to them within required timescales.
Ward/Team Managers	▪ Owner of their ward/team risk log. ▪ Identification of emerging/potential risks for escalation to their QuAG. ▪ Delivery of mitigating actions assigned to them by their Head of Service.

All staff	Awareness of risk in performing their day to day duties, and reporting situations which they consider present risk to their line manager.
Risk Owner	▪ Day to day management of the risk on behalf of a governance group (e.g. LMGB, DMT, QuAG, etc). ▪ Reporting to the governance group on the status of risks contained in its risk register and the provision of assurance on: ▪ The operation of controls ▪ Progress on mitigating actions ▪ Responsibility for ensuring maintenance of records on the DATIX system. ▪ Appointment of risk managers (if appropriate).
Risk Manager	Day-to-day management of individual risks assigned to them including: ▪ Being able to report on their status ▪ Ensuring appropriate controls are enacted ▪ Ensuring that mitigating actions, if appropriate, are completed within agreed resources/timescales. (The risk owner/risk manager can be the same person)

4 Policy

4.1 Definition of Risk

Risk is an uncertain event or set of events which, should it/they occur, will have an effect on the achievement of objectives.

Risks, therefore, have three elements:

- A definite cause.
- An uncertain outcome.
- An impact/effect on objectives.

It is important to differentiate “risks” from “issues”:

Issue	**Risk**
Is happening	Not happening now but there is a genuine possibility that it might happen
Action taken to resolve it	Action taken to eliminate the possibility of it occurring

	or reduce the impact if it does

In simple terms, once a risk occurs it becomes an issue.

4.2 Risk Appetite

Risk appetite is the amount and type of **risk** that an organisation is willing to accept in order to meet its objectives (Strategic Goals).

The Trust recognises that:

- It is impossible to deliver services and achieve positive outcomes for patients and other stakeholders without risk; however, these risks must be managed in a controlled way.
- Methods of controlling risks must be balanced in order to support innovation, learning and the imaginative use of resources when it is to achieve substantial benefit.
- The Trust may accept some high risks because of the cost of controlling them.

In general the Trust:

- Has a low appetite for risks that impact on safety and security, both individually and organisationally. It will, therefore, seek to avoid or substantially control all risks that have the potential to:
  - cause significant harm to patients, staff, visitors, contractors and other stakeholders;
  - have severe financial consequences which could jeopardise the Trust's viability;
  - threaten the Trust's compliance with law and regulation.
- Has a moderate risk appetite for risks that impact on operational delivery or reputational issues. It will, therefore, balance the impact of risks with the potential opportunities; accepting those which provide a satisfactory level of reward (or value for money).
- Has the greatest appetite to pursue quality improvement and innovation and prepared to take opportunities where positive results can be anticipated.

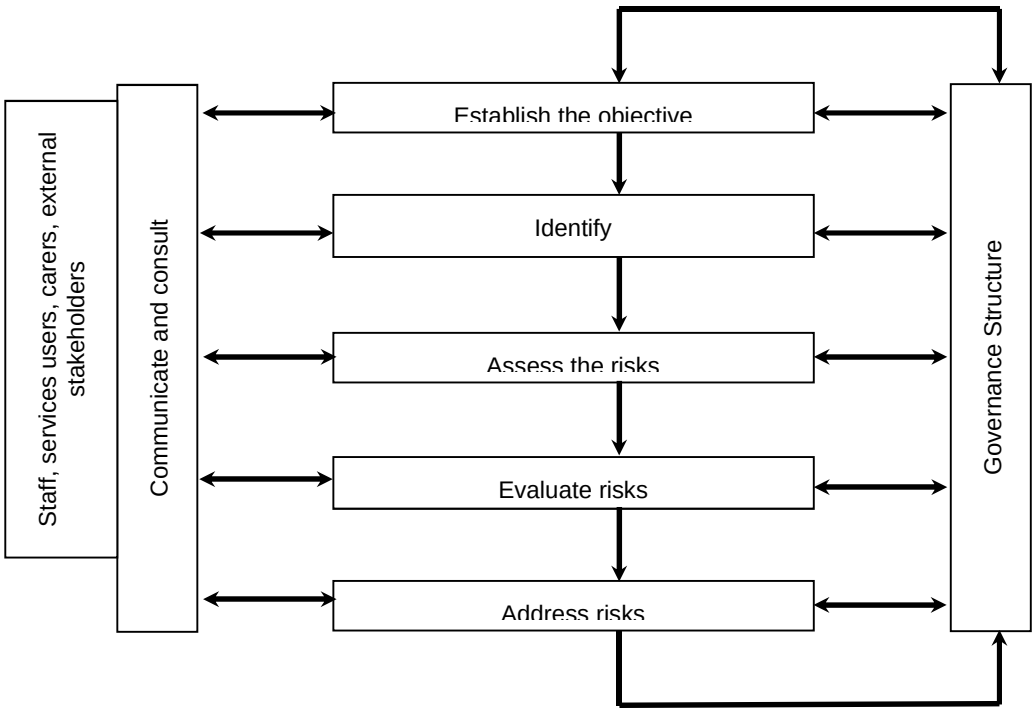
The risk appetite is operationalised through:

- The Risk Management Framework
- The Business Planning Framework
- The Trust's Scheme of Delegation
- Programme and project management arrangements

4.3 Risk Management Framework

4.3.1 The Trust's framework for risk management has five stages: **Establishing** the objective, **Identifying** the risk, **Assessing** the risk, **Evaluating** the acceptability of the risk and finally **Addressing** the risk.

Framework for Risk Management



*The principles of the risk management model will be employed to assess all risks in th*e organisation.

4.3.2 Detailed guidance on the components of the Framework is provided in Appendix 1.

4.4 The Board Assurance Framework

The Board Assurance Framework (BAF) is a key means of providing assurance to the Board that the Trust's Strategic Risks are being managed effectively across the organisation.

It has two main purposes:

- It is a strategic risk register providing a tool to capture and assess actual, specific risks to the achievement of the Trust's objectives and, most importantly, to plan and track the delivery of actions to reduce the likelihood or impact of those risks.
- It provides focus on the health of critical controls to help the Board know whether they are actually working in practice.

The BAF sets out:

- The Trust's principal business objectives.
- The principal risks to their achievement.
- The controls in place to manage the risks.
- The means by which the Board plans to receive assurance as to the adequacy and effectiveness of those controls (for example, internal audits, performance metrics or third party assessments).
- Details of any identified gaps in control.
- Details of any identified gaps in sources of assurance i.e. where there is limited or reasonable assurance available in respect of particular controls
- Remedial actions agreed to close off/strengthen gaps in controls and assurances.
- Planned actions to reduce the likelihood or impact of the identified risks.

The Board has reserved, to itself, oversight for each corporate objective and management of the associated risks and assurances; however, in doing so it relies significantly on assurances (as detailed in the BAF) from its Committees, the Executive Management Team and third parties e.g. the Internal Auditors.

The BAF is maintained by the Trust Secretary on behalf of the Chief Executive.

4.5 Risk Grading and Risk Ownership

All risks will be evaluated to understand the current controls in place to manage them, the potential impact if the risk was to materialise and the likelihood of this occurring.

This is undertaken using a defined process (detailed in Appendix 1 to this policy) through which a risk score (number) and risk grade (narrative/colour) are calculated.

A risk score has three aspects:

- The inherent (original) risk score – this is the level of risk before the application of controls. The calculation of the inherent risk can assist in determining which controls are key.
- The present risk score – this the level of risk at the time of reporting taking into account the controls in place and the progress of actions to mitigate the risk.
- The target (residual) risk score – this is the level of risk once all reasonable actions have been taken to mitigate the risk.

(Note: The present and target risk scores might be the same where it is appropriate to tolerate the risk).

The risk grade determines the approach to oversight, monitoring and escalation/de-escalation of a risk.

The tables below define the risk ownership together with monitoring arrangements and risk tolerance based on the risk grade:

Risk Grade	Authority to accept*	Overseen by:	Monitored by/Assurance to:	Risk Manager appointed by:
Strategic	*Board*	*Board*	-	*Chief Executive*
Very High	EMT	EMT	Board	Chief Executive
High	LMGB/DMT	LMGB/DMT	EMT	Director
Moderate	QuAG	QuAG	LMGB/DMT	Head of Service
Low	Ward/Team Manager	Ward/Team Manager	QuAG	Ward/Team Manager

(Notes:

- "Accept" includes approval of the risk description, risk score/grade and treatment
- *When accepting the risk consideration should be given to the Trust's risk appetite. The risk should be escalated if it is considered that it breaches the general principles set out in section 4.2*
- *Unless stated, delegation arrangements (e.g. to accept risks) in Corporate Directorates shall be at the discretion of the Corporate Director)*

4.6 Risk Registers

The Trust has risk registers at the following levels within its governance structure:

Risk Register	Risk Levels:	Oversight:	Maintained by:
Board Assurance Framework	*Strategic Risks*	*Board of Directors*	*Trust Secretary*
Corporate Risk Register	Very high	EMT	Director of Quality Governance
Locality/Corporate Directorate Risk Register	High	LMGB/DMT	Director of Operations/Executive/ Corporate Director
Clinical Directorate/Corporate Department Risk Register	Medium/Low	QuAG	Head of Service
Team/Ward Risk Logs	Low	-	Ward/Team Manager

(Note: The provision of risk registers in Corporate Departments shall be at the discretion of the Corporate Director. Where these are not maintained the relevant risks shall be included in the DMT risk register)

4.7 Risk Recording

The Trust uses an electronic risk management system, a module of the DATIX system, to maintain the BAF and all risk registers.

The DATIX risk management module is accessible through the Trust's intranet ("Intouch). With the exception of the BAF all staff have access to the risks recorded on the system.

All fields in the system should be completed (including "nil" entries) for all risks.

The system is owned and maintained by the Director of Quality Governance.

Ward/Team Risk Logs are held as hard copies and record the following information only:

- A description of the risk.
- The date is was identified.
- The immediate action taken to address or mitigate the risk.
- The date the risk was discussed by the QuAG or other locality governance group (this must be within 31 days of the risk being identified).
- The outcome of the QuAG or locality group discussion.

4.8 Reporting

4.8.1 **The Board**

The Board shall consider:

(a) The BAF, in its entirety, twice per year (including to report the outcome of the fundamental review following the approval of the Business Plan).

(b) In the intervening months, reports providing:

- A summary of the positions of risks contained in the BAF.
- The profiles for risks contained in the BAF where approval of significant changes is required or those with mitigating actions due/behind plan.
- A schedule (by exception) of mitigating actions behind plan for those risks contained in the Corporate Risk Register.
- Any new strategic risks identified by the Board's Committees or EMT for potential inclusion in the BAF.

4.8.2 **Quality Assurance Committee**

The Committee shall determine the format for the reporting of risk as part of the LMGB reports.

4.8.3 **EMT**

The EMT shall receive and consider quarterly reports on:

(a) The corporate risk register.

(b) The Locality Risk Registers (by exception) including mitigating actions behind plan.

4.8.4 **LMGBs/DMTs/QuAGs**

At each meeting the LMGB/DMT/QuAG (or equivalent) shall receive and consider:

(a) Its own risk register.

(b) For the LMGBs and DMTs (where appropriate) the QuAG or similar level risk registers (by exception) including:

- Any new risks escalated.
- Mitigating actions behind plan.

(c) For the QuAGs, any risks identified by wards and teams through their monthly reports.

(Note: Report templates are available at: intouch/standard work)

4.9 Amending Risk Registers

Changes to a risk register must be approved by the relevant governance group (e.g the Board, LMGB, QuAG, etc).

A formal note must be made of all significant changes in the minutes of the meeting.

Nothing in the above requirements shall prevent a risk owner from escalating a risk in an emergency but the matter should be formally reported to the next meeting of the relevant governance group.

4.10 Risk Escalation & Step Down

The escalation of risks within the governance structure shall be undertaken in accordance with the Assurance and Escalation Framework based on the risk score.

Appropriate assurance groups for escalation/step-down are as follows:

Risk Register	Group for Escalation	Group for Step Down
Corporate	*Board (if there are strategic implications)*	LMGB/DMT
LMGB/DMT	EMT	QuAG (or equivalent)
QuAG	LMGB	Relevant Governance Group/Ward or Team Manager

Ward Team Risk Log	QuAG	-

Risks shall be escalated/stepped down by the risk owner (on the decision/recommendation of the relevant governance group) based on the assessed risk grading (see section 4.5 above).

Risks may also be escalated where it is considered, taking into account the Trust's risk appetite, that the approval of a higher level governance group is required (e.g. an LMGB might wish to seek the views of the EMT prior to accepting a high graded clinical risk).

(Note: see also the Assurance and Escalation Framework on the requirement, and process, to escalate significant issues/concerns directly to the Chief Executive or another Director)

4.11 Risk Transfers

Where a risk is identified in one area, but the appropriate risk owner sits in another Trust area the risk should be discussed at the escalation level (i.e. the level above which it was first identified, entered and scored). The risk owner at that escalation level should then decide whether to discuss the management of the risk with the proposed receiving area or whether to escalate it further.

For example, *a risk identified by a Team manager within MHSOP but which was felt should be transferred to E&FM would be discussed at QuAG. The Head of Service would then decide whether to raise the risk directly with the E&FM Directorate or whether to escalate the issue to Director of Operations level.*

Where a risk is identified in one area, but the appropriate risk owner sits outside of the Trust, the risk should be discussed at the escalation level (i.e. the level above which it was first identified, entered and scored). The senior risk owner at that escalation level should then decide whether to discuss management of the risk with the proposed external risk owner or whether to escalate it further.

4.12 Risk Closure

A governance group (e.g. EMT/LMGB/QuAG) may determine that a risk should be closed (rather than stepped down in accordance with section 4.10) including in the following circumstances:

- The risk has been terminated or transferred (see Appendix 1)
- Mitigating actions have been completed, resulting in the target risk score being achieved, and there is assurance (evidence) that the actions have been successful.
- Changes have occurred that mean the underlying condition creating the risk has disappeared.

The closure of a risk, including the reasons for doing so, shall be recorded in the minutes of the relevant governance group.

5 Definitions

Term	Definition
Annual Governance Statement	An annual statement signed by the Accountable Officer on behalf of the Board that forms part of the Annual Report. The AGS provides public assurances about the effectiveness of the organisation's approach to governance, risk and control.
Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved.
Board Assurance Framework (BAF)	The document which brings together, in one place, all of the relevant information on the risks to the Trust's strategic objectives
Control	A process, policy or procedure which is being used to manage the risk i.e. to prevent, detect and correct an undesired event.
Consequence (impact)	The effect of a risk if it happened.
Gap in assurance	An area where there is insufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives.
Inherent risk	The assessed level of raw or untreated risk i.e. the amount of risk before the application of controls
Likelihood	The probability that the risk will happen
Mitigation/mitigating action	An action to manage or contain a risk to an acceptable level or to reduce the threat of the risk occurring e.g new or strengthened controls, improved assurance arrangements, etc
Positive assurance	Actual evidence that a risk is being reasonably managed and objectives are being achieved e.g. an auditor's report
Risk	Risk is an uncertain event or set of events which, should it/they occur, will have an effect on the achievement of objectives. There must be a genuine possibility that the risk will occur.
Risk appetite	The amount and type of risk that an organisation is willing to accept in order to meet its strategic objectives.
Risk assessment	The systematic approach and processes used to understand and document the threat posed by a risk

Risk grade	An expression of the seriousness of the risk based on the risk score
Risk management	The process by which risk is understood, analysed, addressed and monitored to make sure organisations achieve their objectives.
Risk register	A tool for documenting risks and the actions being taken to mitigate them
Risk score	A numerical value on the quantum of a risk based on its consequence and likelihood.

6 Related documents

The integrated Governance Framework
The Quality Governance Arrangements document
The Assurance and Escalation Framework
The Business Plan
The Corporate Planning Framework
The Performance Management Framework
The Programme Management Framework
The Project Management Framework
As risk controls - all other strategies, frameworks, policies and procedures.

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.
- 1:2:1 coaching will be provided to all Directors and Heads of Service.
- The Board will review and approve the draft BAF (March 2018) taking into account changes to the Trust Business Plan.
- The EMT will consider and approve the draft Corporate Risk Register (February 2018).
- Each LMGB/DMT/QuAG will review their risk registers to reflect this policy and changes arising though the development of their Service Plans (March 2018).

7.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Board Members	Briefing	One to two hours	Three yearly cycle
Directors/Head of	1:2:1 coaching	One hour	On appointment

Service	Group Briefing	Half day	Three yearly cycle
Members of QuAGs	Group Briefing	Half day	Three yearly cycle
Staff identified by Directors/Heads of Service	Coaching (Datix risk management module)	One to two hours	On appointment and thereafter by request

8 How the implementation of this policy will be monitored

An audit of the implementation of the policy will be undertaken by the Nursing and Governance Directorate on behalf of the EMT by the end of April 2018.

The focus of the audit shall be to provide assurance that:

- Risk registers are in place for both EMT and all LMGBs, DMTs and QuAGs.
- Risk logs are in place for all wards/teams.
- The risk registers are held in the approved format.
- Risks are being properly assessed and graded.
- There is evidence of risk escalation/step down etc.
- Reporting of risks is taking place in accordance with this policy.

The EMT will provide a report to the Audit Committee on the outcome of the audit.

Assurance will also be provided by the annual review of the Trust's risk management arrangements in accordance with the Internal Audit Strategy.

The outcomes of the reviews by the EMT and the Internal Auditors will inform the Annual Governance Statement for consideration by the Audit Committee and Board in May 2018.

On an ongoing basis assurance will be provided on the operation of the policy though exception reporting, including progress on mitigating actions, in accordance with section 4.8.

9 Document control

Date of approval:		
Next review date:		
This document replaces:		
Lead:	Name	Title
Members of working party:	Name	Title

This document has been agreed and accepted by: (Director)	Name	Title
This document was approved by:	Name of committee/group	Date
This document was ratified by:	Name of committee/group	Date
An equality analysis was completed on this document on:		

Change record

Version	Date	Amendment details	Status

Appendix 1

Risk Management Framework - Guidance

1 Purpose

1.1 This document provides detailed guidance on the Trust's risk management framework as set out in paragraph 4.3 of the Organisational Risk Management Policy.

1.2 It covers the following matters:

- Establishing the objective
- Identifying risks
- Describing risks
- Accessing risks
- Addressing risks
- Mitigating risks

1.3 A "one page" overview of the risk management model is set out in Annex 1.

2 Establishing the objective

2.1 The Trust's objectives (its Strategic Goals and Priorities) are set out in the Business Plan and supporting Service Plans.

3 Identifying Risks

3.1 **Annual Review:**

The principal risks to the achievement of the Trust's Strategic Goals will be considered, annually, as part of the refresh of the Business Plan. These discussions will form the basis for the review of the Board Assurance Framework.

The LMGBs/DMTs will undertake a review of the risks to the delivery of their service plans, other key operational risks and risks arising from third parties. In doing so the LMGB/DMT will take into account any directions from the EMT and, if appropriate, the views of the SDGs.

The EMT will consider the outcome of the assessment undertaken by the LMGBs/DMTs to refresh the Corporate Risk Register.

3.2 In-year Reviews:

The identification of risk is not limited to an annual review but is also dynamic. During the year risks will also be identified by the Board, EMT, LMGBs, DMTs, etc through both internal and external sources as set out below:

The standard processes set out in the Trust's Quality Governance Arrangements document, including the work of the Specialty Development Groups, daily lean management and relevant policies (e.g.: the External Agency Visits Protocol) support this approach.

The standard report template has also been designed to ensure visibility of risks.

The governance group identifying the risk will undertake an assessment (see (5) below) to determine its inclusion in the appropriate risk register.

4 Describing Risks

The descriptions of all risks should include:

- *A statement on the hazard (what could go wrong)*
- *A statement on the cause*

Care should be taken in framing the description as it will impact on how the risk is assessed and addressed.

5 Assessing Risks

The assessment of risk will tell us how significant the risk is, how well we control the risk and areas where improved control is required. This will enable us to ensure appropriate oversight of the risk within the Trust's governance arrangements.

It is critical that all available information is gathered at the risk identification stage in order to assess the impact and inform the approach to managing the risk.

The Trust uses the following approach to ensure risks are assessed consistently:

- The risk will be rated in terms of consequence and likelihood.
- The ratings are used to determine the Risk Score.
- The risk grade is identified from the Risk Score.

The following assessments of the risk should be undertaken:

- The position if no controls were in place to manage the risk (the "inherent" risk score).
- The position at the time of assessment taking into account the controls in place and their effectiveness (the "present" score).
- An assessment of the position if all reasonable controls were in place and operating effectively (the "target" risk score).

The assessments will be undertaken by the Risk Manager and reported to the next meeting of the Board, LMGB, DMT or QuAG, etc, as appropriate.

However, where a risk is assessed as having a present risk grade of "very high" (risk score 27+) or "high" (risk score 18-25) the Chief Executive or the relevant Director, respectively, should also be notified under the Assurance and Escalation Framework.

5.1 Rating Consequence and Likelihood

Ratings for a risk's consequence and likelihood are as follows:

Categories for Consequence	Rating	Categories of Likelihood	Rating
Negligible	1	Rare	1
Minor	3	Unlikely	2
Moderate	5	Possible	3
Major	7	Likely	4
Catastrophic	9	Almost Certain	5

Descriptions of the above ratings are provided in Annex 2.

Risks can be multifaceted, therefore, the domain providing the highest rating should be used.

5.2 Risk Scores

Risk scores are calculated by multiplying the consequence rating by the likelihood rating:

Likelihood Rating							
	Almost Certain	5	5	15	25	35	45
	Likely	4	4	12	20	28	36
	Possible	3	3	9	15	21	27
	Unlikely	2	2	6	10	14	18
	Rare	1	1	3	5	7	9
			1	3	5	7	9
			Negligible	Minor	Moderate	Major	Catastrophic
			Consequence rating				

5.3 Risk Grades

The Trust has identified four risk levels based on the following risk scores:

Risk Grades	Risk scores	
	From	To
Very High	27	45
High	18	25
Medium	7	15
Low	1	6

Example

An LMGB considers that there is a risk to the future provision of services due to projected staff turnover rates.

The LMGB recognises that the risk could impact on safety, quality, regulatory compliance, human resources and on the Trust's reputation.

Firstly, the LMGB examines the inherent risk. Using the criteria set out in Annex 2 it considers:

- *A score of 7 under the "human resources" domain best describes the potential consequences of the risk .*
- *The likelihood of the risk occurring, if there were no controls, should be scored 4 (likely).*

This provides an inherent risk score of 28 (7x4) - a "very high" risk.

Next the LMGB considers the present level of risk.

It recognises that some controls are in place (e.g. the retire and return policy) or are being implemented (e.g. the recruitment and retention action plan; discussions with staff approaching retirement; actions in response to staff friends and family test results, etc); however, it is aware that some of these actions are ongoing and others are not fully embedded.

Taking into account the criteria in Annex 2 it considers that the consequence score should remain at 7 but the likelihood should be 3 (possible). As this risk is, therefore, "high" it is agreed that it should be accepted for inclusion on the LMGB risk register.

Looking at the target (residual) risk score, the LMGB takes into account the position if all reasonable mitigating actions are fully implemented and embedded in the Locality. Once again the consequence score (7) is unchanged but the likelihood is reduced to 2 (unlikely) providing a target risk score of 14 (medium risk).

6 Addressing the risk

The objective in addressing a risk it to ensure that it does not develop into a problem where its potential impact is realised. It is important at this stage to consider the arrangements (controls) that already exist to manage the risk and whether these are sufficient and are operating effectively (assurance). Having properly identified, then assessed the risk and reviewed current control measures one of the following general approaches (the four Ts') can be selected:

- ***Transfer the risk*** - this might be undertaken through contracting out, service level agreements etc and conventional insurance. These arrangements might transfer some of the risk, but may also give rise to some new ones to manage, e.g. the management of contracts.

- ***Tolerate the risk*** – our ability to take effective action against some risks may be limited, or the cost of taking action may be disproportionate to the benefit gained. If the risk is tolerated a 'watching brief' is required by the risk manager and contingency plans should be developed to address any impact.

  Risks are also tolerated when all of the mitigating actions have been implemented and are shown to be working and there are no further actions that would reduce the risk score.

- ***Treat (control) the risk*** – the majority of risks will be in this category. This will require the implementation of remedial action, setting up of systems, infrastructure, assigning management responsibility, processes, equipment, staffing, training and development, etc. The introduction of new technology or processes of care or service may eliminate the identified risk; however, they could also lead to new risks.

  Advice should be taken, where appropriate on the development of mitigating actions e.g. from a Specialty Development Group or experts in corporate services.

  Care should be taken to frame the mitigating actions so they are outcome focussed. For example a consequence or likelihood score should not be changed as the result of the development or completion of an action plan but on there being assurance that the actions have had their intended effect.

- ***Terminate the risk*** – this is a variation on the 'treat' approach and involves taking quick decisive action to eliminate the risk altogether. This could include restricting or suspending a service until adequate controls are put in place.

To assist in determining the appropriate approach, the risk manager will calculate the target risk score (the risk score if all appropriate and proportionate controls were in place and working effectively).

- If the difference between the present and target risks scores is insignificant it might be appropriate to tolerate the risk depending on its nature.

- If there is a significant difference between the present risk score and the target risk score it might be appropriate to treat, transfer or terminate the risk.

7 Mitigation Plans

Mitigation plans should be developed:

- To close off any gaps in control or assurance.
- To reduce the threat (likelihood and consequence) of the risk.

All mitigations must:

- Include a description of the planned action, a due date and identify an individual responsible for delivering the action.
- Be outcome focussed and directly related to the threat.
- Be approved (together with any resource implications) by the appropriate governance group for the risk (EMT/LMGB/DMT, QuAG, etc)

Monitoring of the delivery of mitigating actions will be undertaken through usual reporting arrangements (see section 4.8 of the main policy).

A mitigating action should not be closed unless the risk manager has assurance that it has been completed.

The completion of a mitigating action should trigger a review of the risk score; however, care should be taken to ensure that, before making any changes, the action has had its intended outcome.

Risk 'One Pager' **Annex 1**

Principles: *Transparent, Co-ordinated, Knowledge and Learning and Effective*

Identify the Risks	Assess the Risks	Address the Risks	Report, Monitor and Review on the Risks
• Objective driven: Relate risks to the impact they will have on Trust/service objectives, standards, patient care or mandatory requirements. • Hazards, threats and risk: something that may have an impact on the achievement of objectives, the organisation, staff or patients. • Hazard/risk types: Clinical, service objectives/standards, project, reputation, strategic partner, strategic, staff, patient safety, compliance/targets, integrated working, property • Gathering intelligence: Through horizon scanning (forward-looking research identifying tomorrows risks and getting better prepared, patient information, incident information, near-miss reporting, incidents and events in the NHS	• Impact/consequences: Quality/objectives and targets, injury and ill health, finance and resources, reputation/publicity, litigation • Risk rating: the classification of each risk based on multiplying the potential impact/consequences by the likelihood of it occurring. • Uncertainty: some risks will have uncertain impact/consequence and likelihood. Seek help with these and remember our key principles and desire to be transparent.	The four 'Ts'' • Transfer: Passing the risk on to someone outside the Trust. • Tolerate: Watch the risk to ensure that its likelihood or impact doesn't change and that existing controls are effective. • Treat: (controls): Plan and implement a series of actions to bring the risk down to an acceptable level, e.g. care plan, procedures, policy, standards, training, education, revised working arrangements. • Terminate: Take quick decisive action to remove the risk, e.g. case review, crisis meeting. • Existing Control Measures: The measures already in place to mange the risk. Make sure these are effective and monitor. • Contingency: An action or arrangement that can be put into place to minimise the impact of a risk when is has gone wrong or is about to.	• Risk Register: Information about the risks at strategic level and service level. Has to be prepared and monitored regularly. The register indicates the risk, existing control measure, risk owner, impact and likelihood, action to be taken, and contingencies. • **K**ey risks to the delivery of the Trusts Strategic Direction (the BAF) are kept under regular review by the Board of Directors • Reporting: Informing key stakeholders internal and external about the risk we have identified, our arrangements that exist to manage these and any action to improve control.

Know your Role and Responsibility

Annex 2

Risk Ratings

Descriptions of Consequence Ratings:

Assessments should be made against all relevant domains. The score for the domain with the highest consequence should be used to calculate the risk score.

	Consequence ratings (severity levels) and examples of descriptors				
	1	**3**	**5**	7	**9**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Formal complaint (stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	Consequence ratings (severity levels) and examples of descriptors				
	1	3	5	7	9
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ regulatory	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

	Consequence ratings (severity levels) and examples of descriptors				
	1	**3**	**5**	7	**9**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
	environment				
Personal Data Security	-	Potentially serious breach but risk assessed as low e.g. files were encrypted	Serious breach and risk assessed as high (e.g unencrypted data). Non-clinical data	Serious breach and risk assessed as high (e.g unencrypted data) Clinical Data	Serious breach with likelihood that the ICO will take formal action against the Trust.

Descriptions of Likelihood Ratings:

Likelihood ratings can be determined using either the potential frequency or probability of the risk occurring.

Likelihood rating	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Chance of the risk happening	<5%	5% - 20%	20% - 50%	50-80%	.>80%

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th January 2018**
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:	**30th January 2018**
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
322	28.11.17	Project manager collateral warranty in relation to Beckwith Head Road	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
323	28.11.17	Counterpart lease of premises at The Woodside Resource Centre, Marton Road, Middlesbrough	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
324	28.11.17	Licence to underlet premises relating to The Woodside Resource Centre, Marton Road, Middlesbrough	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
325	6.12.17	Lease of office premises at The Friarage Hospital, Northallerton	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
326	21.12.17	Appointment agreement for landscape design services in relation to the York inpatient development	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary

327	21.12.17	Deed of variation of the transfer agreement relating to land at Beckwith Head Road, Harrogate	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
328	16.1.18	TP1 form (Transfer of Part of Registered Title) relating to land at Belle Vue Grove, Middlesbrough	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
329	16.1.18	Contract for collaboration agreement relating to a clinical practitioner service offer.	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register