AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 28TH FEBRUARY 2017 VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting of the Board of Directors held on **31st January 2017**.		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 8	To consider the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**

Performance (11.10 am)

Item 9	To consider the Finance Report as at 31st January 2017.	**DK**	**Attached**
Item 10	To consider the Trust Performance Dashboard as at 31st January 2017.	**SP**	**Attached**
Item 11	To consider the Strategic Direction Performance Report for Quarter 3, 2016/17.	**SP**	**Attached**

Items for Information (11.30 am)

Item 12	To receive and note a report on the use of the Trust's seal.	**CM**	**Attached**
Item 13	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 14 To note that the next meeting of the Board of Directors will be held on Tuesday **28th March 2017** in the Board Room, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.35 am)

Item 15 **The Chairman to move:**

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

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

Information 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.

Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
22nd February 2017

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 31ST JANUARY 2017 IN THE DURHAM CENTRE, BELMONT INDUSTRIAL ESTATE, DURHAM AT 9.30 AM

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

In Attendance:
Mr. C. Watson, Inspection Manager, Care Quality Commission
Mr. P. Scott, Director of Operations for County Durham and Darlington (minute 17/06 refers)
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Ms. D. Oliver, Deputy Trust Secretary (Corporate)

Ms. Z. Khalifa, Ms. A. Phillips, Ms. D. Potter, Ms. L. Stafford and Ms. K. Wall, student nurses.

17/01 MINUTES

Agreed *– that the public minutes of the last ordinary meeting held on 29th November 2016 and the special meeting held on 20th December 2016 be approved as correct records and signed by the Chairman.*

17/02 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Further to minute 16/121 (21/5/16) the Board supported Mr. Kilmurray's proposal that, instead of providing a briefing to a Board Seminar (which was impracticable due to changes to the overall programme), a separate event should be arranged to update Directors and stakeholders on the Trust's progress on recovery and its future plans. In doing so Board Members:

(1) Asked for the event to be held before the end of March 2017.
(2) Suggested that the Chief Officers of the CCGs should be invited to attend.

Action: Mr. Kilmurray

17/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/04 CHAIRMAN'S REPORT

The Chairman reported on the discussions at the Governor Development Day held on 24th January 2017.

The Board noted that:

(1) There had been particular interest in the briefing provided on the recovery programme.

It was noted that a Governor had been asked to put his concerns, raised at the event, about the Trust's approach to recovery in writing and he would be invited to a meeting with the Chairman, Trust Secretary and Deputy Trust Secretary / Head of Members Services to further discuss them.

(2) A Governor had also raised the issue of cancelled leave in forensic services.

Mrs. Bessant advised that, although there had been an overall improvement in the provision of leave, the Governor had highlighted instances where the cancellation of leave could impact disproportionately on a particular ward or individual patient.

It was noted that Mr. Buckley (Director of Operations) and Dr. Khouja (Deputy Medical Director) had been asked to examine the provision of leave from this perspective in the next report of the Forensic Services' Locality Management and Governance Board to the Quality Assurance Committee.

Mrs. Bessant also advised that she was due to hold the next of her regular meetings with the Public Governors on 23rd February 2017 and asked Board Members to provide her with information on any relevant issues.

17/05 GOVERNOR ISSUES

This matter was dealt with in conjunction with minute 17/04 above.

17/06 LOCALITY BRIEFING – COUNTY DURHAM AND DARLINGTON

Mr. Scott (Director of Operations) gave a presentation on the key issues facing the County Durham and Darlington Locality.

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

In its discussions the Board explored:

(1) The key areas of concern to the Locality.

Mr. Scott advised that workforce issues within inpatient services were his greatest concern. These concerns were not only in relation to having sufficient, appropriately trained and skilled staff to deliver the services but also in relation to ensuring staff were meaningfully engaged and that there was capacity to provide high quality care and to deliver improvements.

He considered that to fully understand the issues, and to deliver absolute quality, it was necessary for the Locality to have the same level of detail for its inpatient services as was available for community services through the Purposeful and Productive Community Services (PPCS) programme.

(2) Significant improvements which had been made in the Locality.

The Board noted that Mr. Scott, whilst recognising pressures remained, was particularly proud of the improvements to children and young people's services (C&YPS) over the last year.

(3) The Locality's role in the delivery of STP priorities.

Mrs. Pickering advised that the STP core priorities for mental health were focussed at the local, rather than footprint, level and, through its work on community hubs and other service developments, the Locality was contributing to their delivery.

Mr. Martin reported that the Accountable Care Partnership (which he jointly chaired with the Chief Officer of North Durham CCG) was clear about the need to implement the STP priorities at the local level.

(4) The potential risks to the continued provision of integrated services arising from recent changes to the senior management within the social services department of Durham County Council.

Mr. Scott recognised that there were potential risks and, to seek to mitigate them, the Locality had:

(a) Sought confirmation from the Locality Authority that it had no motivation to move away from the partnership arrangements.
(b) Recognised that to be sustainable the integrated arrangements needed to continue to deliver improvements and add value.

He advised that some tensions had arisen between the two organisations, in relation to the PPCS programme and engagement on some pathways, but, overall, the County Council appeared to remain committed to the continued operation of the integrated arrangements.

(5) The further developments to be taken forward though the West Park review.

Mr. Scott highlighted two key elements as follows:

(a) Improving the visibility of, and leadership from, the senior team at the Hospital and mobilising other staff to provide leadership.

(b) Making improvements to the environment to transform the experience of people receiving services and their families.

(6) The Locality's approach to further developing service user and carer engagement.

The Board noted that:

(a) Whilst there was a lot of passion and commitment, there was also recognition that to support buy-in and shared ownership the Locality needed to further develop its own identity; its understanding of involvement in the context of its governance arrangements; and its understanding of the needs of people working with the organisation.

(b) There was a sense that present arrangements were quite traditional and that, although relationships were strong, there were variations across the Locality.

(7) The attrition rate of staff recruited through recruitment fairs.

Mr. Levy drew attention to the information provided in the Workforce Report on this matter (see minute 17/13 below).

The Chairman:

(1) Congratulated Mr. Scott on the improvements he had made to the operation of the Locality since coming into post 12 months ago.

(2) Asked Mr. Scott to pass on the Board's appreciation to the staff in the Locality for their hard work.

17/07 NURSE STAFFING REPORT

The Board received and noted the six monthly review report, for the period 1st June 2016 to 30th November 2016, 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 National Quality Board (NQB) guidance.

The Non-Executive Directors raised the following matters:

(1) The reduction of 5.40 WTE registered nurses as a result of the closure of Picktree Ward at a time when the recruitment and retention of nurses presented a significant risk to the Trust.

Mr. Kilmurray responded that the nett reduction correlated to changes in the bed complement and nurses from the ward had been successfully redeployed to backfill existing vacancies.

Mrs. Pickering, noting that the closure of Picktree Ward was a Business Plan priority, considered that it would be beneficial, in terms of assurance, for the nurse staffing reports to identify whether or not staffing changes were planned and offered to work with Mrs. Moody on this matter.

Action: Mrs. Moody and Mrs. Pickering

(2) The challenges, in terms of reporting, of the proposal to extend the safe staffing programme to cover community services and multi-disciplinary working in line with expected service specific guidance from the NQB.

In response Mrs. Moody:

(a) Recognised that greater use of dashboards and exception reporting would be required.
(b) Advised that there were no plans to provide 'planned versus actual' tables on staffing for each community service at this time.
(c) Considered that the assurances available to the Board should increase as the work undertaken through the workforce work stream of the PPCS programme developed.

Board Members highlighted their concerns that:

(a) The triangulation of quality and safe staffing data would be difficult as the Trust was not responsible for all aspects of service users' lives in the community.
(b) The productivity improvements sought through the PPCS programme would make it more difficult for services to respond to unforeseen activity, going forward, and work was required on how the matter of flexible staffing in the community should be addressed.

Mrs. Moody suggested that it would be appropriate for this issue to be monitored through the inclusion of a metric in the safe staffing dashboard for community services.

(3) Whether enhanced observations to prevent falls was having unintended consequences as, based on feedback received during a Directors' visit, there were concerns that staff had to be close enough to intervene but their proximity was contributing to increased challenging behaviour from some patients.

Mrs. Moody explained that:

(a) Although the Trust had introduced the "falls CLiP" the number of falls was increasing.
(b) The work being undertaken as part of the Quality Account priority on reducing the occurrences of serious harm resulting from falls should improve the Trust's understanding and inform its future approach to preventing falls.
(c) The use of zonal observation, introduced under the revised Harm Minimisation Policy, might mitigate the risks highlighted during the Directors' visit.

(4) Whether work was being undertaken to ensure ward environments in MHSOP were appropriate in response to patients living longer and being fitter than previously.

The Board noted that:

(a) The issue was one of the reasons why patients had been moved from Westerdale South to Westerdale North.

(b) The MHSOP Specialty Development Group had carried out a gap analysis of the Trust's position against the Stirling dementia design guidelines and a programme of work was being undertaken to incrementally address its findings.

The Chairman asked for a briefing to be provided to the Board on this matter.

Action: Mr. Kilmurray

(5) The requirement, identified in the report, to undertake a further analysis of 'enhanced observations' to fully understand the level of clinical need and practices at ward level and to seek an effective solution to bank usage.

In relation to this matter, the Non-Executive Directors, reflecting on their visits to services and the variations between specialties, questioned the extent that the need for 'enhanced observations' could be planned.

In response it was noted that:

(a) The use of staff for 'enhanced observations' was usually unplanned.

(b) Through the establishment review, as part of the safe staffing programme, work was being undertaken to seek to understand and predict the requirement for 'enhanced observations'; however, it was recognised that some variation was inevitable e.g. there was more scope to manage staff across wards on the Trust's main hospital sites than in isolated units.

(c) From this work consideration would be given to whether the baseline staffing establishments of some wards should be increased to reflect the need for 'enhanced observations'.

Dr. Land considered that a tiered, ward by ward, approach to providing additional staff for 'enhanced observations' was required.

He also observed that:

(a) There were very few barriers to services bringing in additional staff and this supported patient safety.

(b) The work being undertaken to embed positive behavioural support, harm minimisation and recovery should assist services recognise that there might be better ways to keep patients safe than to deploy additional staff.

The Board also noted that some additional staffing was required for specific packages of care and this explained the spike in 'enhanced observations' in September 2016.

Mrs. Moody took on board a suggestion that 'enhanced observations' linked to specific packages of care should be shown separately in future reports.

Action: Mrs. Moody

(6) The incidence of missed breaks 'not given' compared to those 'not taken'.

The Board noted that evidence of the reasons why staff were not taking breaks was being sought; however, overall, the number of missed breaks had reduced in recent months. It was also noted that this issue was being closely managed by the Localities.

(7) With regard to the information provided in the interim safe staffing dashboard (Appendix 6 to the report):

(a) The use of overtime as levels were higher than expected and it was understood that it should only be used as a last resort.

Concerns were also raised about the contribution of overtime, coupled with the Trust's 12 hour shift system, to sickness absence rates.

In relation to this matter:

- Mr. Kilmurray recognised that the data raised concerns and the use of overtime needed to be revisited.
- Mrs. Moody advised that the safe staffing group had discussed the introduction of a "red rule" to limit the number of hours worked by individual staff.

(b) The number of incidents relating to pressure ulcers.

The Board noted that:

- The number of pressure ulcers had increased since the last six monthly nurse staffing report.
- All pressure ulcers were reported as incidents and assessed for appropriate treatment by the tissue viability nurse.
- Whilst it was not possible to draw any meaningful conclusions, the data supported the need to further review levels of clinical activity and safe nursing indicators across MHSOP.

(c) The 22 reported incidents of medication errors at Lustrum Vale.

Mrs. Moody:

- Advised that all incidents of medication errors were reviewed.
- Undertook to seek further assurance on this matter including that there were no trends relating to individual members of staff.

Action: Mrs. Moody

(d) How assurance was gained on escalation processes as, in many cases, there might not be a clear correlation between an incident and staffing availability.

The Board noted that it was difficult to provide positive assurance on the operation of escalation processes; however, ward managers considered the new process was clear and provided greater consistency in reporting.

(e) How the impact of staffing levels on complaints and SIs was assessed.

Mrs. Moody responded that, at present, although the direct impact of staffing levels and availability of staff was considered, the level was analysis was still rather crude and the Trust was working towards having a series of headings which could be used to theme and log issues.

Mrs. Moody also reported that, in response to the discussions on the presentation of the quality metrics under minute 16/285 (29/11/16), a severity score was being developed which would be used to rank wards in the Appendix on "Scored Fill Rate compared to Quality Indicators" in future monthly nurse staffing reports.

(8) The timescale for reporting against the national metric "care hours per patient day".

Mrs. Moody advised that reporting to the Board against the metric was expected to commence in May 2017; however, the data provided would be subject to "health warnings" as the metric had not been tested in a mental health setting.

In addition Mr. Levy reported that the sickness absence rate in inpatient services was approximately 1% - 2% higher than in community services and this was cited as one of the reasons for wards having low fill rates.

The Board supported the work being undertaken to examine whether there was a link between bank and agency usage and higher sickness absence rates.

17/08 RECOVERY AND WELLBEING STRATEGY 2017 - 2020

Consideration was given to the Recovery and Wellbeing Strategy 2017 – 2020.

Mr. Kilmurray advised that a scorecard supporting the Strategy was being prepared and was due to be presented to the EMT for approval by the end of March 2017.

At his suggestion, it was agreed that the scorecard should be signed off by the Board.

Action: Mr. Kilmurray

The Chairman considered that it would be beneficial to include a statement within the Strategy to demonstrate organisational commitment to recovery; to emphasise that recovery was central to the achievement of the Trust's Strategic Direction; and to recognise that structures and processes needed to be aligned to its delivery.

This was taken on board.

Action: Mr. Kilmurray

In addition, Board Members:

(1) Emphasised the importance of carers in supporting recovery.

With regard to this matter:

(a) Mr. Kilmurray assured the Board that engagement with carers was a priority of the next phase of the recovery programme.

(b) Mrs. Moody suggested that a metric developed by the Triangle of Care Steering Group, on the extent carers were listened to and heard, might be appropriate for inclusion in the scorecard.

(c) The Non-Executive Directors highlighted the benefits of providing training to carers so that they understood what they needed to do to support recovery.

Mr. Kilmurray responded that training opportunities were available through the recovery college and these would be expanded through the establishment of the Virtual Recovery College.

However, it was noted that further thought needed to be given to the alignment of the Recovery Strategy and the work being undertaken on the Triangle of Care in relation to this matter.

Action: Mr. Kilmurray and Mrs. Moody

(2) Sought clarity on the reporting arrangements for the scorecard.

It was noted that reports would be provided to the EMT, in the monthly report on strategic projects, and to the Board through the quarterly Strategic Direction Performance reports.

(3) Highlighted potential tension between coproduction in the development of individual care plans, a core value and principle of recovery, and the focus on standardisation through the PPCS programme.

Mr. Kilmurray responded that the “purposeful” element of the PPCS programme related to supporting individual patients attain their goals. The changes to the operating model and skill mix of community teams to deliver this through the PPCS programme and the cultural changes being sought through the Recovery Strategy were, therefore, aligned and contributed to the delivery of the Trust’s Mission.

(4) Sought clarity on the resources made available for the delivery of the Strategy.

The Board noted that the implementation of the Strategy, which was being taken forward through a programme management approach, had two key elements:

(a) A central recovery team, which included additional resources agreed by the EMT, to deliver core work streams.

(b) Influencing the embedding of recovery through other strategic projects / programmes e.g. PPCS, PIPA/Model Ward, safe staffing, etc.

(5) Emphasised the importance of embedding recovery within the Trust’s ways of working e.g. to ensure the recovery principles were taken into account in all projects and developments.

Mr. Kilmurray:
(a) Assured the Board that this was already happening and would continue.
(b) Advised that, as discussed at the Board Business Planning Event in October 2016, recovery underpinned all the Trust's priorities and work was being undertaken, through the development of the programme management approach, to better co-ordinate them.

(6) Highlighted the importance of spirituality to recovery; the topic of a conference being organised by the Trust later in the year.

(7) Sought clarity on the actions being taken by the Trust to build resilience and support people manage their own mental wellbeing.

It was noted that:
(a) The issue had been discussed by the Health and Wellbeing Boards.
(b) The Trust had put in place a number of initiatives including the mindfulness project and work in schools in the York and Selby Locality which was starting to be replicated in other areas.
(c) Overall there was a growing emphasis on prevention.

Agreed –
(1) that the Recovery and Wellbeing Strategy 2017-2020, as amended, be approved; and
(2) that the strategy scorecard be presented to the Board for approval by the end of March 2017.

Action: Mr. Kilmurray

17/09 WAITING TIMES IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Further to minute 16/219 (27/9/16), the Board received and noted a progress report on action taken to minimise waiting times for children and young people accessing the Trust's child and adolescent mental health services (CAMHS).

The focus of discussions was on the summary of waiting times and investment by Locality provided in Appendix 1 to the report.

With regard to this matter the Board noted the significant variation in funding between the Teesside Locality (£10,757,749 pa) and the North Yorkshire and York and Selby Localities (£4,404,806 pa and £2,821,511 pa respectively).

It was noted that the relatively low levels of funding in North Yorkshire and York and Selby:
(1) Constrained the services' ability to cope with unforeseen events (e.g. staff sickness) and to release staff to attend training.
(2) Was reflected in the levels of stress reported by staff in the service in York and Selby during a recent Directors' visit.
(3) Contributed to the very high levels of emergency referrals in Harrogate and Scarborough.

Dr. Land advised that the levels of emergency referrals in these areas, and the consequential impact on the services' ability to undertake positive work, had been and would continue to be raised with the CCGs.

(4) Made it difficult to access some additional national funding due to the CCGs not being able to provide required match funding.

Mrs. Pickering observed that the new care model in tertiary care for tier 4 CAMHS provided opportunities for the Trust to seek to address funding inequalities.

In response to a question it was noted that the "other income" in 2016/17 in the summary of CAMHS funding by Locality and by funding source in section 3.5.1 of the report related to "looked after children".

The Non-Executive Directors also sought further information on the GP early intervention pilot scheme to support the reduction of waiting lists which was being supported by the three CCGs in North Yorkshire following a successful bid to access short term funding via national non-recurring monies.

Mr. Kilmurray responded that no further information was available at present as the initiative had only commenced earlier in the month and an evaluation would not be undertaken until March 2017.

Overall the Board recognised that, although improvements in waiting times had been achieved, the position remained fragile and it was important for the Trust's focus in this area to be maintained. On the suggestion of the Chairman it was therefore:

Agreed -

(1) that a further report on waiting times in CAMHS be provided to the Board at its meeting to be held 20th July 2017;

(2) that the report provide information on the Trust's position against the national reporting requirements being introduced by NHS England.

Action: Mr. Kilmurray

17/10 SUMMARY FINANCE REPORT AS AT 31ST DECEMBER 2016

Consideration was given to the summary Finance Report as at 31st December 2016 including the Trust's Quarter 3, 2016/17, submission to NHS Improvement.

It was noted that, although the Trust's financial position was £2,261k ahead of plan, this was due, in the main, to non-recurrent factors e.g. a refund of historic National Insurance payments linked to widening access trainees.

The Non-Executive Directors considered that care was needed in how this matter was communicated within the Trust in the context of the continuing requirement for services to make CRES savings.

***Agreed** – that the Trust's Quarter 3, 2016/17 submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*

Action: Mr. Kendall

17/11 PERFORMANCE DASHBOARD AS AT 31ST DECEMBER 2016

The Board received and noted the Performance Dashboard Report as at 31st December 2016.

It was noted that, in the Summary Trust Dashboard, the 2016/17 target for the metric "cash against plan" was incorrectly stated.

Board Members sought clarity on the reasons why the Trust had breached NHS Improvement (NHSI) targets for the metrics "Admissions should have assessment by crisis resolution team prior to admission" and "Patients on CPA who are discharged from acute ward should be followed up within 7 days" in November and December 2016 respectively.

Mrs. Pickering responded that:

(1) The breaches represented the first time that NHSI standards had not been met, in month, at a Trustwide level.
(2) Notwithstanding the breaches, the Trust had met the operational performance targets required by NHSI for Quarter 3, 2016/17.
(3) The reasons for the breaches were being investigated; however, it was apparent that some unusual circumstances had contributed to them e.g. a patient had gone abroad on holiday immediately after discharge and could not be followed up within the target time.

17/12 PERFORMANCE DASHBOARD TARGETS 2017/18

Further to minute 16/C/270 (25/10/16) and on the recommendation of the Executive Management Team, consideration was given to the targets for the key performance indicators included in the 2017/18 Performance Dashboard.

Agreed –

(1) that the targets for the key performance indicators included in the 2017/18 Performance Dashboard, as set out in Appendix A to the report, be approved subject to:

- *(a) the target for KPI 5 ("Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months") being a 10% reduction on that for 2016/17;*
- *(b) the target for KPI 10 ("Percentage of patients surveyed reporting their overall experience as excellent or good") be to maintain the 2016/17 outturn position;*
- *(c) the definition of KPI 9 (out of locality admissions) being aligned to that supporting the new national reporting requirement for "Out of Area Placements";*
- *(d) the definition of KPI 17 (mandatory and statutory training) being expanded to cover all mandatory and statutory training;*
- *(e) the setting of the targets for KPIs 9 and 17 being deferred to enable the impact of the changes to the definitions of those metrics to be reviewed;*

(2) that the further work being undertaken on the development of the two outcome indicators, as set out in the report, be noted; and

(3) *that the intention to undertake a review of the Performance Dashboard targets in July 2017 be noted.*

Action: Mrs. Pickering

17/13 QUARTERLY WORKFORCE REPORT

The Board received and noted the Workforce Report for the period October to December 2016 including:

(1) Information about the non-medical workforce (Appendix 1 to the report).
(2) Information about the medical workforce (Appendix 2 to the report).

Arising from the report:

(1) Further to minute 17/06 above, Mr. Levy reported that the attrition rates from recruitment fairs organised by the Trust were far lower than those for events organised by third parties.

He advised that, following the next couple of recruitment events, a stock take of recruitment activity, including that for AHPs and medical staff, would be undertaken.

Action: Mr. Levy

(2) Dr. Land highlighted that difficulties, nationally, in recruiting consultants was increasing competition with some neighbouring Trusts now offering recruitment premia. He considered that the Trust needed to reflect on the action it could take in response to this.

Board Members expressed concerns that compliance with mandatory training was deteriorating.

Mr. Levy recognised that, overall, the position was deteriorating but considered that the Trust's understanding of, and confidence in, the data on mandatory training had improved in recent months.

At the request of the Chairman, Mr. Levy undertook to review the indicators included in the key performance summary dashboard and to reformat the document to ensure consistency with other dashboards.

Action: Mr. Levy

The Non-Executive Directors highlighted that the statement in Appendix 2 to the report that "it's quite evident that North Yorkshire and York and Selby highly favour European doctors" could be misinterpreted as suggesting potential discriminatory behaviour.

Dr. Land recognised that the statement was unfortunate but provided assurance that it merely reflected the ethnicity of consultants across the Localities.

17/14 SINGLE OVERSIGHT FRAMEWORK

Consideration was given to a report which examined the data available to support internal monitoring of the Trust's position against the performance requirements of NHS Improvement's Single Oversight Framework (SOF).

Notwithstanding the difficulties in providing assurance on the Trust's position against the requirements of the SOF, as detailed in the report, the Board considered that it would be worthwhile for it to receive regular reports on this matter.

It was therefore:

Agreed *– that performance against the themes included in the Single Oversight Framework be reported:*
(1) By exception in the monthly Performance Dashboard reports.
(2) Through quarterly reporting.

Action: Mrs. Pickering and Mr. Bellas

17/15 USE OF THE TRUST SEAL

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

17/16 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

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

17/17 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting of the Board of Directors would be held, in public, at 9.30 am on Tuesday 28th February 2017 in the Board Room, West Park Hospital Darlington.

17/18 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).

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

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

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Durham and Darlington Locality
An Interesting Year

Patrick Scott

Director of Operations

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Themes

" Sort performance and Create an identity"

- Redefining the Team
- Create a line of sight
- Engagement with the external world
- Performance + Efficiency + Continuous Improvement
- Keeping the people we serve at the centre of everything we do

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- System leadership for CYPS - building on the success - bespoke package of care
- Organic centre of excellence, and beyond…
- West Park transformation programme
- Pathways / Performance / Leadership
- Service user and carer engagement in service governance

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work

- PPCS
  - 'Emperors new clothes' to transformational vehicle for change
- QIS
  - More relevant and important than ever
  - Daily Lean Management

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Locality Head of Nursing leading workforce plan; Recruit, Retain, Develop and Engage
- Challenges and opportunities
  - Medical staffing
  - Safer staffing - broadest sense
  - Talent management - embedding within locality

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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
- 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

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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
  - Much improved position from last year! Forecast a surplus! But……..
  - Flexible staffing
  - CRES
  - Contractual arrangements
- LMGB
  - Embedding lessons from CQC and other external inspections, internal and external reviews and feedback from users, carers, stakeholders etc.
  - QuAGs managing broad range of issues

making a difference together

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th February 2017**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

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

Date	Minute No.	Action	Owner(s)	Timescale	Status
24/05/2016	16/123	A briefing on human rights to be provided to a future Board Seminar	DL/PB	Mar-17	
21/07/2016	16/176	A briefing on pathways to be provided to a Board Seminar	BK/PB	Apr-17	
27/09/2016	16/218	Automatic reporting of seclusion from the PARIS system to be urgently addressed	DK	Jun-17	
25/10/2016	16/258	The existing international links of local universities to support overseas medical recruitment to be explored	NL	Feb-17	
29/11/2016	16/284	Report to be provided to assure the Board on future bed capacity taking into account the developments planned in Harrogate and York and the impact of work to reduce bed pressures	BK	Mar-17	
29/11/2016	16/285	The information provided in Appendix 2 to the Nurse Staffing Reports (Scored Fill Rate compared to Quality Indicators) to be listed based on the quality indicators rather than alphabetically	EM	Feb-17	See Agenda Item 7
29/11/2016	16/286	The significant variation between services in relation to nurse placement activities to be looked into	EM/DL	Mar-17	
29/11/2016	16/286	A more refined approach to nurse recruitment focussed on experience as well as numbers to be looked into	DL	May-17	

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/11/2016	16/286	A progress report to be provided to the Board on the Recruitment and Retention Action Plan	DL	May-17	
29/11/2016	16/289	A report to be provided to the Board on the proposed values consultation in early summer 2017 prior to its launch	DL	Jun-17	
29/11/2016	16/289	A report on the findings of the values consultation exercise to be provided to the Board	DL	Mar-18	
29/11/2016	16/289	Team based culture metrics reports to be introduced	DL	Nov-17	
29/11/2016	16/290	Subject to the EMT being assured that sufficient resources are available to support the process, the Trust seek re-accreditation under the Investors in People scheme	DL	Nov-17	
29/11/2016	16/293	A briefing to be provided to a Board Seminar on Teepa Snow's "Positive Approach to Care for people living with Dementia"	CM	Mar-17	
20/12/2016	16/311	Further work to be undertaken on the reporting and presentation of assurances in relation to the Quality Strategy	EM	Mar-17	
20/12/2016	16/312	Opportunities to develop RMNs to take responsibility in a learning disability setting to mitigate the lack of specialist nurses for this speciality to be looked into	EM	Apr-17	
20/12/2016	16/312	A report to be provided to the QuAC detailing the proportion of experienced nursing staff versus those on preceptorship on each ward in forensic services	EM	Mar-17	
20/12/2016	16/313	The operation of the Resources Committee to be reviewed in 12 months or sooner if issues arise	PB	Dec-17	
31/01/2017	17/02	An event to be arranged to update Directors and key stakeholders, including the Chief Officers of the CCGs, on the Trust's progress on recovery and future plans	BK	Mar-17	
31/01/2017	17/07	Work to be undertaken to enable staffing changes in response to Business Plan priorities to be identified in future nurse staffing reports	EM/SP	Feb-17	Verbal update to be provided at the meeting

Date	Minute No.	Action	Owner(s)	Timescale	Status
31/01/2017	17/07	A briefing to be provided to the Board on the Trust's position against the Stirling dementia design guidelines and the Trust's programme of work to address the gaps identified	BK	Apr-17	
31/01/2017	17/07	Enhanced observations linked to specific packages of care to be identified in nurse staffing reports	EM	Mar-17	
31/01/2017	17/07	Further assurance to be sought in relation to the incidents of medication errors at Lustrum Vale including that there were no trends relating to individual staff	EM	Feb-17	Verbal update to be provided at the meeting
31/01/2017	17/08	The scorecard to support the Recovery Strategy to be signed off by the Board	BK	Mar-17	
31/01/2017	17/08	A statement to be included in the Recovery Strategy to demonstrate organisational commitment to recovery; to emphasise that recovery was central to the achievement of the Trust's Strategic Direction; and to recognise that structures and processes need to be aligned to its delivery	BK	Mar-17	
31/01/2017	17/08	Further thought to be given to the alignment of the Recovery Strategy and the work being undertaken on the Triangle of Care in relation to carer training	BK/EM	Mar-17	
31/01/2017	17/08	Approval of the Recovery and Wellbeing Strategy, as amended, 2017-2020	BK	-	Approved
31/01/2017	17/09	A further report on waiting times in CAMHS, including the Trust's position against the national reporting requirements being introduced by NHS England, to be presented to the Board	BK	Jul-17	
31/01/2017	17/09	Approval of the Quarter 3, 2016/17 submission to NHS Improvement	DK	-	Approved
31/01/2017	17/12	Approval of the Trust Performance Dashboard targets for 2017/18 subject to: - Changes to the definitions of KPIs 9 and 17 - Deferral of setting the targets for KPIs 9 and 17 to enable the impact of the changes to the definitions to be reviewed	SP	-	Approved

Date	Minute No.	Action	Owner(s)	Timescale	Status
31/01/2017	17/12	A review of the Trust Performance Dashboard targets to be undertaken	SP	Jul-17	
31/01/2017	17/13	A stock take of recruitment activity, including in relation to AHPs and medical staff, to be undertaken	DL	May-17	
31/01/2017	17/13	The indicators included in, and the format of, the summary workforce dashboard to be reviewed	DL	Apr-17	
31/01/2017	17/14	Approval of reporting arrangements against the requirements of the Single Oversight Framework	SP/PB	-	Approved

Item 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 28 February 2017**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Assurance statement pertaining to QuAC meeting held on 02 February 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 Tees and Durham & Darlington, where key concerns were around recruitment (nursing and medical), placement availability for complex young people and increased activity in CYPS services.
- Updates from the Patient Safety Group, Patient Experience Group and the Quality account quarterly update.
- CQC compliance and Safeguarding and Public Protection assurance updates.
- Governance matters were considered and noted through assurance, with reports from the Drug and Therapeutics Committee and the Workforce report.
- It was agreed that the matter of medical staff recruitment should be a separate strategic risk (rather than included in the generic recruitment risk) and this would be escalated to the Board for consideration.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 02 February 2017.

- Note the confirmed minutes of the meeting held on 01 December 2016 (appendix 1).
- Be recommended to include a separate strategic risk relating to medical recruitment in its chapter of the integrated assurance framework and risk register.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 28 February 2017**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 02 February 2017.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from Tees and Durham and Darlington localities.

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

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

4.1 **TEES LMGB** – where key issues raised were:

1. Lack of nursing home provision for older people and people with learning disability despite discussions with providers and commissioners in Hartlepool.
2. Recruitment, particularly consultant medical staff.
3. The difficulties finding a placement for an 18 year old male from Newcastle, currently in Westwood, due to lack of funding from commissioners.

4.2 **DURHAM & DARLINGTON LMGB** - where key issues raised were:

1. High numbers of vacancies of both clinical and non-clinical staff across all services. The locality Head of Nursing was developing a workforce plan and would be linking into Trust initiatives for additional support.
   Medical recruitment had been identified previously on the Trust risk register as a separate risk but later had been combined into the strategic risk relating to the recruitment and retention of all staff groups. It was agreed by the Quality Assurance

Committee that in view of the growing pressures across all localities this issue should be escalated to the Board of Directors as a risk in its own right.

2. The ongoing management of violent and aggressive patients. This issue has been escalated through the Senior Clinical Director and the Service Development Group as it continues to cause concern. The numbers of incidents which require support from the Police continue to increase and this leads to increased concerns for staff and patient safety at these times.
3. Internal waiting times in Children and Young People's Services and access to inpatient beds and psychiatric Intensive Care Unit Beds, which was also a national issue. Commissioners are well sighted on these problems.

4.3 **Patient Safety Group Assurance Report**

The key matters raised from two meetings of the Patient Safety Group, held on 16 December 2016 and 16 January 2017 were as follows:

1. Mortality tools for the categorisation of death were to be tested for those Trust cases which warranted further scrutiny (those which are categorised EN2 and UN1 as per the Southern Health report). The group were still only considering those service users on CPA at this time, although it has been acknowledged that this aspect may need to be widened in future.
2. There had been seven recommendations following the publication of a national report from the CQC 'Learning, Candour and Accountability', one of which would be aimed at provider organisations. Staff from the Patient Safety Team are attending a CQC event in March 2017 which will provide guidance on the expectations of provider organisations in implementing this recommendation.

The Quality Assurance Committee was assured that there were no significant matters of escalation and were satisfied that all programmes of work were being progressed by appropriate leads.

4.4 **Patient Experience Group Assurance Report**

The key matters raised from two meetings of the Patient Safety Group, held on 13 December 2016 and 10 January 2017 were:

1. An Away Day was being held by the Complaints and PALS team in February 2017, to look at the lack of learning lessons noted following responses sent out in January 2017.
2. The Trust had officially re-joined the Triangle of Care national initiative to improve the experience of carers, with plans in the first months to assess 80% of inpatient areas and all Crisis teams. In years 2 and 3 this would be rolled out to community services.

The Quality Assurance Committee was assured that the Patient Experience Group had consistently reviewed all relevant Trust patient experience activities, in line with the Group's Terms of Reference and any issues were being progressed by the appropriate leads.

4.5 **Safeguarding & Public Protection Exception Report**

The key matters covered in this report were:

1. The various serious case reviews underway in Teesside, Durham, Darlington and Redcar, which were being progressed.

2. The CQC inspection of services in 2016 had raised some concerns around Worsley Court, which were shared with the Local Authority and the ward had taken immediate action to remedy the issues raised.
   The Trust was meeting its legal requirements for safeguarding adults and children within the legislative framework.

4.6 Quality Account Quarterly Update Report

The key updates in Quarter 3 from the Quality Account were:

1. 3 out of the 4 quality priorities for 2016/17 were on track.
2. The Harm Minimisation priority, which was at red status in Quarter 3 was due to training levels for staff not being met although it was noted that 1,300 clinical staff had been trained. Consideration was being given to whether training on Harm Minimisation could be aligned with other key training programmes, such as Recovery Focused Care and Management of Violence and Aggression.
3. Patient falls had reduced from 113 to 94 in Quarter 3, however still remained above target. The Trust wide falls review, being led by the Associate Director of Nursing, was ongoing and once completed a report identifying areas for improvement would be presented to the Clinical Leaders Board.
4. Length of stay for adults had increased however the year to date position continued to be ahead of target.
5. The position for complaints resolved satisfactorily was 21% worse than target and at the lowest level of performance in the year to date.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 Compliance with CQC Registration Requirements

1. Draft reports had been received from the CQC following two unannounced visits to the MHSOP and Adult inpatient services. The factual accuracy check on both reports had been completed and returned to the CQC within agreed timescales. A summary of the findings had been circulated to all ward Team Managers.
2. From 23 January 2017 the CQC undertook a well led review of the organisation and also inspected the LD community teams and rehabilitation services across the Trust. These reports are expected in March 2017.
3. The NHS Wales Quality Improvement team would visit West Lane Hospital on 09 February 2017 and the outcome would be fed back to QuAC at the 02 March 2017 meeting.

6 GOVERNANCE

6.1 Drug & Therapeutics Report

The key updates from the Drug and Therapeutics Committee were:

1. Formulary issues had been discussed, including details of the EULAST clinical trial which had looked at the effectiveness of 2 long-acting antipsychotics.
2. Responses to NHS Improvement Patient Safety alerts had been signed off.
3. Following a challenge by the CQC around how medicines management issues were appropriately escalated through the organisation, an initiative had been launched in January 2017 for inpatients across TEWV.

6.2 **Workforce Report**

The key matters from this report were as follows:

1. Further actions around Workforce Race Equality Standard (WRES) indicators (1-9) had been proposed and agreed, relating to monitoring information about protected characteristics of ethnicity, gender disability and age.
2. Following recent CQC feedback it was agreed to change the TEWV Equality Delivery System 2 (EDS2) statement back to the previously published EDS2 (2014). This was due to the TEWV EDS2 (2016) being based on a self-assessment and not on external feedback as required.

7. IMPLICATIONS

7.1 **Quality**

One of the key objectives within the QuAC terms of reference is to provide assurance to the Board of Directors that the organisation is discharging its duty of quality in compliance with section 18 of the Health Act 1999. This is evidenced by the quality assurance and exception reports provided, with key priorities for development and actions around any risks clearly defined.

7.2 **Financial/value for money**

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

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

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

7.4 **Equality and Diversity**

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

8. CONCLUSIONS

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

9. RECOMMENDATIONS

That the Board of Directors:

- Be recommended to include a separate strategic risk relating to medical recruitment in its chapter of the integrated assurance framework and risk register.
- Note the issues raised at the Quality Assurance Committee meeting on 02 February 2017 and to note the confirmed minutes of the meeting held on 01 December 2016 (appendix 1).

Jennifer Illingworth
Director of Quality Governance
February 2017

APPENDIX 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 1 DECEMBER 2016, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

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

In attendance:
Mrs Karen Agar, Associate Director of Nursing and Governance, (for minute 16/170)
Mrs Liz Herring, Acting Director of Operations for North Yorkshire
Mrs Ruth Hill, Director of Operations for York & Selby, (for minute 16/168)
Dr Ahmad Khouja, Deputy Medical Director, Forensic Services, (for minute 16/167)
Mrs Linda Parsons, Associate Director of Operational Services, (for minute 16/175)
Professor J Reilly, Clinical Director for Research & Governance, (for minute 16/177)
Mr Stephen Scorer, Deputy Director of Nursing, (for minute 16/169,172,173 & 174)
Mrs Rachel Weddle, Head of Nursing, Forensic Services
Mrs Donna Oliver, Deputy Trust Secretary

16/164 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Elizabeth Moody, Director of Nursing & Governance, Mr Darren Gargan, Head of Nursing, York & Selby, Mrs Jennifer Illingworth, Director of Quality Governance, Dr Ingrid Whitton, Deputy Medical Director, Mr Levi Buckley, Director of Operations, Forensic Mental Health.

16/165 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 3 November 2016 be signed as a correct record by the Chairman of the Committee.

16/166 ACTION LOG

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

The following updates were noted:

15/137 Review of scorecard metrics with Dept. Heads in October then bring back to QuAC.

This matter was covered under agenda item number 16/173

Completed

16/48	Analysis of dashboard indicators: to discuss with OMT how to ensure that in investigating any breaches we can gain assurance that the care provided was appropriate. **Completed**
16/125a)	Normalise the data for force reduction taking out the hot spot areas. This matter was covered under agenda item number 16/176. **Completed**
16/153	Further investigation into the SI's that had been changed before going to Directors Panel. This matter linked to adult services had been raised with the team involved and the outcome would be brought back to QuAC in the next North Yorkshire LMGB report.
16/154	Circulate the CQC thematic review and have further discussion at the December QuAC meeting. This matter would be brought back to the February 2017 QuAC meeting.

16/167 FORENSIC SERVICES LMGB REPORT

The Committee received and noted the Forensic Services LMGB Report.

Dr Khouja highlighted the main concerns at present, which were:

1. The ongoing pressure of vacancies for Registered Nurses and vacancies. The overall vacancy position had been improved within IP services from 42.0 WTE to 9.0 WTE vacancies and steps had been taken to manage pressure across the wards, with discussions ongoing around medium and longer term recruitment strategies. On this matter it was noted that recruiting to psychology posts was also proving difficult.
2. A continued lack of clear agreement with CCGs and NHS England around the Transforming Care work stream, regarding service models and investment into community services.
3. Ongoing concerns around the quality of estate and in particular fire safety issues at Roseberry Park. The service was working closely with EFM around remedial actions and robust alternative measures were in place. There would be tested ward evacuation plans carried out in December 2016.

Following discussion it was noted that:

i) The service had opened the internal gates within the perimeter following a recent Kaizen event to increase patient movement. This would be monitored at 30, 60 and 90 days against agreed metrics.

ii) There had been very good feedback following a recent CQC visit to the team at HMP Durham.

iii) There had been 2 Regulation 28 letters, as a result of an inquest following the death of a patient at HMP Low Newton.

iv) There had been an increase in missed signatures regarding medication, however this amounted to 21 signatures omitted out of a possible 9122 administrations

during the 7 day audit period, giving an omission rate of 0.23%, within the standard of 0.5% or less stipulated for the audit.

16/168 YORK & SELBY LMGB REPORT

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

Arising from the report it was noted that:

1. The beds at Peppermill Court had been reopened with minor problems being worked through.
2. There continued to be key concerns around estate issues and ongoing concerns around timeliness of response, quality of work and backlog of work with NHS PS.

Mrs Hill highlighted the main concerns at present, which were:

1. Staffing, with particular issues in MHSOP services linked to recruitment, sickness and the use of bank and agency staff.
   There had been some recent staff sickness within LD services, possibly as a result of the introduction of the Working Time Directive and support was being provided to staff.
2. Delayed discharges, with weekly huddles to monitor the position.
3. Data quality and staff using PARIS, due to the move from paper based information gathering.
4. Compliance with appraisal, statutory and mandatory training, which had improved slightly, however remained below target.

16/169 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee received and noted the Patient Safety Group report.

Arising from the report it was noted that:

1. The key messages from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness had been included as appendix 4 to the report. Benchmarking would now take place within localities and the key clinical lessons would be shared with LMGBs.
2. There had been some data analysis using the Mazars tool for death categorisation from 1 October to 15 November 2016, where 145 deaths had been reported through Datix, 26 of which the service users had been on CPA.
   On this matter it was noted that a brief synopsis of each case would be taken to the next Patient Safety Group in order that a consensus be reached around categorisation with clinicians involved.

Following discussion it was noted that the percentage of action plans forwarded to CCGs within 60 days, (unless an extension agreed) would be monitored closely.

At the conclusion of the debate it was agreed:

i) The Committee would require further assurance on the actions taken following 5 reported, level 3 incidents on Cedar Ward, Harrogate.

Action: Mrs J Illingworth

ii) The data on seclusion should be checked for accuracy and inclusivity and a more detailed report included in future Patient Safety Group reports.

iii) A review of the systems used to support the reporting of seclusion should be undertaken and reported back to the Committee.

Action: Mr C Martin

16/170 SAFEGUARDING & PUBLIC PROTECTION REPORT

The Committee received and noted the Safeguarding & Public Protection report.

Mrs Agar highlighted the following from the report:

1. The MAPPA serious case review would conclude by December 2016.
2. The 3 serious case reviews in Hartlepool were expected to complete in early 2017.
3. Staff from CAMHS and the safeguarding children team would attend a practitioner event in Durham regarding the long term neglect of 2 children.
4. Feedback from a CQC inspection in Durham for Safeguarding and Looked after Children had outlined some improvements for the Trust around recording safeguarding issues.
5. The Trust would support a single inspection from OFSTED of York Children's Social Care.

16/171 PATIENT EXPERIENCE GROUP (PEG) ASSURANCE REPORT

The Committee received and noted the Patient Experience Group report.

Arising from the report it was highlighted that:

1. The assurance statement provided to the QuAC meeting followed the Patient Experience Group meeting held on 12 October 2016, the November 2016 meeting had been cancelled due to the CQC inspection.
2. There had been 11 complaints in September 2016, a reduction of 3 from August 2016. PALS overall had continued to increase, with 164 in September 2016 compared to 150 in August 2016, however there had been no particular trends or themes identified.

Following discussion it was highlighted that:

i) The Patient Experience Group meeting held on 12 October 2016 had been inquorate and the previous 6 months should be checked .
ii) More detail should be provided to the Committee around the exception report on page 5, detailing the increase in PALS issues reported in Durham, Darlington & Tees, together with a baseline for comparison.

Action: Dr I Whitton

16/172 INFECTION, PREVENTION AND CONTROL ASSURANCE REPORT

The Committee received and noted the Infection, Prevention and Control Report for Quarter 2, 1 July 2016 to 30 September 2016.

Arising from the report it was highlighted that:

1. There had been a significant improvement regarding the Essential Steps monitoring data following the introduction of the escalation process.
2. Agreement had been reached that IPC Nurses wold undertake unannounced IPC audits of any new premises, new builds and clinical areas where audits had scored less than 85%. The IPC audit tool had been amended to include information on medical devices and distributed to Modern Matrons for completion.

16/173 QUALITY STRATEGY 2017 - 2020

The Committee received and noted the Draft Quality Strategy Review for 2017 – 2020.

In introducing the report Mr Scorer highlighted the following:

1. That the Draft Quality Strategy had gone through a lengthy and thorough consultation period, with staff and Governors and other key stakeholders, since February 2016, when the process had first been approved at QuAC.
2. 2 preferences had been identified for target setting, a Trust target for each measure and a variant target according to different service areas.
3. The Draft Quality Strategy had been benchmarked against other Organisations and final re-formatting would be supported by the Communications Team.

The focus of discussion was around the difficulty setting aspirational versus realistic targets and also how there could be misinterpretation around key messages for staff and service users.

Mrs Bessant noted that the Trust should always be striving for 100% and this should be demonstrated in any public documents.

Approved: the draft Quality Strategy Review, which would be presented to the Board of Directors at its meeting on 20 December 2016.

16/174 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

Arising from the report it was noted that:

1. The CQC had published their Annual Review of the Mental Health Act.
2. The Compliance Team had been notified of 2 joint Ofsted and CQC inspections in York and Durham in respect of Safeguarding.
3. There had been a recent unannounced CQC visit to all AMH and MHSOP inpatient areas, with the subsequent receipt of a Regulation 17 letter in relation to Cherry Tree and Worsley Court premises. An action plan of remedial measures to address the issues raised would be submitted to the CQC.
   On this matter it was noted that the Trust had decided to bring forward the closure of Worsley Court and arrangements had been put in place to transfer the patients in the unit to the most appropriate setting. Other environmental issues such as cleaning and privacy and dignity were being addressed.

16/175 HEALTH, SAFETY, SECURITY AND FIRE REPORT

In introducing the report Mrs Parsons highlighted the following:

1. A rectification plan had been agreed with PFI partners around the fire defects at Roseberry Park.
2. There had been a reduction of 59% in lone working incidents, which were mainly related to home visits by community staff.
3. There had been a 25% increase between 2015/16 and 2016/17 in Violence and Aggression incidents against staff that fell under the NHS Protect Criteria and a 16% increase in incidents reported to the Police.
4. Audits revealed there had been 45 complete workbooks out of a total of 107 during Quarter 1 & 2 and the H&S team continued to chase outstanding actions.
5. EMT were considering the results of a task and finish group to look at assurances around the management arrangements for compliance with the working time regulations.

Following discussion it was noted that there had been incidents of staff not adhering to risk assessments for staff/patient ratio in isolated areas.

On this matter Mrs Bessant expressed concern following a recent ward visit this had been seen by a Housekeeper not following the guidance.

Agreed: That this would be taken back to the next Health & Safety session and team briefing.

Action: Mrs L Parsons

16/176 FORCE REDUCTION PROJECT QUARTERLY REPORT

In introducing the report Mr Davison highlighted the following:

1. The Force Reduction project remained on track to fully implement the core interventions, set out in the Trust wide restraint reduction plan.
2. Working in collaboration with the Paris and Datix teams further enhancements to qualitative information were being made.
3. There had been a significant reduction in the use of severe types of physical interventions and there would continue to be support and clinical leadership to maintain this.
4. Behaviour Support Plans were embedding into Adult Mental Health and Tier 4 CAMHS services and would be audited on an annual basis going forward.
5. The Behaviour that Challenges policy was out for consultation and a new clinical procedure was in development on the safe use of physical holds.
6. The overall number of incidents and restrictive interventions had increased during the Quarter, however the most severe restrictive practices remained at 40%.

In response to questions it was noted that the patient on Evergreen Ward had received 40 incidents of rapid tranquilisation due to the complexities of the individual's mental health.

It was noted that the long term sustainability and leadership for the work around force reduction would be essential for the continued reductions in restrictive practices.

16/177 ASSURANCE REPORT OF THE RESEARCH GOVERNANCE GROUP

The Committee received and noted the Assurance Report of the Research Governance Group.

In introducing the report Professor Riley highlighted that:

1. The Research Governance Group had met on 16 June 2016 and 15 September 2016.
2. There had been developments around leadership, the Research & Development Strategy implementation plan and a review of collaborations with Universities.
3. Good progress had been made against the key performance indicators, both on the recruitment to the National Institute of Health Research portfolio studies and the annual external R&D income.
4. Following the Research Governance exception report to QuAC in October 2016, local Caldicott approval at Trust level would continue to be sought if patient identifiable information was leaving the Trust for the purpose of research. Further guidance from the Health Research Authority was awaited.

16/178 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

16/179 ANY MATTERS ARISING TO BE ESCALATED TO THE TRUST BOARD OR PROPOSED FOR ADDITION TO THE TRUST RISK REGISTER, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR CLINICAL LEADERSHIP BOARD.

There were no matters to escalate to the Board of Directors.

16/180 ANY OTHER BUSINESS

There was no other business to note.

16/181 COMMITTEE MEETING EVALUATION

There was nothing to note.

16/182 DATE AND TIME OF NEXT MEETING:

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

The meeting concluded at

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Dr Hugh Griffiths
CHAIRMAN
2 February 2017

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 28th February 2017**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

The purpose of this report is to present to the Board by 'exception' the monthly safe staffing information as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to December 2016 and January 2017 data.

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

- The number of rosters equates to 67 inpatient wards.
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 27 wards.
- The Forensic directorate have the highest level of 'red' fill rates (10 in January and 14 in December)
- The lowest fill rate indicators in December related to Primrose Lodge (sickness), The Orchard (sickness and supporting Cedar Ward) and Esk (vacancies)
- The lowest fill rate indicators in January related to Primrose Lodge (sickness), The Orchard (sickness and vacant posts) and Northdale (sickness and staff on non- clinical duties)
- The Highest fill rates in December were observed by Westerdale South (uplift of budget – roster changes are apparent in the January data with all 4 indicators reporting as 'green'), Sandpiper (newly qualified working as HCA's) and Oakwood (to cover RN sickness).
- The highest fill rates in January were observed by Mallard (creation of a twilight shift to support enhanced observations); Cedar (to support enhanced

observations) and Westwood (patient acuity and enhanced observations)

- In relation to bank usage there were no wards identified that was utilising in excess of 50% bank during December and January. The highest bank users were identified as Cedar (PICU) and Westerdale South with 39% in December. In January the highest bank user was Bransdale ward with 43% bank usage.
- Agency usage equated to 1.45% in December and 1.03% in January. The highest user of agency within the reporting period related to Cedar (NY) equating to approximately 950 hours per month. This is due to the amount of vacancies that they have and difficulties in recruiting to these posts.
- In terms of triangulation with incidents and complaints:

December 2016:

- There were 3 Serious Incidents (SI) that occurred within the month of December. One of these relate to Springwood who have also been cited in this report for utilising agency workers.
- There were 3 level 4 incidents that occurred in December that were also classified as an SUI.
- There were 7 level 3 incidents (self-harm) that occurred in December. One of these relates to Cedar (NY) who has also been cited in this report for utilising agency workers.
- There were 4 complaints raised in December. None of these areas have been cited within the report to date.
- There were 30 PALS related issues raised with the following featuring within this report as follows:
  - Harrier / Hawk (2 PALS) – agency usage in the reporting period
  - Minster (1 PALS) – agency usage in the reporting period
  - Birch (1 PALS) – bank usage in excess of 25%
  - Bransdale (4 PALS) – bank usage in excess of 25%
  - Worsley Court (2 PALS) – agency usage in reporting period
- A number of incidents requiring control and restraint occurred during December. The highest user was Sandpiper with a total of 57 incidents. Sandpiper has also been cited in this report for having a high staffing fill rate.

January 2017:

- There were 0 (inpatient) Serious Incidents (SI) that occurred within the month of January.
- There were 0 level 4 incidents that occurred in January
- There were 9 level 3 incidents (self-harm) that occurred in January. One of these relates to Westwood who have also been cited in this report for having a high staffing fill rate. Another incident relates to Swift Ward who has been cited in this report for having bank usage in excess of 25%.
- There were 2 complaints raised in January one of which relates to Harrier/Hawk who have been cited in this report in relation to utilising agency workers.
- There were 44 PALS related issues raised with the following featuring within this report as follows:
  - Primrose Lodge (1 PALS) – low staffing fill rate
  - Northdale (4 PALS) – low staffing fill rate and bank usage in excess of 25%
  - Harrier / Hawk (3 PALS) – agency usage and a complaint
  - Cedar (NY) (1 PALS) – agency usage

  - Westwood (1 PALS) – high staffing fill rate and a level 3 incident
  - Bransdale (5 PALS) – bank usage in excess of 25%
  - Bedale (2 PALS) – bank usage in excess of 25%
  - Clover / Ivy (2 PALS) – bank usage in excess of 25%
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was Sandpiper with a total of 129 incidents. Sandpiper has not been cited within this report when looking at the January data.

There were 438 shifts allocated in December and 368 in January where a break had not been taken. From those shifts where breaks were not taken the majority were in relation to day shifts (310 in December and 242 in January).

There were 6 incidents raised in December (2 of which were in relation to community services) and 5 in January citing concern's in relation to staffing levels.

A severity calculation has been applied within the quality indicators section of this report and can be used to highlight any areas of concern from a safe staffing point of view. In December Springwood had the highest score whilst the Orchards were highlighted in January. The top 10 can be found on page 10 of this report along with an explanation of severity scores. Appendices 3 and 6 show all scores for all wards.

A work stream approach to Safe Staffing is underway with a full update provided on page 12 and 13 of this report; this includes a review of roster planning efficiencies which is taking place during quarter 3 and 4.

Further analysis of vacancies, pressures and flexible staffing usage across N.Yorkshire locality has been requested due to emerging hot-spots across a number of wards.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 28th February 2017**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the exceptions falling out of the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to December 2016 and January 2017 data.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (http://www.tewv.nhs.uk/site/about/how-well-are-we-doing/nurse-staffing). The full monthly data set of day by day staffing for each of the 67 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

3. EXCEPTIONS:

3.1 Safe Staffing Fill Rates – December 2016 and January 2017

3.1.1 The daily nurse staffing information aggregated for the month of December 2016 and January 2017 are presented at Appendix 1 and 4 of this report.

The highest numbers of red fill rate indicators relate to Registered Nurses on day shifts which equates to 36 in December and 25 in January. This compares with November 2016 where there was 27 wards reporting a 'red' fill rate.

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

Ward	Fill Rate Indicator	Comments
December 2016		
Primrose Lodge	43.6% for RN on Days	The shortfall is in relation to sickness being covered by un-registered staff based on the unit in redeployment. This is apparent when you look at HCA fill rate on days which equates to 131.1%. .
The Orchard (NY)	56.5% for RN on Nights	The shortfall is in relation to sickness and supporting Cedar Ward (NY).
Esk Ward	61.6% for RN on Days	The shortfall relates to vacancies. The ward has ensured that there has been a nurse in charge on all shifts utilising the ward manager and community staff.
January 2017		
Primrose Lodge	50.6% for RN on Days	The shortfall is in relation to sickness. The increase in HCA's is as a consequence of this. Additional Staff were redeployed on a shift by shift basis from the community rehab team and staff from other disciplines to provide appropriate cover. This is apparent when you look at HCA fill rate on days which equates to 134.4%. Further exploration is required with regard to meeting the rostered requirement for registered nurses as this has remained a regular feature for over 6 months on this ward
The Orchard (NY)	87.5% for RN on Days 71.0% for HCA on Days 53.2% for RN on Nights 83.9% for HCA on Nights	January has been a challenging month staffing wise due to sickness and vacant posts. All 4 of the fill rate indicators are reporting as 'red'.
Northdale Centre	54.8% for RN on Nights	The shortfall is in relation to sickness, 1 staff nurse on non-clinical duties due to pregnancy, and 1 staff member who has been working on another ward for clinical reasons. In addition there are two preceptorship nurses. The ward has advised that shifts are always covered with at least one RN. Agency have been utilised for RN night duties. The ward has also had high levels of patients on enhanced observations

		which have meant extra duties have had to be created. Due to the above the ward has advised that they have run below agreed staffing levels and shifts have not been filled by bank or overtime.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In January there were 58 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues. When compared to December this is an increase of 2 fill rate indicators (56 in December 2016).

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

Ward	Fill Rate Indicator	Comments
December 2016		
Westerdale South	124.3% RN on Days 228.9% HCA on Days 219.8% HCA on Nights	Agreed uplift on the budgeted established as a result of enhanced observations and clinical activity. The electronic roster has been amended to reflect this position and the benefit of this change is noticeable in the January data below ensuring a 'green position'.
Sandpiper	203.9% HCA on Nights 134.9% HCA on Days	RN shifts given to newly qualified who were recorded as HCA's on HealthRoster. Also the ward has flexed staff to cover the RN shortfall on nights (RN on Nights recorded at 86%).
Oakwood	194.5% HCA on Days	The increase was utilised to cover shortfall of RN due to sickness (RN on Days reporting at 80.3%)
January 2017		
Mallard Ward	210.7% HCA on Nights 131.3% HCA on Days	The increase in HCA's is due to the creation of a twilight shift each day (from 16.00-00.00) due to the high patient acuity. In addition, one patient has had several admissions to JCUH as an in-patient and has been escorted by 2 staff at all times. When the patient is nursed on the ward, again due to the additional clinical need, the ward have one extra day shift and one extra night shift rostered
Cedar Ward (PICU)	206.1% HCA on Days 175.3% HCA on Nights	The additional staffing was to support enhanced observations (3 x

		1:1 and 1 x 2:1), high acuity levels and also reflects the additional flexible staffing agreed for West Park Hospital site.
Westwood Centre	194% HCA on Nights 139.7% HCA on Days	The wards have two young people with high levels of observation / engagement which have resulted in them needing more staff on shift throughout the day and night. One young person is using seclusion and additional staff have been required to meet clinical demands.

Please note that Westerdale South is now reporting as 'green' across all of the 4 fill rate indicators as a result of the changes made on HealthRoster.

3.2 Bank Usage

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

There were no wards reporting 50% or above for bank usage in December and January. The highest users of bank in December relate to Cedar Ward (PICU) and Westerdale South both reporting at 39%. In January the highest user of bank was Bransdale who had a bank usage rate of 43%.

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

	January 2017
Bransdale Ward	43%
Cedar Ward	42%
Westerdale South	35%
Mallard Ward	34%
Merlin	32%
Bedale Ward	27%
Birch Ward	27%
Clover / Ivy	27%
Northdale Centre	27%
Linnet Ward	27%
Swift Ward	27%

	December 2016
Westerdale South	39%
Cedar Ward	39%
Birch Ward	37%
Bransdale Ward	29%
Sandpiper Ward	27%
Ward 15	26%

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

3.3 Agency Usage

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

In December the agency usage equated to 1.45% and 1.03% in January. The January position is a decrease of 0.41% when compared to December.

The highest user of agency within the reporting period related to Cedar (NY) equating to approximately 950 hours per month. This is due to the amount of vacancies that they have and difficulties in recruiting to these posts.

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

The full ward breakdown is available within the appendices of this report.

3.4 Quality Data Triangulation

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

December 2016:

- There were 3 Serious Incidents (SI) that occurred within the month of December. One of these relate to Springwood who have also been cited in this report for utilising agency workers.
- There were 3 level 4 incidents that occurred in December that were also classified as an SUI.
- There were 7 level 3 incidents (self-harm) that occurred in December. One of these relates to Cedar (NY) who have also been cited in this report for utilising agency workers.
- There were 4 complaints raised in December. None of these areas have been cited within the report to date.
- There were 30 PALS related issues raised with the following featuring within this report as follows:
  - Harrier / Hawk (2 PALS) – agency usage in the reporting period
  - Minster (1 PALS) – agency usage in the reporting period
  - Birch (1 PALS) – bank usage in excess of 25%
  - Bransdale (4 PALS) – bank usage in excess of 25%
  - Worsley Court (2 PALS) – agency usage in reporting period
- A number of incidents requiring control and restraint occurred during December. The highest user was Sandpiper with a total of 57 incidents. Sandpiper has also been cited in this report for having a high staffing fill rate.

January 2017:

- There were 0 (inpatient) Serious Incidents (SI) that occurred within the month of January.
- There were 0 level 4 incidents that occurred in January
- There were 9 level 3 incidents (self-harm) that occurred in January. One of these relates to Westwood who have also been cited in this report for having a high staffing fill rate. Another incident relates to Swift Ward who has been cited in this report for having bank usage in excess of 25%.
- There were 2 complaints raised in January one of which relates to Harrier/Hawk who have been cited in this report in relation to utilising agency workers.
- There were 44 PALS related issues raised with the following featuring within this report as follows:
  - Primrose Lodge (1 PALS) – low staffing fill rate
  - Northdale (4 PALS) – low staffing fill rate and bank usage in excess of 25%
  - Harrier / Hawk (3 PALS) – agency usage and a complaint
  - Cedar (NY) (1 PALS) – agency usage
  - Westwood (1 PALS) – high staffing fill rate and a level 3 incident
  - Bransdale (5 PALS) – bank usage in excess of 25%
  - Bedale (2 PALS) – bank usage in excess of 25%
  - Clover / Ivy (2 PALS) – bank usage in excess of 25%
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was Sandpiper with a total of 129 incidents. Sandpiper has not been cited within this report when looking at the January data.

3.5 Missed Breaks

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

A thorough analysis of the HealthRoster system has identified that there were 438 shifts in December 2016 and 368 in January where unpaid breaks had not been taken. The January position shows a reduction of 27 when compared to November 2016.

The majority of the shifts where breaks were not taken occurred on day shifts (310 shifts in December and 242 shifts in January). The number of night shifts where breaks were not taken equated to 128 shifts in December and 67 in January.

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

3.6 Incidents raised citing Staffing Levels

It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. There were 6 incidents reported in December and 5 in January 2017 raised on Datix citing issues with staffing. Of the incidents raised 2 were in relation to community based teams.

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

December:

- Meadowfields raised 1 incident in relation to staffing levels; this ward has also been cited within this report for utilising agency workers.
- Merlin has raised 2 incidents in relation to staffing levels; this ward has not been cited in this report.
- Ceddesfeld have raised an incident in relation to staffing levels; this ward has not been cited in this report.

January:

- Farnham raised 2 incidents in relation to staffing levels; this ward has not been cited in this report.
- Harland has raised 1 incident in relation to staffing levels; this ward has not been cited in this report.
- Ward 15 has raised an incident in relation to staffing levels; this ward has not been cited in this report.
- Brambling has raised 1 incident in relation to staffing levels; this ward has not been cited in this report.

The staffing concerns escalation process is currently undergoing a review, details will be provided in this report once completed.

3.7 Severity

Utilising the data contained within this report it is possible to assign a scoring system to highlight any potential areas of concern. The total score for each inpatient area is contained within Appendix 3 and 6. The higher the score the higher the number of episodes they have been cited in relation to the number of 'red' fill rate indicators, any over establishment, bank & agency usage and the quality metrics.

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

- A 'red' fill rate = 2 points given for each occurrence
- A 'blue' fill rate = 1 point given for each occurrence
- Missed breaks = where there was no improvement from the previous month = 1 point awarded
- Any episode of agency worked = 1 point

- Bank usage = amber score = 1 point and a red rated score equals 2 points
- SUI = 1 point
- Level 4 = 1 point
- Level 3 = 1 point
- Complaint = 1 point
- Control and Restraint – 11 and 39 incidents requiring C&R = 1 point; 40+ incidents of C&R = 2 points.

The top 10 wards cited utilising the above scoring mechanism is identified below for each month:

December 2016:

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 Incidents	Complaints	Control & Restraint	TOTAL
Springwood Community Unit	2	2	1	0	0	1	1	0	0	2	**9**
Cedar Ward (NY)	4	2	0	1	0	0	0	1	0	0	**8**
Harrier/Hawk	2	3	1	1	1	0	0	0	0	0	**8**
Minster Ward	4	1	1	1	1	0	0	0	0	0	**8**
Sandpiper Ward	2	2	1	0	1	0	0	0	0	2	**8**
Westwood Centre	0	2	0	0	1	0	0	3	0	2	**8**
Bankfields Court	4	0	1	0	0	0	0	0	0	1	**6**
Hamsterley Ward	2	2	1	0	1	0	0	0	0	0	**6**
Linnet Ward	2	2	1	0	1	0	0	0	0	0	**6**
Newberry Centre	2	1	1	0	1	0	0	0	0	1	**6**
Newtondale Ward	4	0	1	0	1	0	0	0	0	0	**6**
Overdale Ward	2	2	1	0	1	0	0	0	0	0	**6**
Worsley Court	4	1	0	1	0	0	0	0	0	0	**6**

January 2017:

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 Incidents	Complaints	Control & Restraint	SCORE
The Orchards (NY)	8	0	0	0	0	0	0	1	0	0	**9**
Harrier/Hawk	2	2	1	1	1	0	0	0	1	0	**8**
Meadowfields	4	1	1	1	1	0	0	0	0	0	**8**
Sandpiper Ward	2	1	1	0	1	0	0	1	0	2	**8**
Springwood Community Unit	2	2	0	1	0	0	0	0	0	2	**7**
Westwood Centre	0	2	1	0	1	0	0	1	0	2	**7**
Bransdale Ward	2	2	0	0	2	0	0	0	0	0	**6**
Holly Unit	0	4	1	0	1	0	0	0	0	0	**6**
Linnet Ward	2	2	1	0	1	0	0	0	0	0	**6**
Mandarin	2	2	0	0	1	0	0	0	1	0	**6**
Northdale Centre	4	1	0	0	1	0	0	0	0	0	**6**
Rowan Ward	0	2	1	1	1	0	0	0	0	1	**6**
Swift Ward	0	2	1	0	1	0	0	1	0	1	**6**

3.8 Other

The Forensic directorate have the highest number (14 wards' in December and 10 in January) of 'red' fill rates for registered nurses on day shifts. This is an improving picture with some posts being filled. In line with Transforming Care, there are plans to reconfigure a further ward which should ease staffing pressures going forward.

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

In addition work is being undertaken Trust wide via a work stream approach reporting to OMT. The following update is of relevance:

- Rostering Efficiencies:
  - Standard operating procedures have been developed in relation to the creation and review/approval of the electronic rosters.
  - Reviews of all electronic rosters are underway with an in-progress report being presented to OMT.
  - Requirements gathering in relation to reporting key rostering information into the IIC has been completed. Next step is to assess the requirements and ensure that the data is available before establishing a method of transferring the data into the IIC. A design group may need to be established depending upon the amount of metrics being displayed.
  - Future training and support of those involved in the production of electronic rosters is also being developed.
  - The use of local champions will be considered in future meetings.

- Future Reporting:
  - Care hours per patient day are now being produced in a shadow format for consideration by the group in terms of what 'good' would look like for the trust.
  - Safe staffing information is now being provided for each of the Performance Improvement Groups within the trust.

- Flexibilities of Staff Deployment:
  - Durham and Darlington are in the process of recruiting over and above establishment to produce a flexible on-site staffing response in line with agreement from EMT.
  - The Central Bank Team are currently piloting a flexible pool within Forensic Services utilising a forward booking model. The pilot will be evaluated at the end of March and if successful this model will be expanded to other areas within the trust.

- Escalation:
  - A review of the staffing concerns escalation process is currently underway. This is following the first 3 months since its being in operation. The review will also consider the impact on community teams providing cover to inpatient wards.

- Evidence Based Planning:
  - Utilising the Hurst Tool and the mental health multiplier an electronic process is currently underway and with an anticipated completion date of 31st March 2017 to have the initial data collection.
  - Once the data collection has been completed we will process the data utilising the Hurst Tool. The data will then be assessed taking into account professional judgement

Review of Bank Processes:

- Direct booking has been rolled out utilising Employee Online. This allows bank workers to directly book themselves into vacant shifts. This has reduced the number of calls that the central bank team receive by 50%.
- Requesting habits of ward managers is to be further explored, not all vacant duties requiring bank are submitted in a timely manner.
- The agency centralisation project has been agreed by EMT whereby the trust will be seeking a neutral vendor to supply agency workers (inpatient HCA and RN; as well as community staff trust wide). Once established this will be managed by the Central Bank Team ensuring more accurate reporting of agency working.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

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

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

4.4 **Equality and Diversity:**

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

4.5 **Other implications:**

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

5. RISKS:

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

5.2 The national work is continuing on the implementation of evidence based tools and the Trust is now engaged with this.

6. CONCLUSIONS:

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

6.2 A strategic staffing review will commence during the last quarter of 2016/17 which will refine the usage of the data further and offer confidential benchmarking in line with the national pilot of the Mental Health safe staffing tools. The comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has not shown any significant impact to date although ‘hot-spots’ will be tracked and work is underway to address shortfalls.

6.3 Further analysis of vacancies and pressures across N.Yorkshire locality has been requested due to emerging concerns and hot-spots across a number of wards.

7. RECOMMENDATIONS:

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

Emma Haimes, Head of Quality Data
February 2017

DECEMBER 2016 DATA

Appendix 1

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

				DAY		NIGHT	
WARD	**Locality**	**Speciality**	**Bed Numbers**	**FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)**	**FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)**	**FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)**	**FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	88.4%	91.5%	71.0%	95.2%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	61.6%	106.2%	106.5%	90.3%
Bedale Ward	Teesside	Adults	10	90.5%	137.2%	100.0%	108.6%
Bilsdale Ward	Teesside	Adults	14	91.6%	106.6%	103.4%	100.0%
Birch Ward	Durham & Darlington	Adults	15	103.4%	98.5%	96.4%	138.7%
Bransdale Ward	Teesside	Adults	14	66.6%	125.0%	90.3%	104.8%
Cedar Ward	Durham & Darlington	Adults	10	102.2%	193.2%	100.0%	157.8%
Cedar Ward (NY)	North Yorkshire	Adults	18	79.8%	123.2%	89.1%	167.2%
Ebor Ward	York and Selby	Adults	12	88.0%	98.5%	90.3%	108.3%
Elm Ward	Durham & Darlington	Adults	20	105.8%	96.7%	100.0%	121.3%
Farnham Ward	Durham & Darlington	Adults	20	127.5%	105.6%	103.2%	93.5%
Kirkdale Ward	Teesside	Adults	16	81.7%	107.1%	103.4%	103.5%
Lincoln Ward	Teesside	Adults	20	106.5%	94.6%	100.1%	106.5%
Lustrum Vale	Teesside	Adults	20	95.2%	114.2%	102.5%	110.8%
Maple Ward	Durham & Darlington	Adults	20	76.5%	109.2%	100.0%	100.0%
Minster Ward	York and Selby	Adults	12	129.5%	87.9%	110.2%	87.1%
Overdale Ward	Teesside	Adults	18	83.7%	123.4%	103.6%	121.2%
Primrose Lodge	Durham & Darlington	Adults	15	43.6%	131.1%	100.3%	100.0%

Stockdale Ward	Teesside	Adults	18	100.2%	94.8%	100.3%	98.4%
The Orchards (NY)	North Yorkshire	Adults	10	93.0%	90.2%	56.5%	96.8%
Tunstall Ward	Durham & Darlington	Adults	20	100.6%	109.7%	100.0%	100.0%
Ward 15 Friarage	North Yorkshire	Adults	12	80.3%	122.5%	95.6%	93.8%
Willow Ward	Durham & Darlington	Adults	15	87.0%	162.9%	93.5%	98.4%
Baysdale	Teesside	CYPS	6	96.7%	111.9%	100.0%	102.0%
Holly Unit	Durham & Darlington	CYPS	4	157.6%	114.9%	104.8%	125.0%
Newberry Centre	Teesside	CYPS	14	87.8%	105.1%	105.1%	123.3%
The Evergreen Centre	Teesside	CYPS	16	89.7%	109.4%	109.7%	104.3%
Westwood Centre	Teesside	CYPS	12	104.4%	130.3%	110.6%	183.9%
Clover/Ivy	Forensics	Forensics LD	12	91.7%	103.6%	100.0%	147.6%
Eagle/Osprey	Forensics	Forensics LD	10	92.5%	87.7%	96.8%	100.0%
Harrier/Hawk	Forensics	Forensics LD	10	72.6%	121.4%	122.6%	134.9%
Kestrel/Kite.	Forensics	Forensics LD	16	103.7%	120.5%	109.7%	148.4%
Langley Ward	Forensics	Forensics LD	10	75.9%	144.0%	96.8%	132.0%
Northdale Centre	Forensics	Forensics LD	12	80.3%	132.3%	100.0%	98.7%
Oakwood	Forensics	Forensics LD	8	80.3%	194.5%	100.5%	100.0%
Thistle	Forensics	Forensics LD	5	69.7%	112.0%	103.4%	98.4%
Brambling Ward	Forensics	Forensics MH	13	88.3%	100.4%	100.0%	93.5%
Fulmar Ward.	Forensics	Forensics MH	12	87.3%	90.4%	93.8%	93.8%
Jay Ward	Forensics	Forensics MH	5	78.2%	106.7%	110.3%	113.2%
Lark	Forensics	Forensics MH	15	82.5%	104.6%	110.0%	91.6%
Linnet Ward	Forensics	Forensics MH	17	72.2%	143.9%	106.5%	121.0%
Mallard Ward	Forensics	Forensics MH	16	76.1%	119.1%	108.1%	156.9%
Mandarin	Forensics	Forensics MH	16	90.7%	146.9%	117.3%	161.7%
Merlin	Forensics	Forensics MH	10	102.4%	129.7%	93.5%	187.6%
Newtondale Ward	Forensics	Forensics MH	20	77.6%	103.9%	69.4%	107.2%

Nightingale Ward	Forensics	Forensics MH	16	77.1%	94.0%	100.0%	93.5%
Sandpiper Ward	Forensics	Forensics MH	8	94.3%	134.9%	86.0%	203.9%
Swift Ward	Forensics	Forensics MH	10	67.4%	110.0%	93.5%	126.0%
Aysgarth	Teesside	LD	6	115.1%	147.9%	100.4%	100.4%
Bankfields Court	Teesside	LD	19	74.1%	94.5%	104.9%	89.5%
Bankfields Court Unit 2	Teesside	LD	5	132.2%	96.2%	100.3%	111.6%
Bek-Ramsey Ward	Durham & Darlington	LD	11	110.6%	121.9%	100.0%	100.0%
Oak Rise	York and Selby	LD	8	112.6%	82.3%	100.0%	100.1%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	88.2%	126.5%	100.0%	100.0%
Cherry Tree House	York and Selby	MHSOP	18	113.9%	87.0%	103.2%	124.2%
Hamsterley Ward	Durham & Darlington	MHSOP	15	85.4%	123.6%	100.3%	147.9%
Meadowfields	York and Selby	MHSOP	14	87.8%	93.8%	109.7%	93.2%
Oak Ward	Durham & Darlington	MHSOP	12	96.6%	96.1%	100.0%	100.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	93.9%	98.1%	100.0%	98.4%
Rowan Lea	North Yorkshire	MHSOP	20	101.7%	110.9%	116.1%	103.6%
Rowan Ward	North Yorkshire	MHSOP	16	82.4%	143.7%	100.0%	108.1%
Springwood Community Unit	North Yorkshire	MHSOP	14	79.2%	120.5%	100.0%	126.2%
Ward 14	North Yorkshire	MHSOP	7	74.4%	146.9%	103.2%	98.4%
Westerdale North	Teesside	MHSOP	18	102.6%	129.6%	98.7%	103.5%
Westerdale South	Teesside	MHSOP	14	124.3%	228.9%	100.3%	219.8%
Wingfield Ward	Teesside	MHSOP	10	87.7%	115.3%	109.0%	95.2%
Worsley Court	York and Selby	MHSOP	14	68.8%	85.2%	99.6%	164.0%

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - December 2016				Agency Usage Hours	Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers		Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI (IIC)	Level 4 Incidents (IIC)	Level 3 (Self-Harm) Incidents (IIC)	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11		2368.0	143	6%									
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11		2502.3	243.25	10%						1		2	2
Bedale Ward	Teesside	Adults	10		3243.5	721.5	22%					1	8	1	14	15
Bilsdale Ward	Teesside	Adults	14		2533.7	149.5	6%									
Birch Ward	Durham & Darlington	Adults	15		3321.8	1225.46	37%					1	4		5	5
Bransdale Ward	Teesside	Adults	14		2545.0	739.5	29%					4	2		2	2
Cedar Ward	Durham & Darlington	Adults	10		4316.5	1687.67	39%						12	1	19	20
Cedar Ward (NY)	North Yorkshire	Adults	18	933.7	4032.5	392.25	10%			1			5		9	9
Ebor Ward	York and Selby	Adults	12	535.0	2772.5	137.5	5%						4		4	4
Elm Ward	Durham & Darlington	Adults	20		2811.5	361	13%				1		1		3	3
Farnham Ward	Durham & Darlington	Adults	20		2787.8	108	4%				1	1				
Kirkdale Ward	Teesside	Adults	16		3148.3	78.75	3%									
Lincoln Ward	Teesside	Adults	20		3130.8	123.25	4%				1	1	2		3	3
Lustrum Vale	Teesside	Adults	20		2956.1	239	8%						3		3	3
Maple Ward	Durham & Darlington	Adults	20		2571.4	191.82	7%			1		2	1		1	1
Minster Ward	York and Selby	Adults	12	191.5	2563.8	368.5	14%					1	1		1	1
Overdale Ward	Teesside	Adults	18		3002.5	690	23%					2	1		1	1
Primrose Lodge	Durham & Darlington	Adults	15		2473.0	84	3%									
Stockdale Ward	Teesside	Adults	18		2656.5	586.5	22%						3		5	5

The Orchards (NY)	North Yorkshire	Adults	10		1961.0	12	1%									
Tunstall Ward	Durham & Darlington	Adults	20		2843.2	60	2%						2		2	2
Ward 15 Friarage	North Yorkshire	Adults	12		2482.2	650.36	26%						1		1	1
Willow Ward	Durham & Darlington	Adults	15		2786.3	108	4%						1		1	1
Baysdale	Teesside	CYPS	6		2196.5	149.35	7%									
Holly Unit	Durham & Darlington	CYPS	4		1543.8	49.68	3%									
Newberry Centre	Teesside	CYPS	14		3768.9	497.66	13%					1	39	1	82	83
The Evergreen Centre	Teesside	CYPS	16		4744.3	136	3%			1			9		15	15
Westwood Centre	Teesside	CYPS	12		5695.8	934.5	16%			3			42	3	73	76
Clover/Ivy	Forensics	Forensics LD	12		4099.0	931.83	23%					2	1		4	4
Eagle/Osprey	Forensics	Forensics LD	10		3155.7	327.75	10%									
Harrier/Hawk	Forensics	Forensics LD	10	247.5	4313.0	949.41	22%					2	4		4	4
Kestrel/Kite.	Forensics	Forensics LD	16		4838.6	940.33	19%						28		52	52
Langley Ward	Forensics	Forensics LD	10		2407.8	245.5	10%					1				
Northdale Centre	Forensics	Forensics LD	12	202.5	5134.0	1300.45	25%						2		4	4
Oakwood	Forensics	Forensics LD	8		2027.0	77	4%									
Thistle	Forensics	Forensics LD	5		2944.3	210.5	7%					1				
Brambling Ward	Forensics	Forensics MH	13		2731.0	182.75	7%						5		6	6
Fulmar Ward.	Forensics	Forensics MH	12		2899.1	243.75	8%									
Jay Ward	Forensics	Forensics MH	5		2897.9	421.75	15%					1	4	1	6	7
Lark	Forensics	Forensics MH	15		2728.3	252.5	9%					1				
Linnet Ward	Forensics	Forensics MH	17		3283.4	607.25	18%						8		11	11
Mallard Ward	Forensics	Forensics MH	16		3648.8	653.5	18%									
Mandarin	Forensics	Forensics MH	16		3815.0	954.5	25%					4				
Merlin	Forensics	Forensics MH	10		4517.5	941	21%									
Newtondale Ward	Forensics	Forensics MH	20		3496.6	485.66	14%					1				
Nightingale Ward	Forensics	Forensics MH	16		2610.6	260.75	10%									
Sandpiper Ward	Forensics	Forensics MH	8		4999.9	1343.75	27%						57	4	181	185

Swift Ward	Forensics	Forensics MH	10		3192.3	465	15%						1		1	1
Aysgarth	Teesside	LD	6		2143.6	450.25	21%									
Bankfields Court	Teesside	LD	19		7627.2	664.98	9%						22		29	29
Bankfields Court Unit 2	Teesside	LD	5		2042.8	188.36	9%									
Bek-Ramsey Ward	Durham & Darlington	LD	11		4424.4	240.67	5%						6	2	6	8
Oak Rise	York and Selby	LD	8		3923.9	173.51	4%						2		2	2
Ceddesfeld Ward	Durham & Darlington	MHSOP	15		3309.4	207.67	6%						7		11	11
Cherry Tree House	York and Selby	MHSOP	18		3425.5	211.5	6%						3		4	4
Hamsterley Ward	Durham & Darlington	MHSOP	15		3544.3	629.85	18%						3		5	5
Meadowfields	York and Selby	MHSOP	14	396.0	3334.0	436.5	13%						3		3	3
Oak Ward	Durham & Darlington	MHSOP	12		2684.0	103.67	4%			1		1				
Roseberry Wards	Durham & Darlington	MHSOP	15		2735.9	342.73	13%									
Rowan Lea	North Yorkshire	MHSOP	20		3693.8	144.37	4%						18		33	33
Rowan Ward	North Yorkshire	MHSOP	16		2915.8	442.5	15%						6		10	10
Springwood Community Unit	North Yorkshire	MHSOP	14		3148.9	333.75	11%	1	1				40		49	49
Ward 14	North Yorkshire	MHSOP	9		2597.8	40.25	2%	1	1				2		3	3
Westerdale North	Teesside	MHSOP	18		2733.8	176.5	6%									
Westerdale South	Teesside	MHSOP	14		4838.6	1895.54	39%						3		4	4
Wingfield Ward	Teesside	MHSOP	10		2547.5	250.5	10%	1	1							
Worsley Court	York and Selby	MHSOP	5	648.0	2438.5	93.5	4%					2	1		1	1

APPENDIX 3

SEVERITY SCORING – DECEMBER 2016

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE
Springwood Community Unit	2	2	1	0	0	1	1	0	0	2	**9**
Cedar Ward (NY)	4	2	0	1	0	0	0	1	0	0	**8**
Harrier/Hawk	2	3	1	1	1	0	0	0	0	0	**8**
Minster Ward	4	1	1	1	1	0	0	0	0	0	**8**
Sandpiper Ward	2	2	1	0	1	0	0	0	0	2	**8**
Westwood Centre	0	2	0	0	1	0	0	3	0	2	**8**
Bankfields Court	4	0	1	0	0	0	0	0	0	1	**6**
Hamsterley Ward	2	2	1	0	1	0	0	0	0	0	**6**
Linnet Ward	2	2	1	0	1	0	0	0	0	0	**6**
Newberry Centre	2	1	1	0	1	0	0	0	0	1	**6**
Newtondale Ward	4	0	1	0	1	0	0	0	0	0	**6**
Overdale Ward	2	2	1	0	1	0	0	0	0	0	**6**
Worsley Court	4	1	0	1	0	0	0	0	0	0	**6**
Meadowfields	2	0	1	1	1	0	0	0	0	0	**5**
Northdale Centre	2	1	0	1	1	0	0	0	0	0	**5**
Ward 14	2	1	0	0	0	1	1	0	0	0	**5**
Ward 15 Friarage	2	1	1	0	1	0	0	0	0	0	**5**
Ayckbourn Unit Danby Ward	4	0	0	0	0	0	0	0	0	0	**4**
Bransdale Ward	2	1	0	0	1	0	0	0	0	0	**4**
Cedar Ward	0	2	0	0	1	0	0	0	0	1	**4**
Cherry Tree House	2	1	0	0	0	0	0	0	1	0	**4**
Ebor Ward	2	0	1	1	0	0	0	0	0	0	**4**
Jay Ward	2	0	1	0	1	0	0	0	0	0	**4**
Kestrel/Kite.	0	2	0	0	1	0	0	0	0	1	**4**
Langley Ward	2	2	0	0	0	0	0	0	0	0	**4**
Mallard Ward	2	1	0	0	1	0	0	0	0	0	**4**

Mandarin	0	2	1	0	1	0	0	0	0	0	**4**
Maple Ward	2	0	1	0	0	0	0	1	0	0	**4**
Merlin	0	2	1	0	1	0	0	0	0	0	**4**
Oakwood	2	1	1	0	0	0	0	0	0	0	**4**
Rowan Ward	2	1	0	0	1	0	0	0	0	0	**4**
Swift Ward	2	1	0	0	1	0	0	0	0	0	**4**
The Evergreen Centre	2	0	1	0	0	0	0	1	0	0	**4**
Westerdale South	0	3	0	0	1	0	0	0	0	0	**4**
Wingfield Ward	2	0	0	0	0	1	1	0	0	0	**4**
Ceddesfeld Ward	2	1	0	0	0	0	0	0	0	0	**3**
Elm Ward	0	1	0	0	1	0	0	0	1	0	**3**
Fulmar Ward.	2	0	1	0	0	0	0	0	0	0	**3**
Holly Unit	0	2	1	0	0	0	0	0	0	0	**3**
Kirkdale Ward	2	0	1	0	0	0	0	0	0	0	**3**
Lark	2	0	1	0	0	0	0	0	0	0	**3**
Primrose Lodge	2	1	0	0	0	0	0	0	0	0	**3**
Willow Ward	2	1	0	0	0	0	0	0	0	0	**3**
Ayckbourn Unit Esk Ward	2	0	0	0	0	0	0	0	0	0	**2**
Aysgarth	0	1	0	0	1	0	0	0	0	0	**2**
Bedale Ward	0	1	0	0	1	0	0	0	0	0	**2**
Bek-Ramsey Ward	0	1	1	0	0	0	0	0	0	0	**2**
Birch Ward	0	1	0	0	1	0	0	0	0	0	**2**
Brambling Ward	2	0	0	0	0	0	0	0	0	0	**2**
Clover/Ivy	0	1	0	0	1	0	0	0	0	0	**2**
Eagle/Osprey	2	0	0	0	0	0	0	0	0	0	**2**
Farnham Ward	0	1	0	0	0	0	0	0	1	0	**2**
Nightingale Ward	2	0	0	0	0	0	0	0	0	0	**2**
Oak Rise	2	0	0	0	0	0	0	0	0	0	**2**
Roseberry Wards	0	0	1	0	1	0	0	0	0	0	**2**
The Orchards (NY)	2	0	0	0	0	0	0	0	0	0	**2**
Thistle	2	0	0	0	0	0	0	0	0	0	**2**
Westerdale North	0	1	1	0	0	0	0	0	0	0	**2**
Bankfields Court Unit 2	0	1	0	0	0	0	0	0	0	0	**1**
Lincoln Ward	0	0	0	0	0	0	0	0	1	0	**1**
Lustrum Vale	0	0	1	0	0	0	0	0	0	0	**1**

Oak Ward	0	0	0	0	0	0	0	1	0	0	**1**
Robin	0	0	1	0	0	0	0	0	0	0	**1**
Rowan Lea	0	0	0	0	0	0	0	0	0	1	**1**
Stockdale Ward	0	0	0	0	1	0	0	0	0	0	**1**
Tunstall Ward	0	0	1	0	0	0	0	0	0	0	**1**
Baysdale	0	0	0	0	0	0	0	0	0	0	**0**

JANUARY 2017 DATA

APPENDIX 4

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN January							
				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Westwood Centre	Teesside	CYPS	12	98.1%	139.7%	105.2%	194.0%
Clover/Ivy	Forensics	Forensics LD	12	99.3%	102.7%	100.0%	151.5%
Eagle/Osprey	Forensics	Forensics LD	10	87.1%	94.5%	100.4%	95.2%
Harrier/Hawk	Forensics	Forensics LD	10	81.0%	128.7%	106.5%	166.1%
Kestrel/Kite.	Forensics	Forensics LD	16	99.8%	126.5%	117.7%	148.3%
Langley Ward	Forensics	Forensics LD	10	75.5%	132.8%	100.0%	100.0%
Northdale Centre	Forensics	Forensics LD	12	75.4%	123.0%	54.8%	99.2%
Oakwood	Forensics	Forensics LD	8	96.6%	191.9%	100.0%	100.0%
Thistle	Forensics	Forensics LD	5	69.5%	108.8%	96.8%	98.4%
Brambling Ward	Forensics	Forensics MH	13	80.6%	105.1%	100.0%	101.8%
Fulmar Ward.	Forensics	Forensics MH	12	90.6%	120.2%	100.3%	141.9%
Jay Ward	Forensics	Forensics MH	5	85.2%	96.6%	103.2%	98.4%
Lark	Forensics	Forensics MH	15	101.1%	99.0%	106.5%	98.5%
Linnet Ward	Forensics	Forensics MH	17	80.7%	141.7%	103.2%	146.8%
Mallard Ward	Forensics	Forensics MH	16	95.2%	131.3%	105.6%	210.7%
Mandarin	Forensics	Forensics MH	16	79.7%	138.5%	100.0%	151.6%
Merlin	Forensics	Forensics MH	10	105.1%	131.3%	96.8%	207.8%
Newtondale Ward	Forensics	Forensics MH	20	92.3%	103.0%	71.0%	116.5%

Nightingale Ward	Forensics	Forensics MH	16	75.0%	102.7%	100.0%	95.8%
Sandpiper Ward	Forensics	Forensics MH	8	90.8%	114.1%	84.9%	150.0%
Swift Ward	Forensics	Forensics MH	10	90.7%	130.7%	106.5%	167.9%
Aysgarth	Teesside	LD	6	107.8%	143.6%	100.1%	100.4%
Bankfields Court	Teesside	LD	19	84.9%	100.5%	103.2%	98.2%
Bankfields Court Unit 2	Teesside	LD	5	131.7%	96.3%	103.4%	107.9%
Bek-Ramsey Ward	Durham & Darlington	LD	11	103.9%	119.2%	100.0%	103.2%
Oak Rise	York and Selby	LD	8	101.8%	94.4%	85.3%	118.6%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	95.1%	115.5%	100.0%	96.7%
Cherry Tree House	York and Selby	MHSOP	18	109.8%	99.1%	93.5%	128.8%
Hamsterley Ward	Durham & Darlington	MHSOP	15	97.4%	129.5%	100.2%	122.6%
Meadowfields	York and Selby	MHSOP	14	93.0%	86.9%	74.2%	140.3%
Oak Ward	Durham & Darlington	MHSOP	12	95.8%	97.1%	100.0%	105.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	107.5%	98.3%	100.0%	103.4%
Rowan Lea	North Yorkshire	MHSOP	20	100.9%	104.4%	110.2%	106.1%
Rowan Ward	North Yorkshire	MHSOP	16	91.2%	140.5%	100.4%	167.6%
Springwood Community Unit	North Yorkshire	MHSOP	14	72.9%	123.7%	100.0%	128.8%
Ward 14	North Yorkshire	MHSOP	9	67.0%	127.4%	100.0%	100.0%
Westerdale North	Teesside	MHSOP	18	97.7%	134.6%	100.8%	108.9%
Westerdale South	Teesside	MHSOP	14	106.8%	113.8%	100.0%	112.3%
Wingfield Ward	Teesside	MHSOP	10	98.8%	110.0%	98.9%	111.9%

APPENDIX 5

Scored Fill Rate compared to Quality Indicators - January 2017					Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Agency Usage Hours	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI (IIC)	Level 4 Incidents (IIC)	Level 3 (Self-Harm) Incidents (IIC)	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11		2173.5	328.0	15%						1		2	2
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11		2693.3	330.0	12%					4	3		3	3
Bedale Ward	Teesside	Adults	10		3431.7	913.5	27%					2	13	3	24	27
Bilsdale Ward	Teesside	Adults	14		2723.5	264.5	10%					1	1		4	4
Birch Ward	Durham & Darlington	Adults	15		3338.4	907.2	27%									
Bransdale Ward	Teesside	Adults	14		3011.0	1302.5	43%					5				
Cedar Ward	Durham & Darlington	Adults	10		4621.9	1949.3	42%						29	1	46	47
Cedar Ward (NY)	North Yorkshire	Adults	18	975.75	3911.5	391.5	10%					1	3		8	8
Ebor Ward	York and Selby	Adults	12	319	3009.8	103.0	3%			1			8		12	12
Elm Ward	Durham & Darlington	Adults	20		2617.8	562.3	21%					1	3	1	4	5
Farnham Ward	Durham & Darlington	Adults	20		2898.4	293.3	10%					1	3		6	6
Kirkdale Ward	Teesside	Adults	16		3181.6	213.8	7%						2		2	2
Lincoln Ward	Teesside	Adults	20		3229.6	103.5	3%						2		2	2
Lustrum Vale	Teesside	Adults	20		2928.1	254.1	9%						4		7	7
Maple Ward	Durham & Darlington	Adults	20		2529.8	362.3	14%					2	7		10	10
Minster Ward	York and Selby	Adults	12		2684.6	395.5	15%					1	8	1	10	11
Overdale Ward	Teesside	Adults	18		2721.5	269.0	10%						1		1	1
Primrose Lodge	Durham & Darlington	Adults	15		2559.6	132.0	5%					1				

Stockdale Ward	Teesside	Adults	18		2674.8	512.8	19%						2		2	2
The Orchards (NY)	North Yorkshire	Adults	10		1761.8	12.0	1%			1						
Tunstall Ward	Durham & Darlington	Adults	20		3133.5	24.0	1%					1	1		1	1
Ward 15 Friarage	North Yorkshire	Adults	12		2679.2	670.8	25%					2	2		3	3
Willow Ward	Durham & Darlington	Adults	15		3029.3	324.0	11%						4	1	3	4
Baysdale	Teesside	CYPS	6		2393.2	111.2	5%									
Holly Unit	Durham & Darlington	CYPS	4		1520.2	196.4	13%									
Newberry Centre	Teesside	CYPS	14		3559.9	335.9	9%						24		31	31
Talbot Direct Care	Durham & Darlington	CYPS	1		1273.0	0.0	0%						17		32	32
The Evergreen Centre	Teesside	CYPS	16		4989.8	23.0	0%						16		22	22
Westwood Centre	Teesside	CYPS	12		5709.1	864.8	15%			1		1	46		81	81
Clover/Ivy	Forensics	Forensics LD	12		4180.3	1112.0	27%					2	1		1	1
Eagle/Osprey	Forensics	Forensics LD	10		3164.3	447.5	14%									
Harrier/Hawk	Forensics	Forensics LD	10	202.5	4661.8	1072.2	23%				1	3	9	1	17	18
Kestrel/Kite.	Forensics	Forensics LD	16		4847.6	905.8	19%						21		50	50
Langley Ward	Forensics	Forensics LD	10		2237.0	260.5	12%									
Northdale Centre	Forensics	Forensics LD	12		4765.6	1299.3	27%					4	1		2	2
Oakwood	Forensics	Forensics LD	8		2157.3	132.0	6%									
Thistle	Forensics	Forensics LD	5		2977.9	287.6	10%					1	9		20	20
Brambling Ward	Forensics	Forensics MH	13		2804.2	281.3	10%			2			1		1	1
Fulmar Ward.	Forensics	Forensics MH	12		3595.7	616.0	17%			1		1	17		30	30
Jay Ward	Forensics	Forensics MH	5		2738.8	261.3	10%									
Lark	Forensics	Forensics MH	15		2859.8	307.6	11%					3				
Linnet Ward	Forensics	Forensics MH	17		3505.3	938.3	27%						7		10	10
Mallard Ward	Forensics	Forensics MH	16		4322.3	1454.0	34%									
Mandarin	Forensics	Forensics MH	16		3497.8	715.5	20%				1	2				

Merlin	Forensics	Forensics MH	10		4736.3	1501.8	32%						12	2	26	28
Newtondale Ward	Forensics	Forensics MH	20		3696.7	642.9	17%						1		3	3
Nightingale Ward	Forensics	Forensics MH	16		2698.9	330.5	12%									
Sandpiper Ward	Forensics	Forensics MH	8		4266.3	1014.5	24%			1			129	7	324	331
Swift Ward	Forensics	Forensics MH	10		3994.6	1080.5	27%			1			26		38	38
Aysgarth	Teesside	LD	6		2341.0	405.2	17%									
Bankfields Court	Teesside	LD	19		8191.1	793.6	10%						32		46	46
Bankfields Court Unit 2	Teesside	LD	5		2302.1	245.5	11%									
Bek-Ramsey Ward	Durham & Darlington	LD	11		4422.7	84.0	2%						2		3	3
Oak Rise	York and Selby	LD	8		3995.2	258.3	6%									
Ceddesfeld Ward	Durham & Darlington	MHSOP	15		3202.7	180.0	6%					1	2		2	2
Cherry Tree House	York and Selby	MHSOP	18		3604.4	154.5	4%						6		7	7
Hamsterley Ward	Durham & Darlington	MHSOP	15		3416.1	428.7	13%						4		7	7
Meadowfields	York and Selby	MHSOP	14	156	3464.1	754.5	22%						2		4	4
Oak Ward	Durham & Darlington	MHSOP	12		2711.3	67.7	2%			1		2				
Roseberry Wards	Durham & Darlington	MHSOP	15		2907.0	620.3	21%									
Rowan Lea	North Yorkshire	MHSOP	20		3718.0	79.0	2%					2	9		11	11
Rowan Ward	North Yorkshire	MHSOP	16	469.5	3394.8	463.0	14%						16		36	36
Springwood Community Unit	North Yorkshire	MHSOP	14	174	3149.1	270.3	9%						40		45	45
Ward 14	North Yorkshire	MHSOP	9		2461.3	9.0	0%						1		1	1
Westerdale North	Teesside	MHSOP	18		2968.2	135.5	5%						3		3	3
Westerdale South	Teesside	MHSOP	14		4343.2	1519.7	35%						2		5	5
Wingfield Ward	Teesside	MHSOP	10		2688.0	221.5	8%									

APPENDIX 6

SEVERITY SCORE – JANUARY 2017

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE
The Orchards (NY)	8	0	0	0	0	0	0	1	0	0	**9**
Harrier/Hawk	2	2	1	1	1	0	0	0	1	0	**8**
Meadowfields	4	1	1	1	1	0	0	0	0	0	**8**
Sandpiper Ward	2	1	1	0	1	0	0	1	0	2	**8**
Springwood Community Unit	2	2	0	1	0	0	0	0	0	2	**7**
Westwood Centre	0	2	1	0	1	0	0	1	0	2	**7**
Bransdale Ward	2	2	0	0	2	0	0	0	0	0	**6**
Holly Unit	0	4	1	0	1	0	0	0	0	0	**6**
Linnet Ward	2	2	1	0	1	0	0	0	0	0	**6**
Mandarin	2	2	0	0	1	0	0	0	1	0	**6**
Northdale Centre	4	1	0	0	1	0	0	0	0	0	**6**
Rowan Ward	0	2	1	1	1	0	0	0	0	1	**6**
Swift Ward	0	2	1	0	1	0	0	1	0	1	**6**
Bedale Ward	2	1	0	0	1	0	0	0	0	1	**5**
Brambling Ward	2	0	1	0	0	0	0	2	0	0	**5**
Cedar Ward	0	2	0	0	2	0	0	0	0	1	**5**
Cedar Ward (NY)	2	2	0	1	0	0	0	0	0	0	**5**
Ebor Ward	2	1	0	1	0	0	0	1	0	0	**5**
Fulmar Ward.	0	2	0	0	1	0	0	1	0	1	**5**
Kestrel/Kite.	0	2	1	0	1	0	0	0	0	1	**5**
Ayckbourn Unit Danby Ward	2	0	1	0	1	0	0	0	0	0	**4**
Ayckbourn Unit Esk Ward	2	1	0	0	1	0	0	0	0	0	**4**
Bankfields Court	2	0	1	0	0	0	0	0	0	1	**4**
Bilsdale Ward	2	1	1	0	0	0	0	0	0	0	**4**
Langley Ward	2	1	0	0	1	0	0	0	0	0	**4**
Mallard Ward	0	2	1	0	1	0	0	0	0	0	**4**

Maple Ward	2	0	1	0	1	0	0	0	0	0	**4**
Merlin	0	2	0	0	1	0	0	0	0	1	**4**
Newtondale Ward	2	0	1	0	1	0	0	0	0	0	**4**
Nightingale Ward	2	0	1	0	1	0	0	0	0	0	**4**
Ward 15 Friarage	2	1	0	0	1	0	0	0	0	0	**4**
Aysgarth	0	1	1	0	1	0	0	0	0	0	**3**
Eagle/Osprey	2	0	0	0	1	0	0	0	0	0	**3**
Elm Ward	0	1	1	0	1	0	0	0	0	0	**3**
Hamsterley Ward	0	2	0	0	1	0	0	0	0	0	**3**
Minster Ward	0	1	1	0	1	0	0	0	0	0	**3**
Newberry Centre	2	0	0	0	0	0	0	0	0	1	**3**
Primrose Lodge	2	1	0	0	0	0	0	0	0	0	**3**
Talbot Direct Care	0	2	0	0	0	0	0	0	0	1	**3**
Thistle	2	0	1	0	0	0	0	0	0	0	**3**
Ward 14	2	1	0	0	0	0	0	0	0	0	**3**
Westerdale South	0	2	0	0	1	0	0	0	0	0	**3**
Bankfields Court Unit 2	0	1	1	0	0	0	0	0	0	0	**2**
Birch Ward	0	0	1	0	1	0	0	0	0	0	**2**
Clover/Ivy	0	1	0	0	1	0	0	0	0	0	**2**
Jay Ward	2	0	0	0	0	0	0	0	0	0	**2**
Kirkdale Ward	2	0	0	0	0	0	0	0	0	0	**2**
Oak Rise	2	0	0	0	0	0	0	0	0	0	**2**
Ceddesfeld Ward	0	0	1	0	0	0	0	0	0	0	**1**
Cherry Tree House	0	1	0	0	0	0	0	0	0	0	**1**
Farnham Ward	0	1	0	0	0	0	0	0	0	0	**1**
Lincoln Ward	0	0	1	0	0	0	0	0	0	0	**1**
Oak Ward	0	0	0	0	0	0	0	1	0	0	**1**
Oakwood	0	1	0	0	0	0	0	0	0	0	**1**
Roseberry Wards	0	0	0	0	1	0	0	0	0	0	**1**
Stockdale Ward	0	0	0	0	1	0	0	0	0	0	**1**
The Evergreen Centre	0	0	0	0	0	0	0	0	0	1	**1**
Tunstall Ward	0	1	0	0	0	0	0	0	0	0	**1**
Westerdale North	0	1	0	0	0	0	0	0	0	0	**1**
Willow Ward	0	1	0	0	0	0	0	0	0	0	**1**
Wingfield Ward	0	0	1	0	0	0	0	0	0	0	**1**

Baysdale	0	0	0	0	0	0	0	0	0	0	**0**
Bek-Ramsey Ward	0	0	0	0	0	0	0	0	0	0	**0**
Lark	0	0	0	0	0	0	0	0	0	0	**0**
Lustrum Vale	0	0	0	0	0	0	0	0	0	0	**0**
Overdale Ward	0	0	0	0	0	0	0	0	0	0	**0**
Robin	0	0	0	0	0	0	0	0	0	0	**0**
Rowan Lea	0	0	0	0	0	0	0	0	0	0	**0**

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 28 February 2016**
TITLE:	**To consider the report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 3, 2016-17.

Key Points:

- CQC MHA specific inspections summary report
- Report on use of Section 136, Street Triage and CAS activity
- Reports on Discharges from Detention by Associate Hospital Managers and MHT
- Seclusion activity report
- Report on MCA and DoLS update and activity

Recommendations:

The Board of Directors is asked to receive and note the assurance report, following the MHLC meeting held on 19 January 2017 and to note the approved minutes of the MHLC meeting held on 19 October 2016. (Appendix 2)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 28 February 2017**
TITLE:	**To consider the report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

1.1 To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 3, 2016-17; through consideration of the work of the Mental Health Legislation Committee, which is a Standing Committee of the Board.

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

Arising from the meeting held on 19 January 2017

3.1 The minutes of the Committee meeting held on 19 October 2016 were reviewed and agreed as an accurate record and signed by the Chairman. (See Appendix 1 for information).

3.2 It was noted from the summary report for CQC MHA inspections that there were 11 visits in Q3 as compared to 10 in Q2. Reports had been received for 9 of the visits held in Q3 and 4 were received from Q2 visits. From the 13 reports, there were 42 issues raised by CQC and 6 issues raised by patients. Future reports will include a summary table of completed and outstanding actions. It was agreed to undertake a piece of work to look at commonly recurring themes and to bring back an action plan to the next committee with recommendation as to how best to take a trust-wide approach to reducing such incidences.

3.3 The Section 136 report was presented. In total there were 162 uses of section 136 across the whole Trust area, a significant decrease of 40% in this quarter, from 271 in the previous quarter. This represents, however, only a 13% decrease when compared to the same quarter last year. Those being taken into police custody remains low at 8% across the whole Trust area. There were 2 individuals aged under 18 years, one aged 16 and one aged 13, both were brought to a hospital place of safety and both were discharged with follow up.

In terms of Street Triage activity there were 112 contacts in the quarter in Teesside compared to 95 in the previous quarter, of which 1 resulted in the use of section 136, and in York there were 85 contacts compared to 88 last quarter of which 4 resulted in the use of section 136. Scarborough had 112 contacts compared to 101 in the last quarter of which 1 resulted in section

136. It has recently been clarified that the Scarborough STT enter each contact with an individual onto the STT spreadsheet, including any follow-up contacts with that person; therefore the figures above include each of these visits and not just initial contact.
The Tees and York STTs only document on their spreadsheet, the initial contact irrespective of any follow up visits they may make. Future reports will show only the initial contact with the individuals. The percentage of contacts by all Street Triage Teams with people already known to services was – Tees 78% known, Scarborough 79% known and York 56% known, though Scarborough's will be impacted by the follow up visits by STT once people are known to services.

Within the Crisis Assessment Suite at Roseberry Park activity continues to be significant though has dropped by 24% in Q3 with 485 assessments compared to 559 assessments undertaken in the previous quarter, (this does not include those assessed subject to section 136). The numbers attending 'voluntarily' with the police and not subject to section 136 continues to be high and far exceeds the number subject to section 136 – in Q3 there were 131 attending voluntarily with the police compared to 40 brought subject to section 136. Of the total 485 assessments 95, 19%, were discharged without mental health follow up or sign-posting to other services

3.4 The Discharge from Detention Report was presented. This report focusses on discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. Two patients were discharged by the Associate Hospital Managers this quarter equating to 1% from the 170 hearings held. Of the 168 FTTs held, the Tribunal ordered 9 discharges in total (5%) – 5 discharged from section 2, 3 discharged from section 3 and 1 discharged from a Community Treatment Order. One of the section 3 discharges was a deferred discharge to allow for DoLS to be put in place instead of MHA. This decision was challenged by the Trust on the basis that the MHT had erred in law in that the patient was not eligible for DoLS due to objection and that the MHT should have adjourned to ascertain whether DoLS was actually available. The decision was set aside by the Second Tier Tribunal to be reconvened and heard by a fresh panel. The DoLS MH Assessor determined that the patient was not eligible for DoLS due to objection but the patient was discharged to a care home placement before the adjourned MHT was set to be reconvened.

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

3.5 The seclusion report was presented. From the information available, there were 27 patients secluded in this period with 37 reported episodes of seclusion in total (one patient with 4 episodes and seven patients with 2 episodes); all episodes extended beyond 12 hours with 32 episodes extending beyond 24 hours. It was noted that one patient had been secluded on 26th October 2016 and that continuous seclusion episode was still running as at 19th January 2017.

3.6 The first Mental Capacity Act (MCA) and DoLS (Deprivation of Liberty Safeguards) Report was presented and this will be a standard agenda item going forward. This was made possible since the temporary appointment of the MHL Advisor (MCA/DoLS Lead) in June of last year. The initial focus of the post has been to develop audit and monitoring tools to enable a clearer view of MCA implementation, to provide additional practical training to staff and to provide a central point for the collation and monitoring of DoLS activity and to provide support and guidance for clinical operational staff in relation to the use of DoLS.

65 audits, both case file audits and a number of staffing questionnaires, were carried out across the Trust. The outcomes of these audits show that whilst there is a level of understanding around MCA and DoLS, the depth of this is variable across different localities and services of the Trust. Action plans to address the issues will be produced and implemented before Q4 end.

In terms of DoLS, it continues to be extremely difficult to monitor activity, which is currently a manual process, and is heavily reliant on operational staff contacting the MHL team regarding the use of DoLS, prior to using it, to enable support and guidance to be provided. A DoLS recording module has been developed for Paris to capture DoLS authorisations in a similar way that MHA activity is recorded which will hopefully ensure that DoLS status is clearly visible on individual care records and reporting of activity becomes clearer and more accurate. Regarding DoLS activity from manual data collection – from Q1 to end of Q3 there have been 65 applications made to Supervisory Bodies for Standard Authorisations, with 10 applications awaiting assessment as at Q3 end. There are currently 99 active DoLS Standard Authorisations in place across the Trust at Q3.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

No implications.

4.3 Legal and Constitutional (including the NHS Constitution):

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

4.4 **Equality and Diversity:**

No implications.

5. CONCLUSIONS:

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

7. RECOMMENDATIONS:

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

Author: Mel Wilkinson
Title: Head of Mental Health Legislation

Background Papers:
Appendix 1 – Background information

Appendix 2 - Approved minutes of the 19 October 2016 MHL Committee Meeting

Appendix 1

Background Information

The Mental Health Act 1983 is the primary legislation that directs and regulates the management, including the assessment and treatment under compulsion, of those whose mental disorders may cause risk to their own health or safety or where the protection of others is necessary.

The Mental Capacity Act 2005 is the primary legislation which provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. This includes decisions around care and treatment, accommodation and financial matters. Within Schedule 1 of the Mental Capacity Act are the Deprivation of Liberty Safeguards (DoLS) which further allow for people who lack capacity to be deprived of their liberty in order to provide care and treatment in their best interests.

The Board of Directors, who may be defined as the Hospital Managers for the purposes of the Act, require assurance that the Trust is compliant with Mental Health Act legislation and regulation. Following the implementation of the Trust Integrated Assurance Framework in 2008, the Mental Health Act Committee was approved as a Standing Committee of, and directly accountable to, the Board of Directors. The quarterly committee is chaired by a non-executive director and the committee receive regular themed performance reports from the corporate Mental Health Legislation administrative team.

The Trust is registered with the CQC for the regulated activity of 'Assessment or medical treatment for persons detained under the 1983 Act'. CQC therefore have a programme of regulatory inspection visits to areas with detained patients and to community teams to assess compliance with the Essential Standards that apply to that regulated activity. Those inspections also feedback intelligence into the CQC compliance processes for all Essential Standards further to observations in clinical areas. Since the review of the MHL Committee in April all reports, including the MHA specific visit reports, are now received and managed by the CQC Registration and Assurance Team.

In addition any areas of concern relating to detained patients or issues related to implementation of the Act are brought to the Committee. Quarterly assurance reports are made to the Board of Directors and forwarded to the Quality and Assurance committee for information in relation to monitoring of CQC registration compliance.

Appendix 2

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 24 OCTOBER 2016 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 11.00AM.

Present:
Dr N Land, Medical Director
Mr R Cowell, Director of Estates & Capital
Mrs J Illingworth, Director of Nursing & Governance
Mrs E Moody, Director of Nursing & Governance
Mr P Murphy, Non-Executive Director
Mr R Simpson, Non-Executive Director, Chairman of the Committee

In Attendance:
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation

Apologies: Apologies for absence were received from Ms P Griffin, Mental Health Legislation Advisor, Mr B Kilmurray, Director of Operations, Mrs L Bessant, Chairman of the Trust, Miss J Clark, Public Governor, Ms S Talbot-Landon, Public Governor and Mrs S Richardson, Non-Executive Director

The Chairman welcomed Mr P Murphy, Mrs S Richardson, Non-Executive Directors and Ms S Talbot-Landon, Public Governor, as newly appointed members to the Committee.

16/27 MINUTES

Agreed – *That the minutes of the last meeting held on 25 July be approved as a correct record and signed by the Chairman, subject to an amendment to Mrs J Ilingworth's title, which should have read "Director of Quality Governance".*

16/28 ACTION LOG

The Committee noted the actions and following updates:

16/20 CQC MHA Visit Feedback summary report: to include in future reports detail and information around actions following MHA inspections.

Assurance was provided to the MHLC that all actions following MHA inspections were reported through to EMT.

Completed

16/21 Section 136: Provide further analysis around CAS, attendance and police involvement.
The Committee was informed that this matter had been pursued for further information and more detail would be provided to the next MHLC meeting.

Completed

16/29 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT, 1 JULY – 30 SEPTEMBER 2016

The Committee considered and noted the Care Quality Commission (MHA) visit feedback summary report for the period 1 July to 30 September 2016.

Arising from the report it was noted that:

1. There had been 10 visits in Q2, compared to 7 in Q1. Reports had been received for 6 of the visits and the September 2016 reports had not yet been received.
2. There had been 21 issues raised by the CQC and 2 patients had raised an issue.
3. Where issues had been raised Provider Action Statements had been approved by EMT and returned to the CQC. All actions would then be monitored through the Quality Assurance Groups and no actions were overdue.

Agreed: that future CQC MHA Feedback Reports would include a summary table of actions completed and outstanding.

Action: Mrs J Illingworth

Following discussion concerns were noted around:

a) Repeated issues raised by the CQC, including old leave forms being left on patients files. The solution for scanning leave forms would be raised again with Mrs E Moody.
Action: Miss M Wilkinson

b) The lack of uptake around Code of Practice training, which had been mandated by EMT with plans for all IP nurses to be trained by March 2017. Miss Wilkinson would arrange for this training to be publicised again, including through E Bulletin.
Action: Miss M Wilkinson

16/30 SECTION 136

(Mrs E Moody joined the meeting)

The Committee considered and noted the Section 136 report.

Arising from the report it was highlighted that:

1. In total there had been 271 uses of section 136 across the whole Trust area, a significant increase of 38% from 198 in the previous Quarter. The 2 areas that had contributed mostly to the increase were North Yorkshire and Cleveland – North Yorkshire rising 43% from 86 to 123 and Cleveland rising 55% from 62 to 96.
2. Durham had remained stable at 52 during the Quarter from 50 previously.
3. Those being taken into police custody remained low at 7% across the whole Trust area.
4. There had been 9 individuals under the age of 18 brought to a TEWV place of safety in the last Quarter; 6 were aged 17 and 3 were 16 years of age from the Harrogate, Darlington, Durham, Middlesbrough and Northallerton area; 1 had been formally detained and the remainder were discharged with follow up from MH services.
5. In terms of Street Triage activity there were 95 contacts in the Quarter in Teesside, compared to 136 in the previous Quarter, of which 1 had resulted in the use of section 136, and in York there were 88 contacts compared to 78 last Quarter, of which 2 had resulted in the use of section 136. Scarborough had 101 contacts compared to 84 in the last Quarter of which 0 resulted in section 136.
6. There had been a high percentage of contacts by all Street Triage teams with people already known to services – Tees 84% known, Scarborough 94% known and York 63% known.

7. Within the Crisis Assessment Suite at Roseberry Park activity continued to be significant, with 559 assessments compared to 487 assessments undertaken in the previous Quarter
   On this matter it was noted that this did not include those assessed subject to section 136.
8. The numbers attending 'voluntarily' with the police and not subject to section 136 continued to be high and far exceeded the number subject to section 136. During the Quarter there had been 147 attending voluntarily with the police, compared to 94 brought subject to section 136.
9. Of the total 559 assessments 87, 16%, were discharged without mental health follow up or sign-posting to other services

16/31 MHA DISCHARGES REPORT

The Committee considered and noted the MHA Discharges Report.

Arising from the report it was highlighted that:

1. There had been 3 patients discharged by the Associate Hospital Managers during the Quarter, equating to 2% from the 142 hearings held.
2. Of the 178 FTTs held, the Tribunal ordered 14 discharges in total (8%) - 7 discharged from section 2, 2 discharged from section 3 and 4 discharged from Community Treatment Orders.
3. There was 1 absolute discharge of a restricted patient, with the agreement of the clinical team.
4. Although 2 of the patients discharged had the same RC, they had different Care Coordinators and their cases had been heard by different Tribunal Panels.
5. With regard to the FTT panels for each of the discharged patients, the Committee was assured that although there had been some commonality between panels, on no occasion had there been the same 2 or 3 people sitting on the panels.

16/32 SECLUSION REPORT

The Committee considered and noted the Seclusion Report.

Arising from the report it was highlighted that:

1. There continued to be difficulties obtaining 'clean' data from Paris and significant manual work was still required, along with some missing data issues.
2. From the information available there had been 23 patients secluded in this period, with 52 reported episodes of seclusion; 12 patients were secluded on multiple occasions between 2 and 6 times.

Following discussion it was noted that:

i) There were some concerns expressed regarding the long term nature of some seclusions and whether an escalation process would be required internally over and above the Code of Practice requirements. This would be discussed through LMGBs and CLODS.
ii) That the Patient Safety Group would receive the Seclusion Report for information in future.

The Committee were provided assurance that seclusion and long term seclusion was reported through the LMGB's and to the Quality Assurance Committee.

16/33 ANY OTHER BUSINESS

The Committee noted a verbal update from Dr Land around long periods of seclusion.

It was noted that there had recently been some longer periods of patient seclusion, with a recent episode lasting longer than 7 days. This would be discussed further at LMGB and SDG meetings, together with the Clinical Leaders Board.

Mrs Moody advised that there would be regular nursing and medical independent reviews, however escalation of longer periods of seclusion would need to be discussed further.

16/34 MENTAL HEALTH LEGISLATION COMMITTEE UPDATED TERMS OF REFERENCE

The Committee noted the updated terms of reference for the MHLC, to include an increase to the number of Non-Executive members from 1 to 2, which had been approved by the Board of Directors in September 2016.

The meeting concluded at 12.05pm

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Richard Simpson
Chairman – Mental Health Legislation Committee
24 October 2016

Item 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28 February 2017**
TITLE:	**Finance Report for Period 1 April 2016 to 31 January 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 January 2017 is a surplus of £10,155k, representing 3.6% of the Trust's turnover. The Trust is ahead of plan by £2,083k largely due to a refund of historic National Insurance payments linked to widening access trainees, contract variations with commissioners, and vacancies. Recruitment to posts is ongoing.

Identified Cash Releasing Efficiency Savings at 31 January 2017 is marginally ahead of plan. The Trust continues to progress schemes to deliver CRES for future years.

The Use of Resources Rating for the Trust is assessed as 1 for the period ending 31 January 2017 and is in line with plan.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**28 February 2017**
TITLE:	**Finance Report for Period 1 April 2016 to 31 January 2017**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2016 to 31 January 2017.

2. BACKGROUND INFORMATION

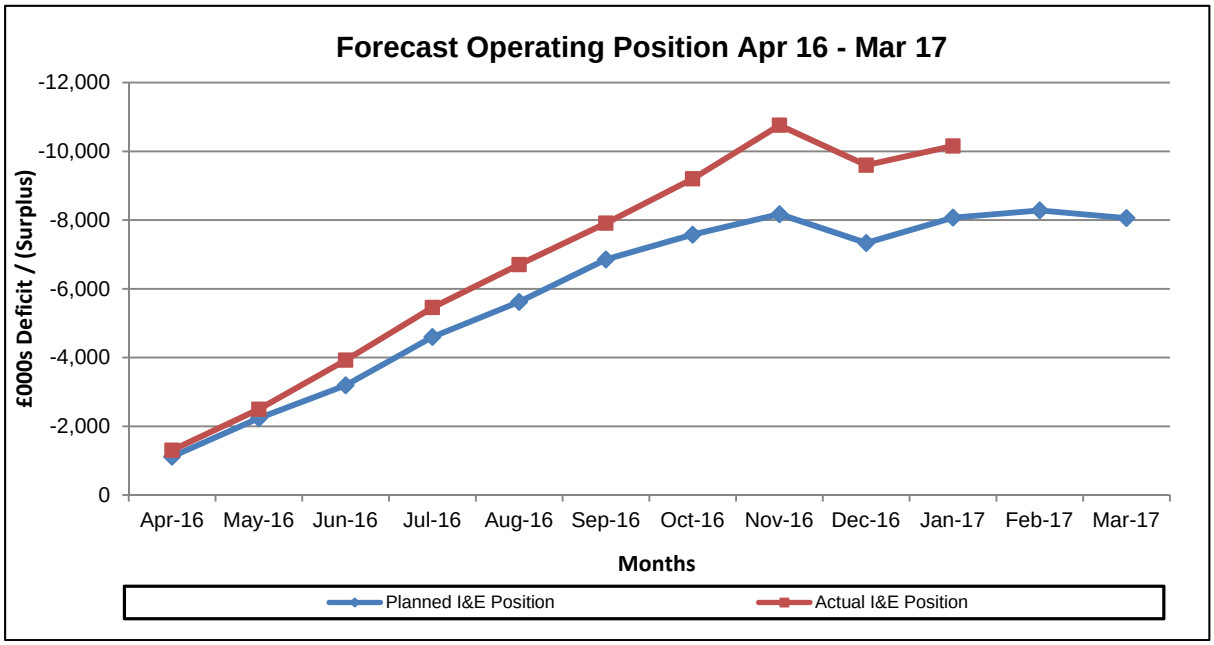
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

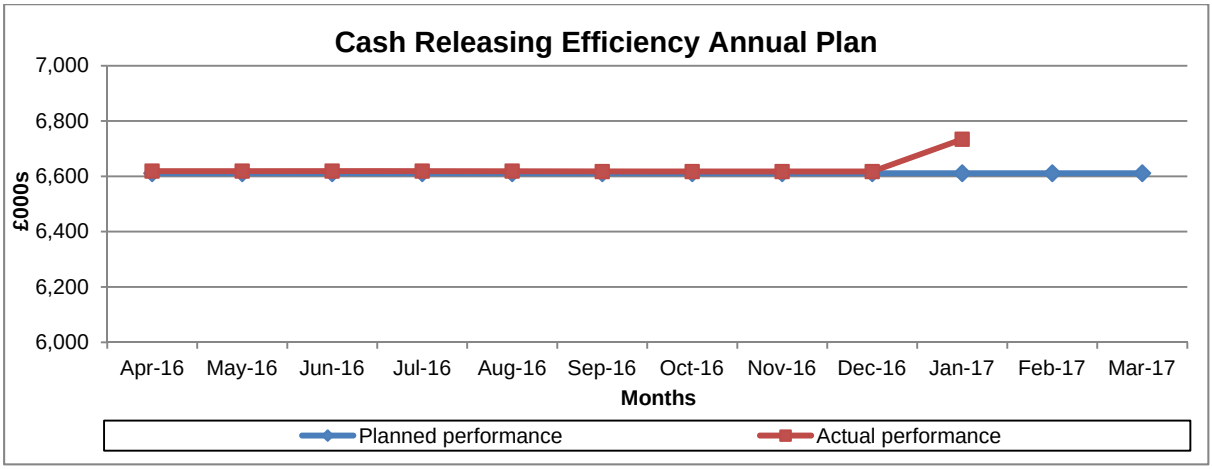
The comprehensive income outturn for the period ending 31 January 2017 is a surplus of £10,155k, representing 3.6% of the Trust's turnover. The Trust is ahead of plan by £2,083k largely due to a refund of historic National Insurance payments linked to widening access trainees, contract variations with commissioners and vacancies. Recruitment to posts is ongoing.

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

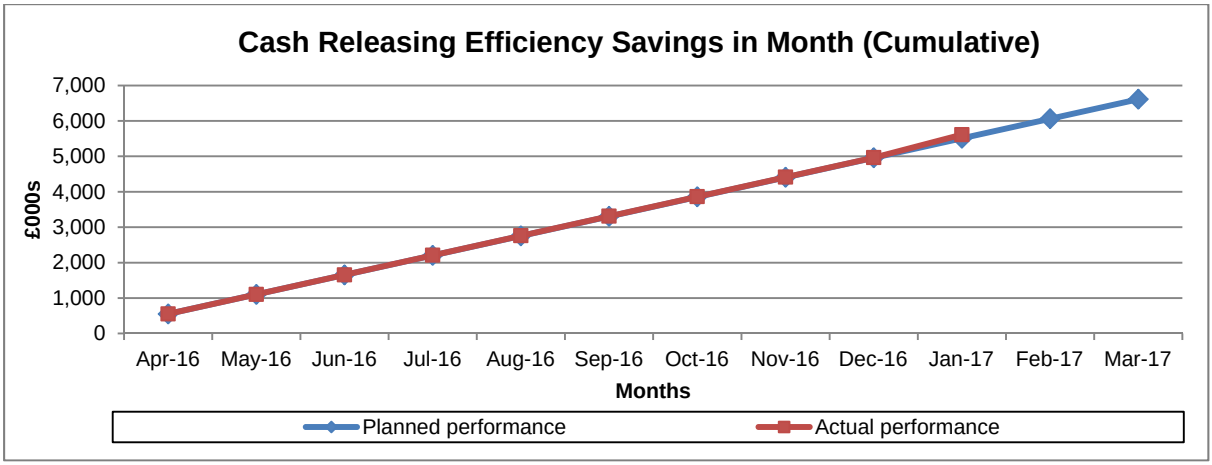


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 January 2017 is £6,734k and is ahead of plan. The Trust continues to progress schemes to deliver CRES for future years.

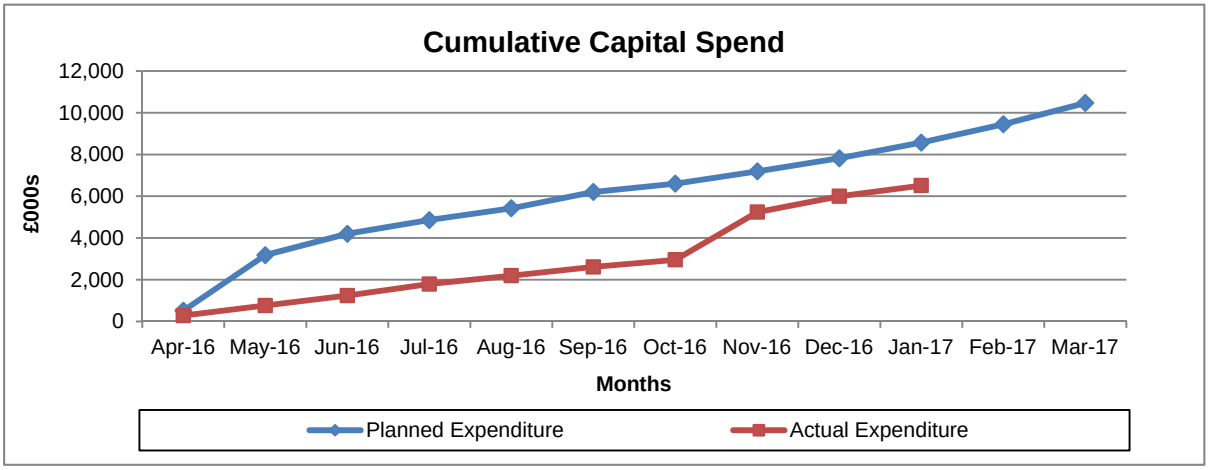


The monthly profile for CRES identified by Localities is shown below.



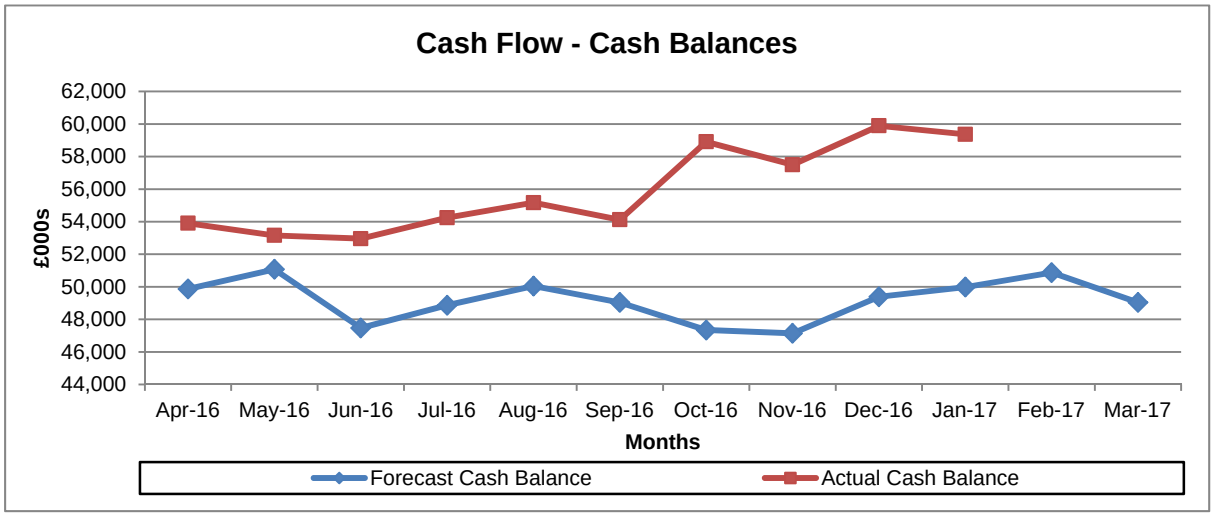
3.3 Capital Programme

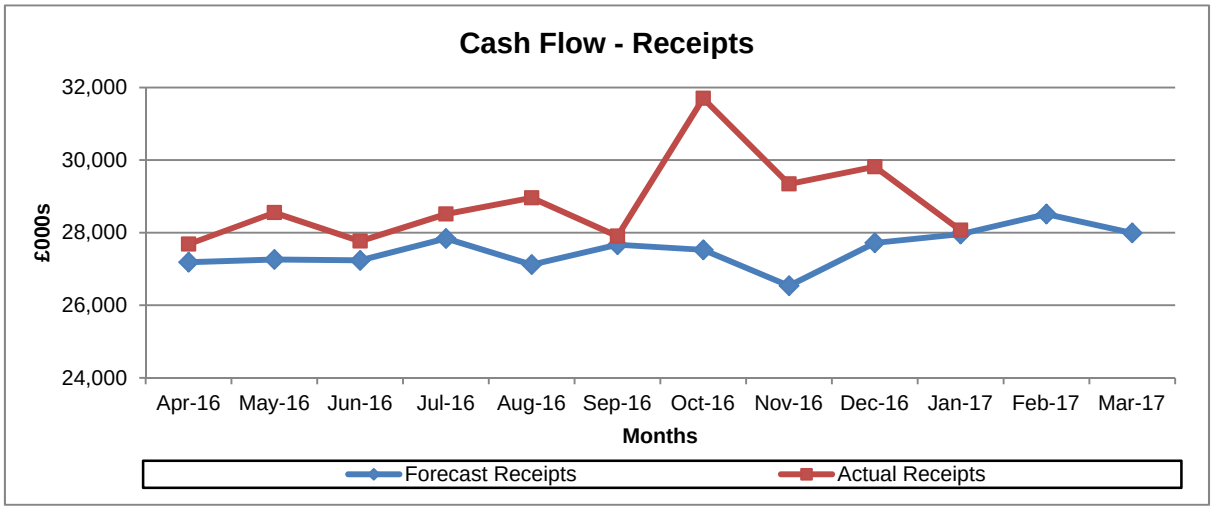
Capital expenditure to 31 January 2017 is £6,512k and is behind plan with schemes now progressing.

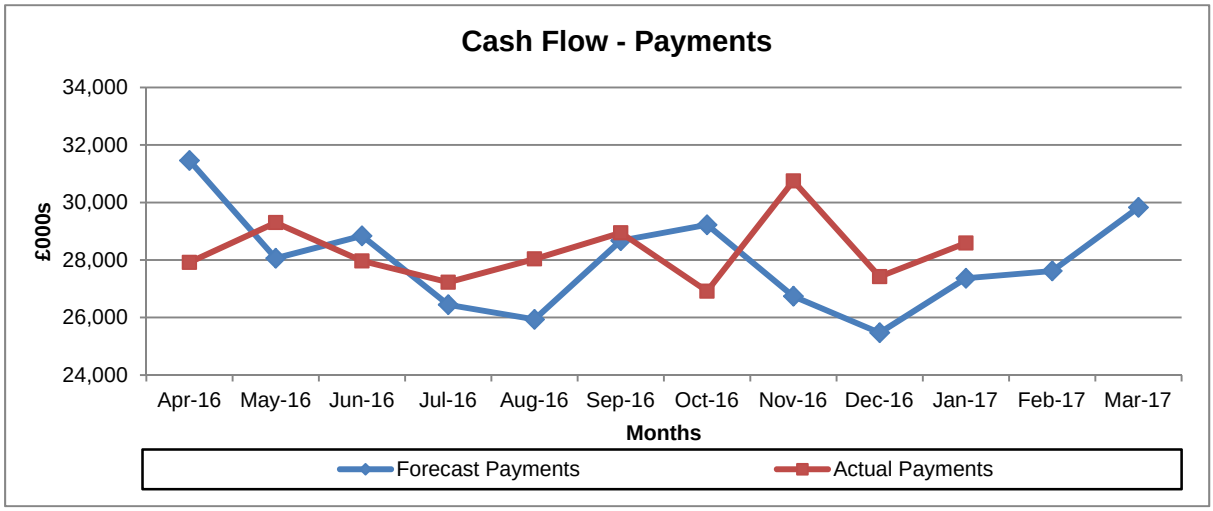


3.4 Cash Flow

Total cash at 31 January 2017 is £59,367k and is ahead of plan largely due to the Trusts surplus position, delays in the capital programme and unanticipated cash receipts related to projects.

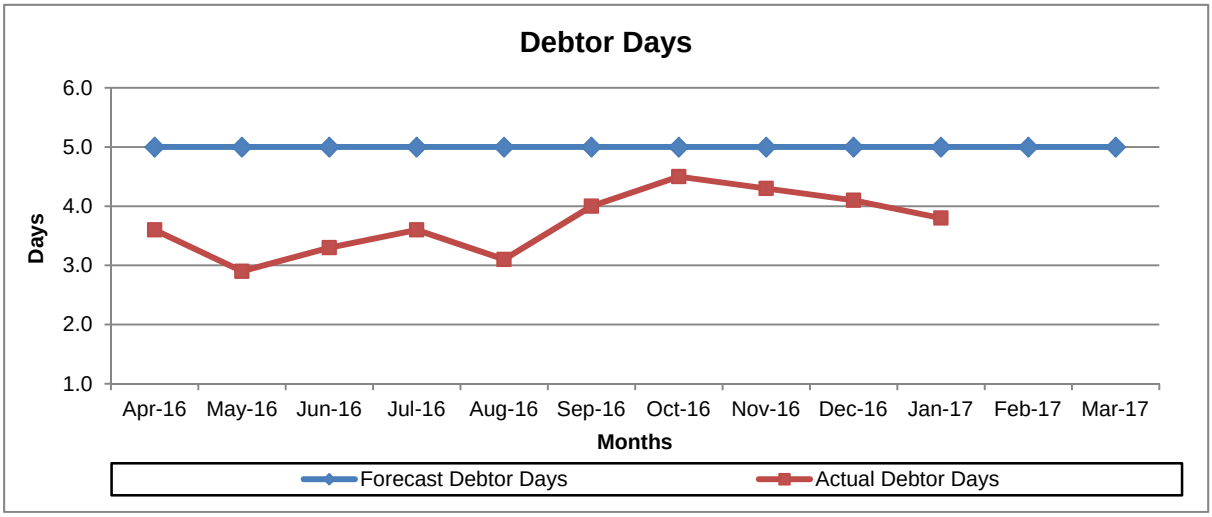






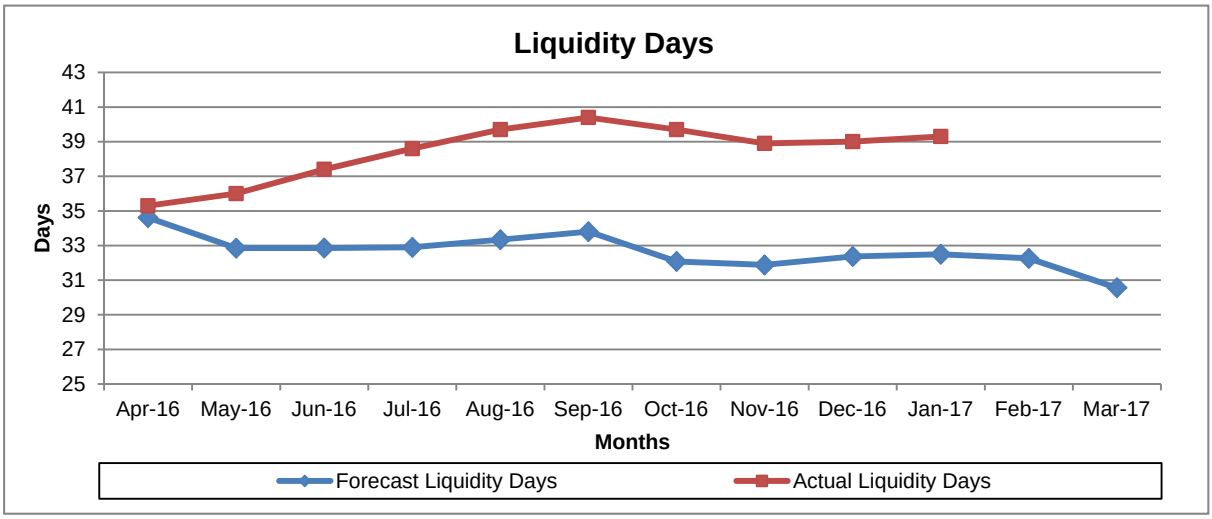
The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.
Working Capital ratios for period to 31 January 2017 are:

- Debtor Days of 3.8 days
- Liquidity of 39.3 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 42.86%
  Non NHS 30 Days – 95.98%



The Trust has a debtors' target of 5.0 days, and actual performance of 3.8 days for January 2017, which is ahead of plan.

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



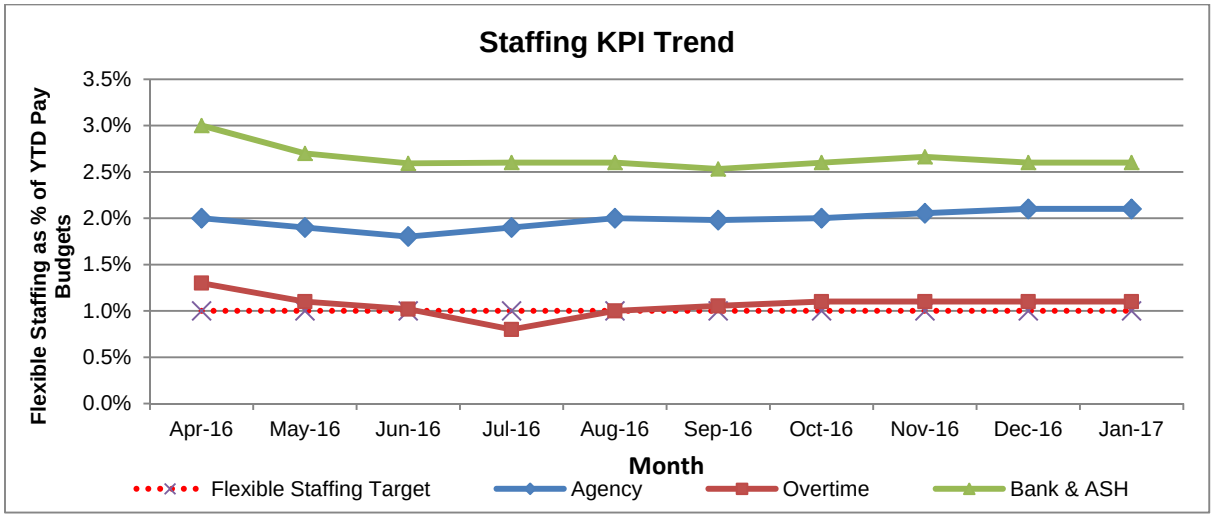
3.5 Financial Drivers

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

Tolerance	Aug	Sept	Oct	Nov	Dec	Jan
Agency (1%)	2.0%	2.0%	2.0%	2.1%	2.1%	2.1%
Overtime (1%)	1.0%	1.1%	1.1%	1.1%	1.1%	1.1%
Bank & ASH (flexed against establishment)	2.6%	2.5%	2.6%	2.7%	2.6%	2.6%
Establishment (90%-95%)	94.6%	94.3%	94.6%	93.7%	93.7%	93.5%
Total	**100.2%**	**99.9%**	**100.3%**	**99.6%**	**99.5%**	**99.3%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For January 2017 the tolerance for Bank and ASH is 4.5% of pay budgets.

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



Additional staffing expenditure is 5.8% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (54%), enhanced observations (19%) and sickness (13%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating is assessed as 1 at 31 January 2017, and is in line with plan.

3.6.2 Capital service capacity rating assesses the level of operating surplus generated, to ensure a Trust is able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.85x (can cover debt payments due 1.85 times), which is ahead of plan and rated as a 2.

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 39.3 days, this is ahead of with 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 4.5% and is rated as a 1.

3.6.5 The variance from plan assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. The Trust surplus is 0.8% ahead of plan and is rated as a 1.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 15% less than the cap and is rated as a 1.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to reduce to a 3 a surplus decrease of £1,187k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £33,192k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £9,595k is required.
- I&E Margin variance from plan – to reduce to a 2 an operating surplus decrease of £1,932k is required.
- Agency Cap rating – to reduce to a 2 an increase in agency expenditure of £759k is required.

Use of Resource Rating at 31 January 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 variance from plan	20	>=0%	-1%	-2%	<=-2%
Agency	20	<=0%	-25%	-50%	>50%

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.85x	2	1.64x	3	
Liquidity	39.3 days	1	34.5 days	1	
I&E margin	4.5%	1	3.7%	1	
I&E variance from plan	0.8%	1	0.0%	1	
Agency	£4,478k	1	£5,179k	1	
Overall Use of Resource Rating		**1**		**1**	

3.6.7 20.2% of total receivables (£891k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as £780k of debts are supported by a SLA and recent discussions to resolve debts are positive.

Excluding debts supported by an SLA the ratio reduces to 2.5%.

3.6.8 3.2% of total payables invoices (£344k) held for payment are over 90 days past their due date. This is below the 5% finance risk tolerance.

3.6.9 The cash balance at 31 January 2017 is £59,367k and represents 71.5 days of annualised operating expenses.

3.6.10 The Trust does not anticipate the Use of Resources Rating will deteriorate below a 2 in the next 12 months.

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 January 2017 is a surplus of £10,155k, representing 3.6% of the Trust's turnover. The Trust is ahead of plan by £2,083k largely due to a refund of historic National Insurance payments linked to widening access trainees, contract variations with commissioners and vacancies. Recruitment to posts is ongoing.

6.2 Total CRES identified at 31 January 2017 is £6,734k and is ahead of plan. The Trust continues to progress schemes to deliver CRES for future years.

6.3 The Use of Resources Rating for the Trust is a 1 for the period ending 31 January 2017 which is in line with plan.

7. RECOMMENDATIONS:

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

Drew Kendall
Interim Director of Finance and Information

Item 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th February 2017**
TITLE:	**Board Dashboard as at 30th January 2017**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to provide the latest performance for the Board Dashboard as at 30th January 2017 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. The dashboard is now inclusive of performance relating to York and Selby.

As at the end of January 2017, 9 (47%) of the indicators reported are not achieving the expected levels and are red, which is an increase on the 7 reported for December 2016. Of those red indicators, 2 are showing an improving trend over the previous 3 month period. There are a further 4 indicators which whilst not completely achieving the target levels are within the amber tolerance levels and 2 of those show an improving trend over the previous 3 months. The Year to Date position is better with only 6 KPIs being reported as red which is the same position as reported as at the end of December 2016.

The key issues/risks are:

- Bed Occupancy (KPI3)
- Number of patients with a length of stay of greater than 90 days (KPI4)
- Access – Waiting Times (KPI 7)
- Out of Locality Admissions (KPI 9)
- Actual Number of Workforce in the month (KPI14)
- Appraisal (KPI 16)
- %age sickness absence rate (KPI 18)

In respect of performance against the key NHSI operational indicators as at the end of January one was reported as not meeting the targets as follows:

- Proportion of people completing treatment who move to recovery (IAPT services).

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:	**28th February 2017**
TITLE:	**Board Dashboard as at 30th January 2017**

1. INTRODUCTION & PURPOSE:

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

2. KEY ISSUES:

2.1 The key issues are as follows:

- As at the end of January 2017, 9 (47%) of the indicators reported are not achieving the expected levels and are red, which is 2 more than the position reported for December 2016. Of those red indicators, 2 are showing an improving trend over the previous 3 month period. There are a further 4 indicators which whilst not completely achieving the target levels are within the amber tolerance levels and 2 of these show an improving trend over the previous 3 months.

  In terms of the Year to Date position 6 indicators (32%) are reporting as not achieving the target set, with a further 6 (32%) being amber. This is the same position as that reported as at the end December 2016

- In terms of the Single Oversight Framework we did not achieve one of the operational metrics in January as follows:

  - **IAPT Services - Proportion of people completing treatment who move to recovery.** The target is 50% of people should move to recovery and the actual performance for January was 47.94%. In terms of performance delivered by Trust services at CCG level only 2 of the CCG are achieving the target of 50% (Hambleton, Richmondshire and Whitby and Harrogate and Rural District CCGs). All other services to CCGs are below target with the services in Durham, Darlington Easington and Sedgefield CCG, Scarborough and Ryedale CCG and Vale of York CCG being significantly under target. Within Durham and Darlington the service has developed an action plan to improve performance and this is starting to be implemented. Whilst there is already an action plan within the services within York and Selby the national Intensive Support Team (IST) is visiting the IAPT service (which is being jointly hosted by ourselves and the CCG) on 23rd February to review how the service is provided and to offer support in terms of where improvements could be made. Once we receive the report of the IST the existing action plan will be updated.

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

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

2.2 The key risks are as follows:

- Bed Occupancy (KPI 3) – The Dashboard shows that there has been further improvement in the Trust wide position mainly as a result of what appears to be very low occupancy levels in York and Selby. However this position is in fact understated because the closure of the 14 beds at Worsley Court in December had not been actioned on the electronic system and therefore these beds are still included in the denominator when clearly they were not available for admission. If Worley Court is removed from the denominator the Trust wide position increases to 92.16% (rather than the 89.2% shown in the dashboard). The York and Selby position increases to 84.56% which is still the best performance across all the localities. There continues to be pressures across the Trust in terms of occupancy. In Durham and Darlington and North Yorkshire this is linked to high levels of occupancy in Adult Mental Health beds whereas with Teesside the pressure is greater on MHSOP beds.

- Number of patients with a length of stay over 90 days – This indicator was highlighted as an issue for the first time in December and the position in January has deteriorated further such that the annual target has now already been exceeded. All localities, with the exception of North Yorkshire, are significantly over target however this reflects that work has been ongoing to improvement the management and discharge of people with long lengths of stay. The large increase in this indicators shows that this work has been successful as the length of stay used within this indicator is calculated at discharge. We are intending to change the indicator construction for 2017/18 so that it reports the number of people still in beds at the end of the month that have had a length of stay at that point over 90 days. This will ensure that we can gain confidence that such long lengths of stay are appropriate or that we are taking appropriate action whilst the patient is still on the ward if this is not the case.

- External Waiting Times (KPI 7) – The Trust remains worse than the target of 90% at the end of January and for the first time since June there has been a worsening of the position. This reflects the trend in previous years where performance has deteriorated in January linked to the reduced capacity in December due to the Bank Holidays. It should however be noted that whilst there has been deterioration in performance the position for January 2017 continues to be better than that in the previous two years. Finally whilst in previous years the reduction in January has been reversed in February we should be aware that the level of increase in External Referrals shown in KIP1 is much greater in January 2017 than the previous two years which may mean the position does not improve as much in February 2017 compared to the February 2016 and 2015.

The areas of concern continue to be Children and Young Peoples Services in North Yorkshire and York and Selby and the agreed action plans are continuing to be implemented. The North Yorkshire service has identified a trajectory for recovery of June 2017.

- Out of Locality Admissions (OoL) (KPI 9). The performance for January continues to be worse that the target and has deteriorated significantly compare to December such that it is the worst performance in the previous 3 years. North Yorkshire and York and Selby are the outliers with both having 50% of admissions in January being Out of Locality. In both localities this relates mainly to adult patients being placed out of locality. The continued pressure on beds reported above will be contributing to this position.

- Actual Number of Workforce in the Month KPI – This indicator is continuing to report as amber and there has been some improvement in the month of January 2017 which has reversed the declining positon seen since October 2016. York and Selby continue to be the areas of greatest concern and work is continuing to improve the recruitment of staff within all localities.

- Appraisal (KPI 16) – Whilst the Trust is not achieving the target of 95% as at the end of January there has been a slight improvement from December and the position continues to be higher than the same time in previous years. Teesside is only slightly under target at 94.32% with Forensic services also above 90%. The area of greatest underperformance continues to be York and Selby however there has been a further improvement of 4 percentage points in January compared to December. The new staff dashboard became available on the IIC in December and appraisal levels are part of the routine performance report outs/huddles which have been implemented in teams and services across the Trust. The position for appraisal is also mirrored in terms of Mandatory Training compliance with a further improvement in January and York and Selby being the outlier in terms of underperformance.

- %age Sickness Rate (KPI 18) – Performance against this KPI continues to be worse than target however we have seen a reduction in the sickness rate reported in January which is the first reduction since October and 'bucks' the trend of previous years where traditionally we have seen increases in sickness absence reported in January. However it should be noted that the position reported in January 2017 remains above that reported in January 2016. A working group has now been established to look at short term sickness and they plan to review the sickness absence audit tool, to identify trends, reviewing training needs of managers and where required providing intensive support for services where short terms sickness is problematic.

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

	January 2017				April 2016 To January 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	8,684.00			76,926.00	82,701.00		91,759.00
2) Caseload Turnover	1.99%	-0.32%			1.99%	-0.32%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	89.20%			85.00%	94.02%		85.00%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	23.00	50.00			232.00	314.00		277.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.35%			15.00%	7.53%		15.00%
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	20.00	23.33			199.00	242.66		237.00

Quality

	January 2017				April 2016 To January 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%	84.33%			90.00%	85.36%		90.00%
8) Percentage of appointments cancelled by the Trust	0.67%	0.66%			0.67%	0.73%		0.67%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	29.05%			15.00%	22.79%		15.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	91.02%			91.44%	92.04%		91.44%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.67			10.00	7.23		12.00

Trust Dashboard Summary for TRUST

Workforce

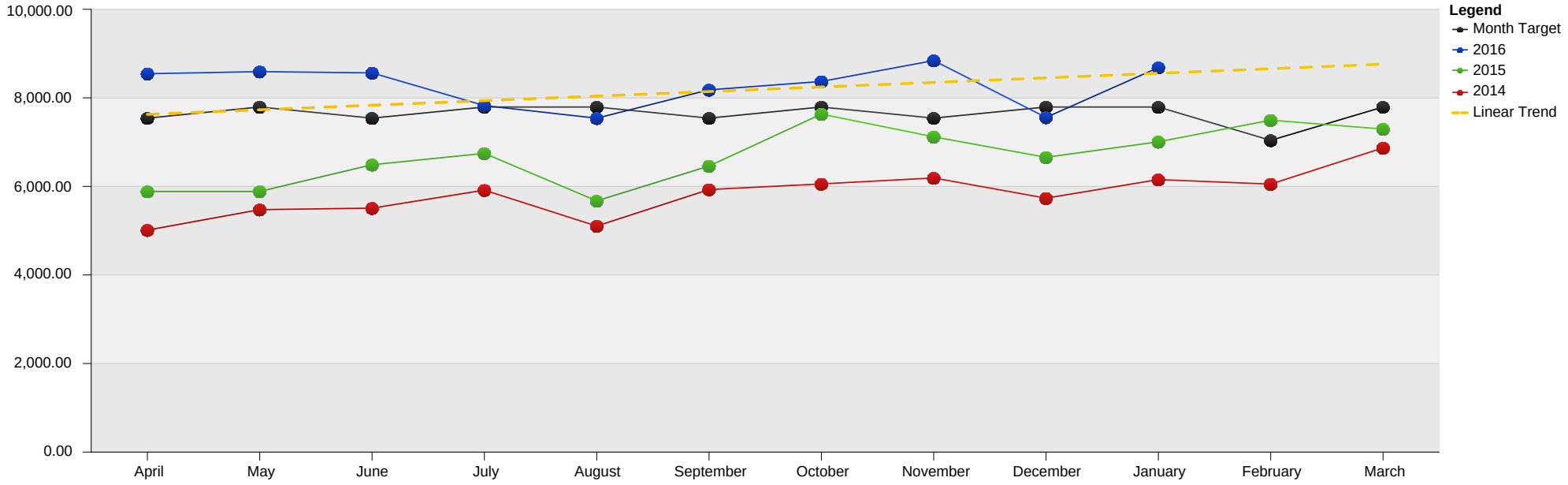
	January 2017				April 2016 To January 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	93.66%			100.00%	93.66%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	17.86%			15.00%	17.09%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	87.67%			95.00%	87.67%		95.00%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	89.75%			95.00%	89.75%		95.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.42%			4.50%	4.94%		4.50%

Money

	January 2017				April 2016 To January 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-736,632.00	-559,000.00			-8,071,801.00	-10,155,000.00		-8,057,087.00
20) CRES delivery	550,854.00	551,455.00			5,508,543.00	5,514,550.00		6,610,251.00
21) Cash against plan	49,980,000.00	59,367,000.00			49,980,000.00	59,367,000.00		49,036,000.00

Trust Dashboard Graphs for TRUST

1) Total number of External Referrals into Trust Services

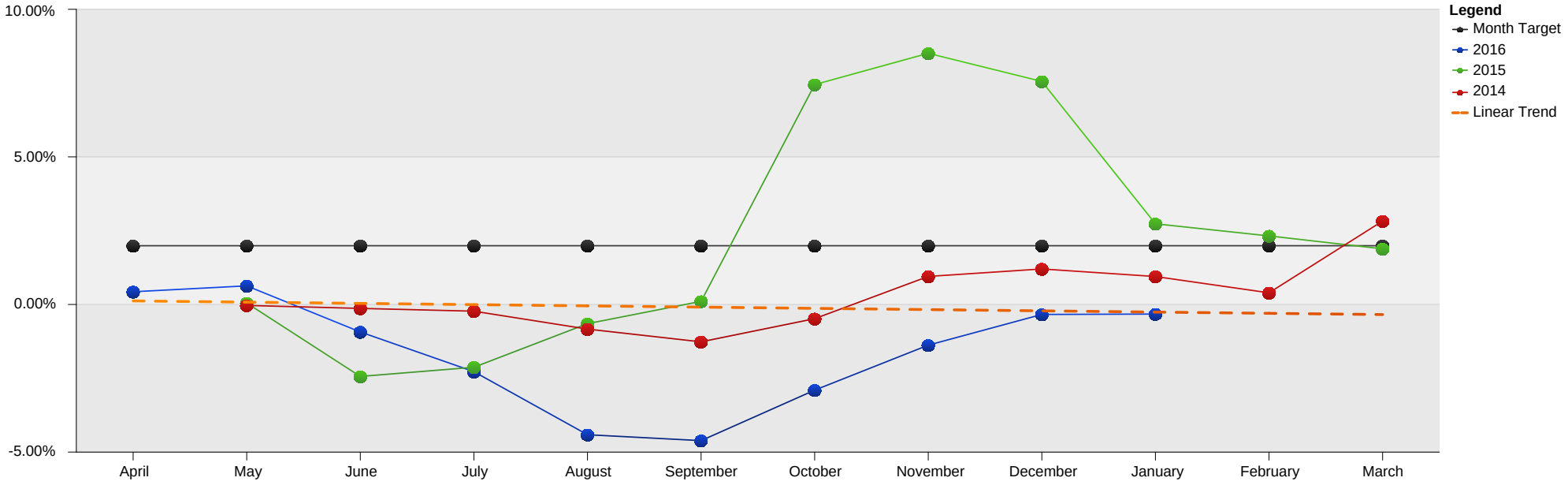


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Total number of External Referrals into Trust Services	8,684.00	82,701.00	1,973.00	19,725.00	2,089.00	19,338.00	2,210.00	20,449.00	613.00	5,913.00	1,798.00	17,256.00

Narrative
The Trust position for January 2017 is 8,684 which is 891 above the Trust target of 7,793 and a deterioration compared to the position reported in December where the target was met. The Trust position for the financial year to date is 82,701.00 which is 5,775 above the target.The number of referrals has increased in each locality and the increase is consistent with seasonal trends seen in previous years but a greater level of increase is seen.Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 6,886 which is higher when compared to the same period last year of 6,783.Based on the increasing trend reported it is anticipated that we will exceed the annual target of 91,759 referrals by more than 10%.

Trust Dashboard Graphs for TRUST

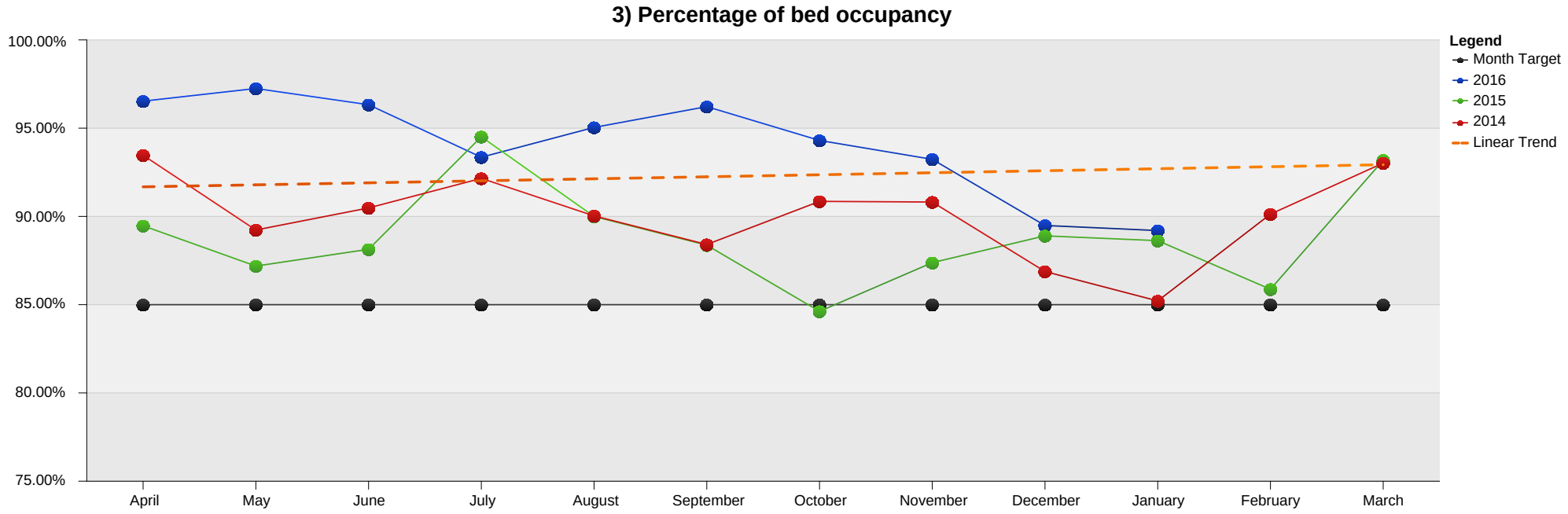
2) Caseload Turnover



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Caseload Turnover	-0.32%	-0.32%	-0.80%	-0.80%	0.80%	0.80%	0.04%	0.04%	NA	NA	-1.61%	-1.61%

Narrative
The Trust position for January 2017 is -0.32% which is meeting the 1.99% target, and is a similar level to that reported in December. All localities are achieving target.Based on current trend it is likely we will achieve the annual target of 1.99%

Trust Dashboard Graphs for TRUST

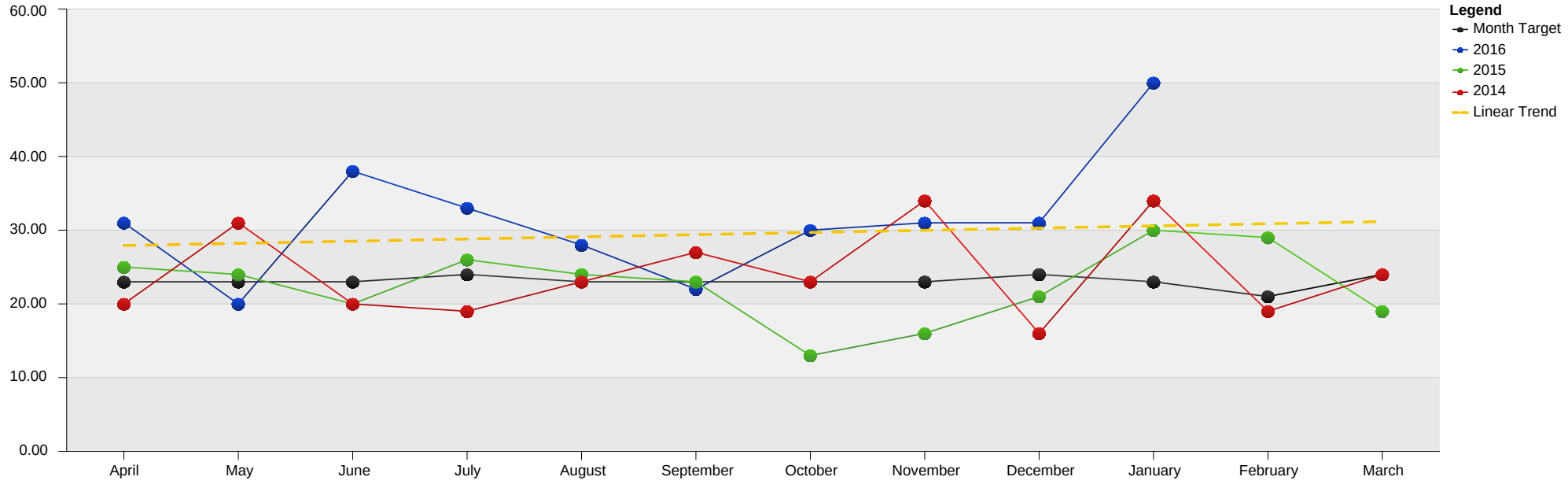


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	89.20%	94.02%	93.21%	93.00%	93.70%	96.33%	93.02%	95.80%	NA	NA	67.65%	87.79%

Narrative
The Trust position for January 2017 is 89.20% which is 4.20% worse than the Trust target of 85.00% but a slight improvement on the December position. This represents the 4th consecutive month where performance has improved and is the best position in the year to date. All localities are exceeding the 85% target with the exception of York and Selby which had an occupancy level of 67.65%. This position however is understated as although Worsley Court was closed in December it still remains open on Trust systems, and therefore the beds are included in the denominator. Steps are being taken to resolve this as a matter of urgency. The Trust position for the financial year to date is 94.02%, which is 9.02% worse than target.A key factor that continues to contribute to this high level of occupancy is linked to the placement of York Adult Mental Health patients requiring inpatient care into beds in other localities within the Trust. The Adult Mental Health beds re opened at Peppermill in York on 3rd October and now the unit is operational the levels of occupancy are moving closer to the target set. However it is recognised that there continues to be pressures in some localities.

Trust Dashboard Graphs for TRUST

4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards



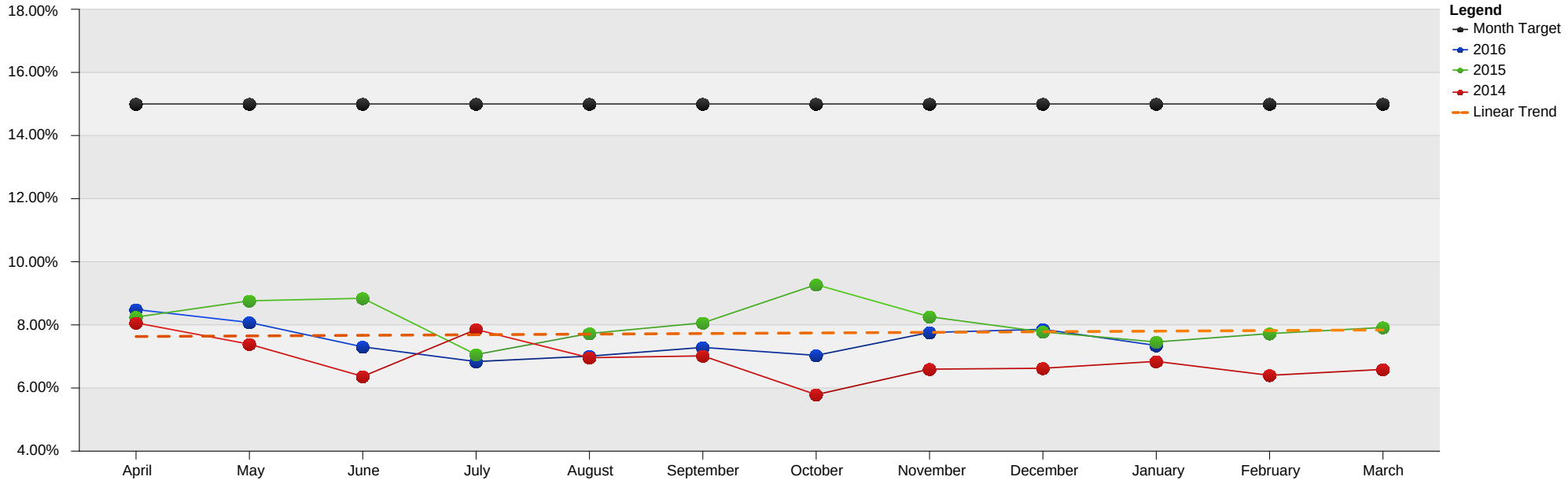
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	50.00	314.00	18.00	79.00	11.00	76.00	5.00	75.00	NA	NA	14.00	70.00

Narrative

The Trust position for January 2017 is 50.00 which is 27.00 worse than the Trust target of 23.00 and is a significant deterioration on the December position. This represents the worst position in the year to date. The Trust position for the financial year to date is 314 which is not meeting the target of 232.This indicator measures LOS of patients discharged and the position demonstrates we have discharged a significant number of people with a long LOS. This may contribute to an improved bed occupancy figure in February.Only North Yorkshire and Teesside are meeting target. Of the 50 admissions with a LoS greater than 90 days:• 18 (36%) were within Durham and Darlington (14 MHSOP and 4 ADULTS) • 14 (28%) were within York & Selby (9 MHSOP AND 5 ADULTS) • 11 (16%) were within Teeside (6 MHSOP and 5 ADULTS) • 5 (16%) were within North Yorkshire (3 MHSOP and 2 ADULTS) • 2 (4%) did not have the CCG recorded (2 MHSOP)The greatest increase has been seen in Durham and Darlington. The weekly report out process is being used to monitor inpatients with a length of stay greater than 70 days to ensure issues of concern are addressed.Comparative data is included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data.Based on the current trend and performance it is unlikely we will achieve the annual target of 277.

Trust Dashboard Graphs for TRUST

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

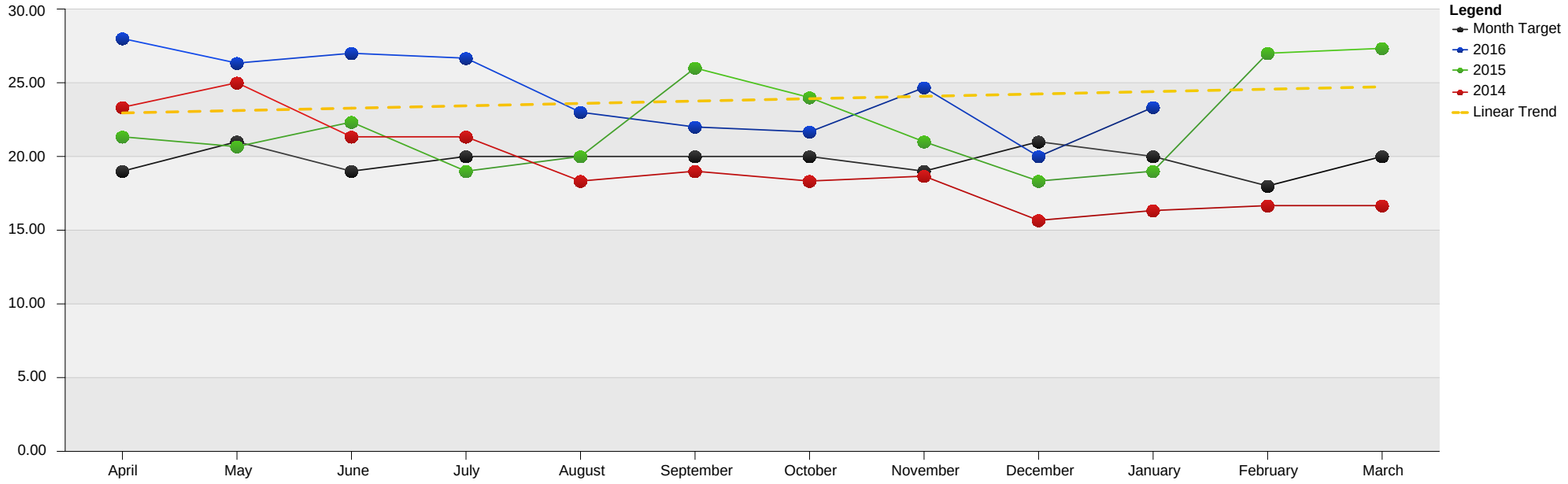


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	7.35%	7.53%	7.69%	7.02%	4.84%	7.19%	6.88%	7.18%	NA	NA	11.11%	11.21%

Narrative
The Trust rolling 3 month position ending January 2017 is.7.35%, which relates to 17.99 patients out of 245 that were readmitted within 30 days. This is meeting the target of 15% and a slight improvement on the position reported in December 2016. The Trust position for the financial year to date is 7.53% which is meeting the target of 15%. Of the 17.99 patients:• 5.99 (33%) were within Durham & Darlington (5.66 AMH and 0.33 MHSOP) • 4.66 (26%) were within York and Selby (2.99 AMH and 0.66 MHSOP).• 4.33 (24%) were within North Yorkshire (4.33 AMH) • 2.99 (17%) were within Teeside (2.99 AMH)(*Please note data is displayed in decimal points due to the rolling position being calculated.)All localities are meeting target.Based on current trend and performance, it can be expected that we will achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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

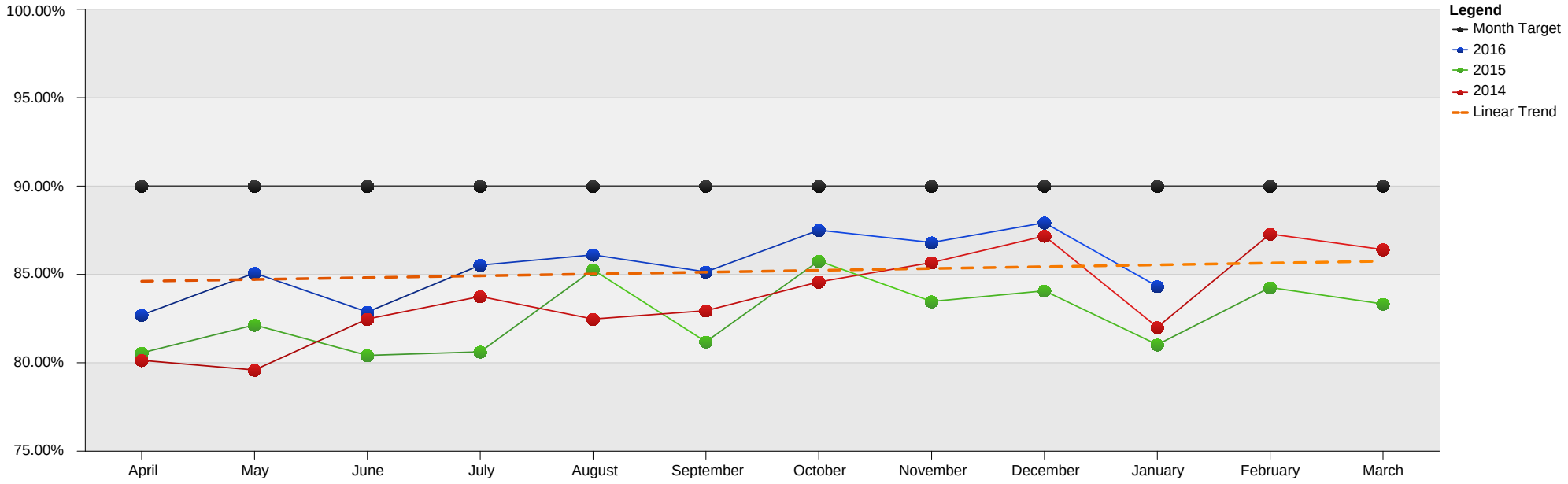


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	23.33	242.66	6.00	82.33	6.00	64.00	6.00	66.67	NA	NA	5.33	29.67

Narrative
The Trust rolling 3 month position ending January 2017 is 23.33, which is 3.33 worse than the target of 20 and a deterioration on the position reported in December when the target was met. The Trust position for the financial year to date is 242.66, which is not meeting the target of 199. Of the 23.33 instances:• 5.99 (26%) were within Durham & Darlington (5.99 AMH)• 5.99 (26%) were within Teesside (5.33 AMH and 0.33 MHSOP)• 5.99 (26%) were within North Yorkshire (6.99 AMH and 0.33 MHSOP)• 5.33 (22%) were within York and Selby (2.99 AMH and 0.33 MHSOP)(*Please note data is displayed in decimal points due to the rolling position being calculated.)Comparative data is now included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data given the indicator measurement is a number. Based on current trend and performance it is unlikely we will achieve the annual target of 237.

Trust Dashboard Graphs for TRUST

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



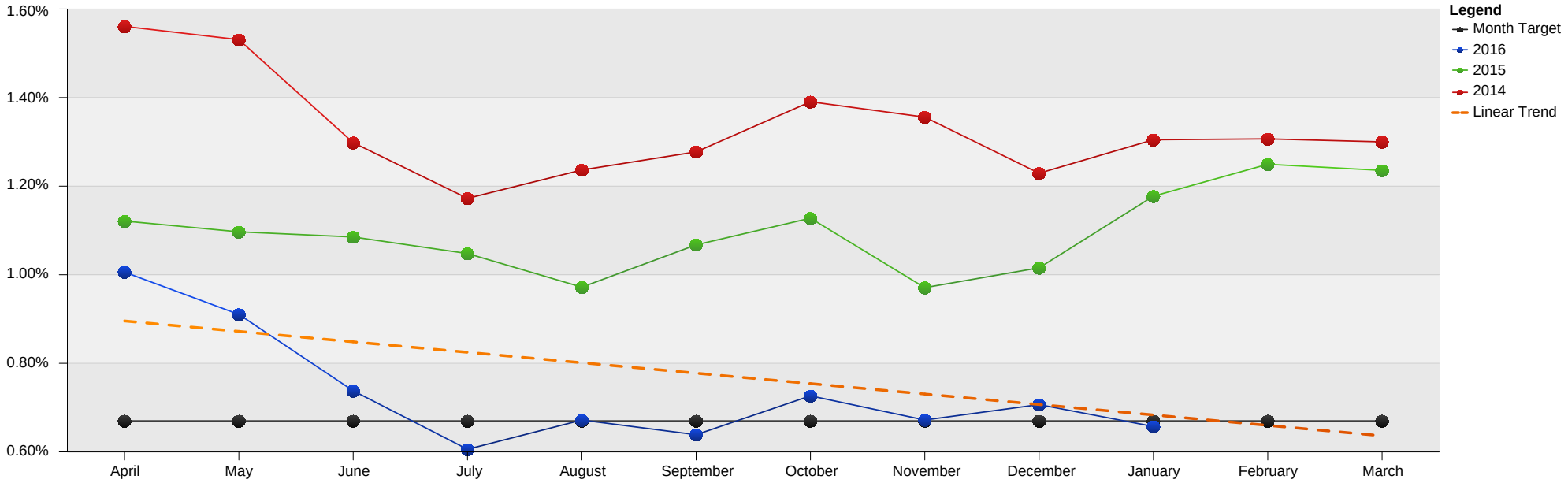
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	84.33%	85.36%	82.89%	81.27%	98.01%	96.80%	68.56%	74.92%	99.25%	99.56%	70.62%	70.33%

Narrative

The position for January 2017 is 84.33%, relating to 734 patients out of 4683 who waited longer than 4 weeks. This is 5.67% worse than target and deterioration on the December position. This follows seasonal trends, but remains a better position than January 2016 and 2015. The position for financial year to date is 85.36%, which is 4.64% worse than target.Areas of concern:• North Yorkshire CYP at 42.36% (61 of 144 patients). This is 17.21% deterioration on the position in December 2016. An overall increase in the number of referrals received has impacted on performance, however the number of patients seen for first appointment has increased. An action plan is in place with work on capacity and demand analysis and actions to address staff vacancies and sickness. The trajectory for recovery is June 2017.• York & Selby CYP at 26.39% (19 out of 72 patients) this is a 26.67% deterioration on December 2016. An action plan continues to progress to timescales with data quality actions being addressed, analysis of current waiting lists carried out, utilisation of partnership working and a single point of access established. An overall increase in the number of referrals has impacted on performance.Based on current trend and performance there is a risk that we will not achieve the annual target of 90%, however if the trend follows previous years we could report the best annual position in the past 3 years.

Trust Dashboard Graphs for TRUST

8) Percentage of appointments cancelled by the Trust



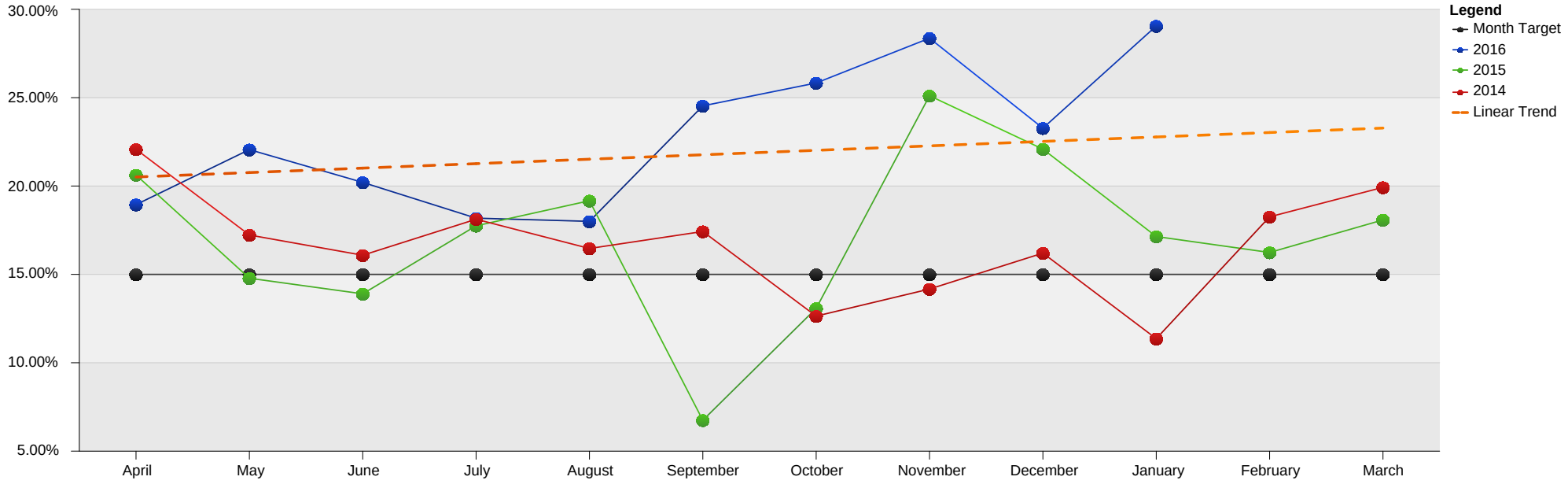
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of appointments cancelled by the Trust	0.66%	0.73%	0.70%	0.88%	0.52%	0.58%	0.93%	0.95%	0.21%	0.16%	0.50%	0.49%

Narrative

The Trust position for January 2017 is 0.66%, which relates to 545 appointments out of 77,031 that have been cancelled. This is meeting target and an improvement on the position reported in December. The Trust position for the financial year to date is 0.73%, which is 0.06% worse than the target.Only Durham & Darlington and North Yorkshire are worse than target as a result of vacancies which are going through the recruitment process and sickness which is being managed in line with Trust Policy. Based on current trend and performance it is possible that we could achieve the annual target of 0.67%.

Trust Dashboard Graphs for TRUST

9) Out of locality admissions (AMH and MHSOP) post validated

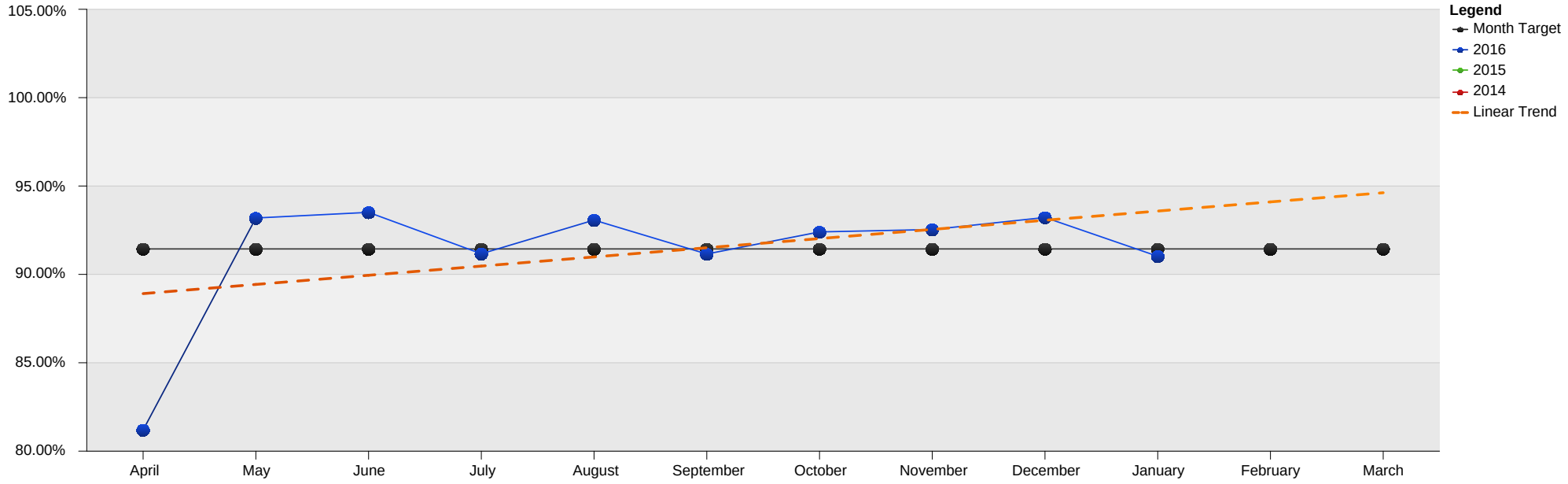


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	29.05%	22.79%	19.44%	20.55%	11.39%	15.12%	52.63%	34.57%	NA	NA	50.00%	27.20%

Narrative
The Trust position for January 2017 is 29.05%, which relates to 86 admissions out of 296 that were admitted to assessment and treatment wards out of locality. This is 14.05% worse than the target of 15%, and a deterioration on the position reported in December when a reversal of the increasing trend since August was seen. The Trust position for the financial year to date is 22.79%, which is 7.79% worse than the target. All localities are worse than target, with the exception of Teesside. The position for Tees is 11.39% which is 3.61% under target. North Yorkshire and Vale of York have seen the greatest increase in OOL admissions for January. The pressures of delayed transfers of care and securing suitable long term placements for patients with complex needs are impacting on performance.Of the 86 patients (AMH 62, MHSOP 24) admitted to an 'out of locality' bed, all were due to no beds being available at their local hospital with the exception of one admission. Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 24.60% which is a deterioration of 7.53% compared to January 2016.Based on current trend and performance there is a significant risk that we will not achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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

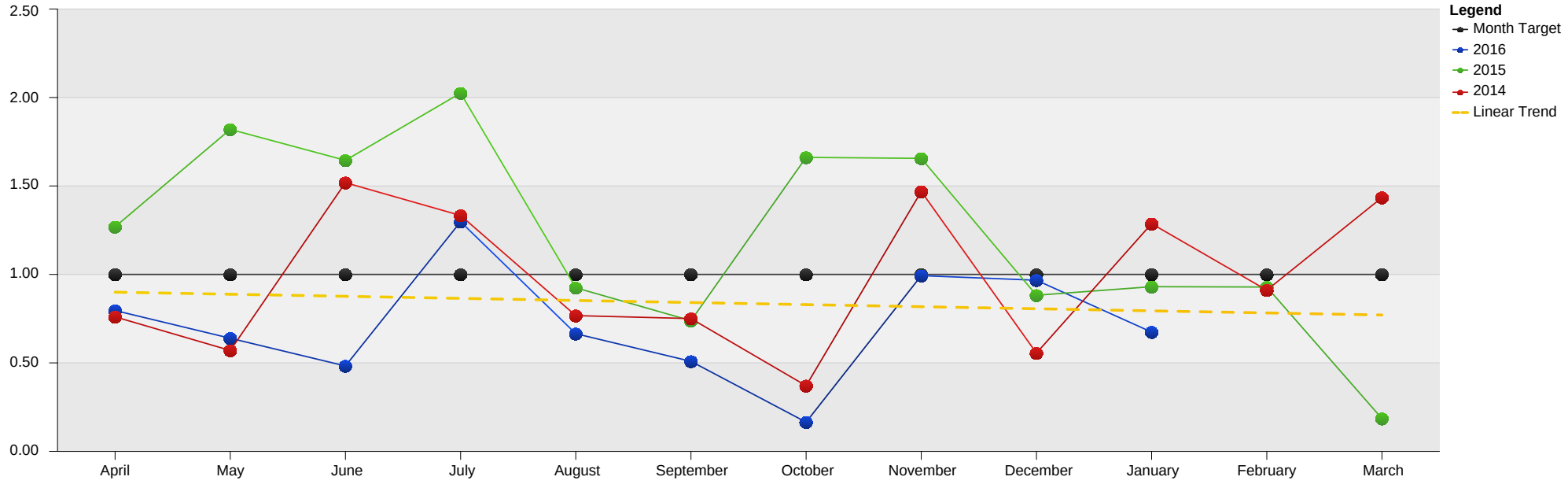


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.02%	92.04%	90.79%	93.71%	94.06%	92.82%	94.04%	92.84%	75.93%	79.77%	97.33%	91.24%

Narrative
The Trust position reported in January relates to December performance. The Trust position for December 2016 is 91.02% which is 0.42% worse than the target of 91.44% and a deterioration on the position reported for November. The Trust position for the financial year to date is 92.04%, which is 0.60% better than the target.Forensic services report the poorest performance, however due to the secure nature of the service performance in this area can fluctuate. Durham and Darlington are also not meeting target, however YTD performance is strong.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. If performance continues at the overall levels achieved, it is anticipated that we will achieve the annual target of 91.44%.

Trust Dashboard Graphs for TRUST

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

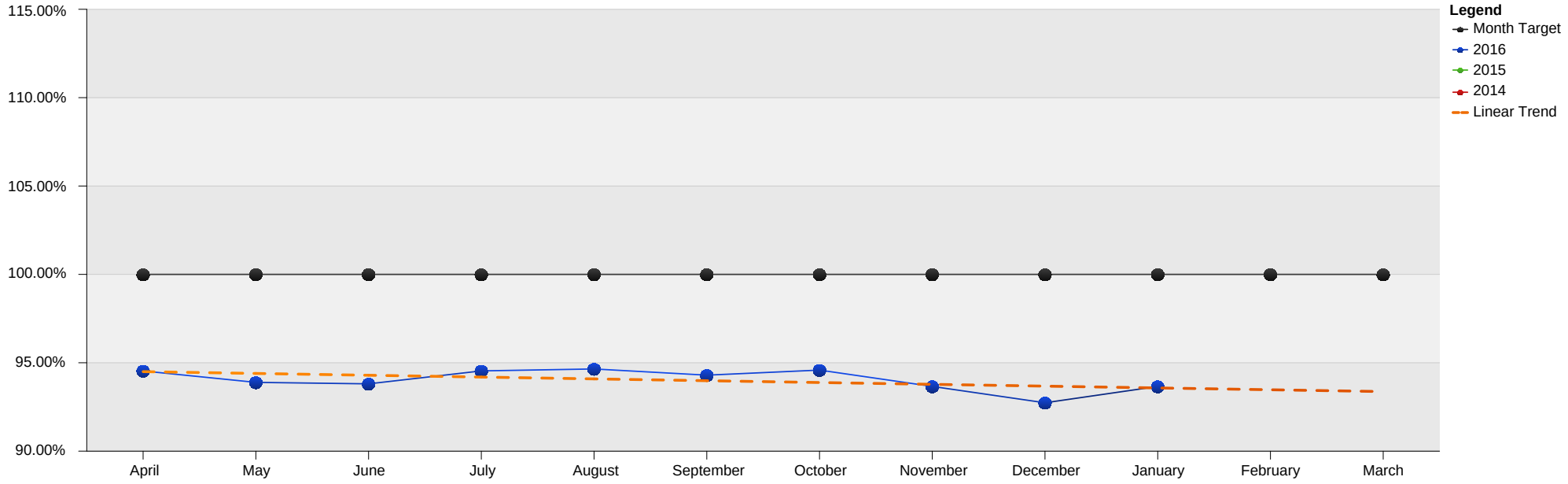


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.67	7.23	0.74	4.14	1.16	5.51	0.74	11.78	0.00	24.53	0.00	10.14

Narrative
The Trust position for January 2017 is 0.67, which is meeting the target of 1.00. This rate relates to 5 unexpected deaths which occurred in January. The Trust position for the financial year to date is 7.23 which is 2.77 better than the target.Of the 5 unexpected deaths in January:• 2 were in in Durham and Darlington (AMH)• 2 were in Teeside (AMH) • 1 was in North Yorkshire (AMH)Given the 2015/16 data did not include York and Selby data it is not possible to compare the position with previous years totals. However the number of unexpected deaths reported in January 2016 were 3 and therefore the figure of 5 across the Trust area (minus York and Selby) in 2017 shows an increase of 2. Based on current trend and performance, it can be anticipated that we will achieve the annual target of 12.00.

Trust Dashboard Graphs for TRUST

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

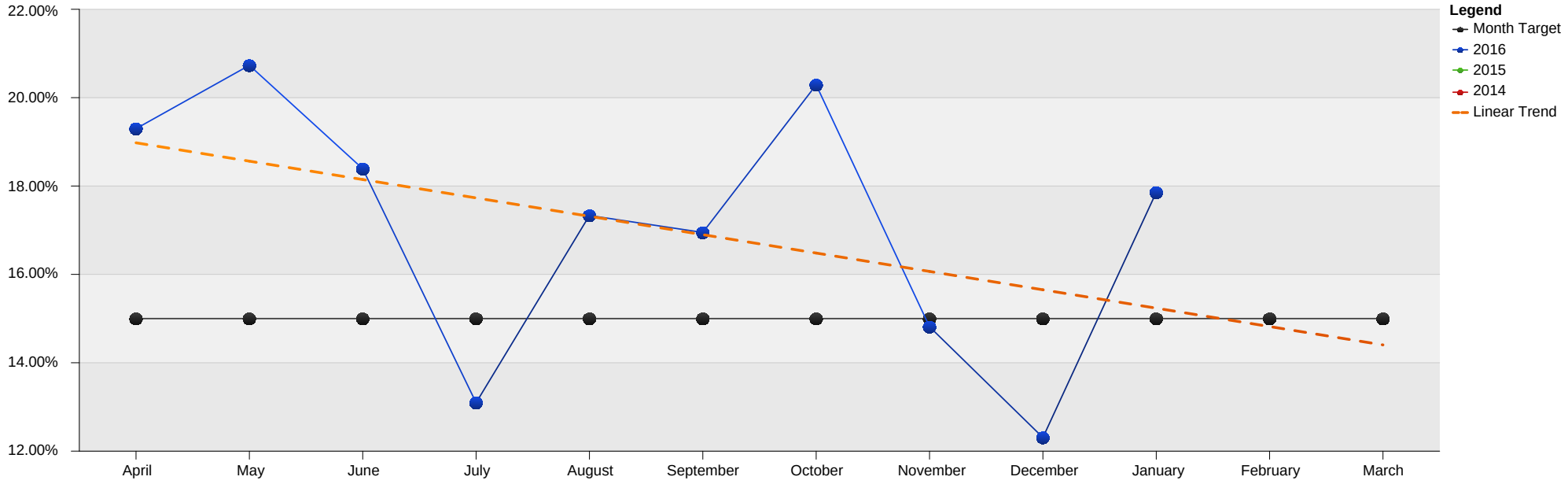


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	93.66%	93.66%	94.19%	94.19%	97.13%	97.13%	92.92%	92.92%	93.50%	93.50%	90.47%	90.47%

Narrative
The Trust position for 31 January 2017 is 93.66% which is below the targeted establishment level of 95-100% but an improvement on that reported in December. It is anticipated that this figure will improve following a number of recruitment events where the Trust have successfully appointed to a number of nursing vacancies. Data only started to be reported in the dashboard from April 2016; therefore no comparative data for 2015/16 is available currently in this dashboard. Based on current trend and performance so far during 2016/17, it can be expected that we will achieve the annual target.

Trust Dashboard Graphs for TRUST

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



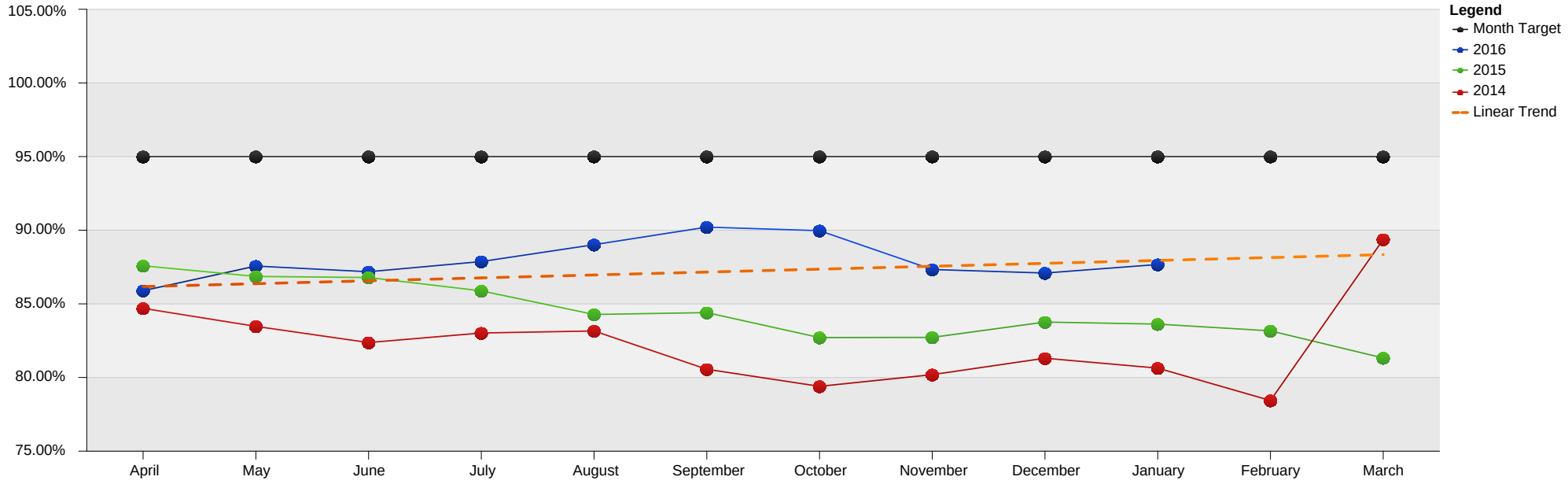
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	17.86%	17.09%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative

The Trust position for January 2017 is 17.86% which is 2.86% worse than the target of 15.00% and a deterioration on the figure reported in December where the target was met. The Trust position for the financial year to date is 17.09%, which is 2.09% worse than the target.There were 14 jobs re-advertised in January for registered healthcare professional jobs. The majority of the posts were nursing opportunities. A number of recruitment fayre's are planned over the next quarter with a focus on registered nursing staff which is expected to improve this position. In addition it is planned to review this approach and roll out to non-registered staff if appropriate. Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available. Based on current trend and performance there is a risk that we will not achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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

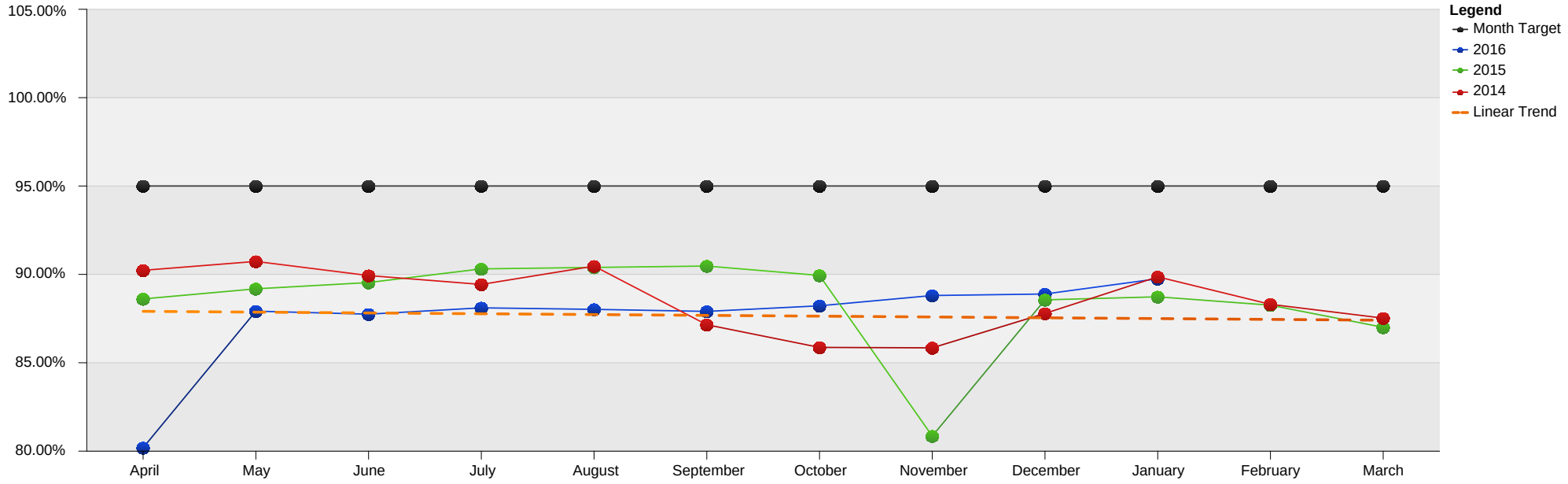


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	87.67%	87.67%	85.37%	85.37%	94.32%	94.32%	82.46%	82.46%	91.96%	91.96%	77.84%	77.84%

Narrative
The Trust position for January 2017 is 87.67% which relates to 703 members of staff out of 5999 that do not have a current appraisal; this is slight improvement on the figure reported in December however 7.33% below target of 95%.No localities are meeting target, however Teesside is marginally under target at 94.32%. York and Selby report the poorest positon at 77.84% however continued improvements in performance have been seen.All localities now have regular operational management huddles which include discussions on appraisal compliance levels and this has had a positive impact on performance levels being achieved. A new staff dashboard was launched on the IIC in December which highlights to managers those staff reporting as non-compliant and also those due to be appraised within the following three months. Based on current performance there is a significant risk that we may not achieve the annual target of 95%.

Trust Dashboard Graphs for TRUST

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

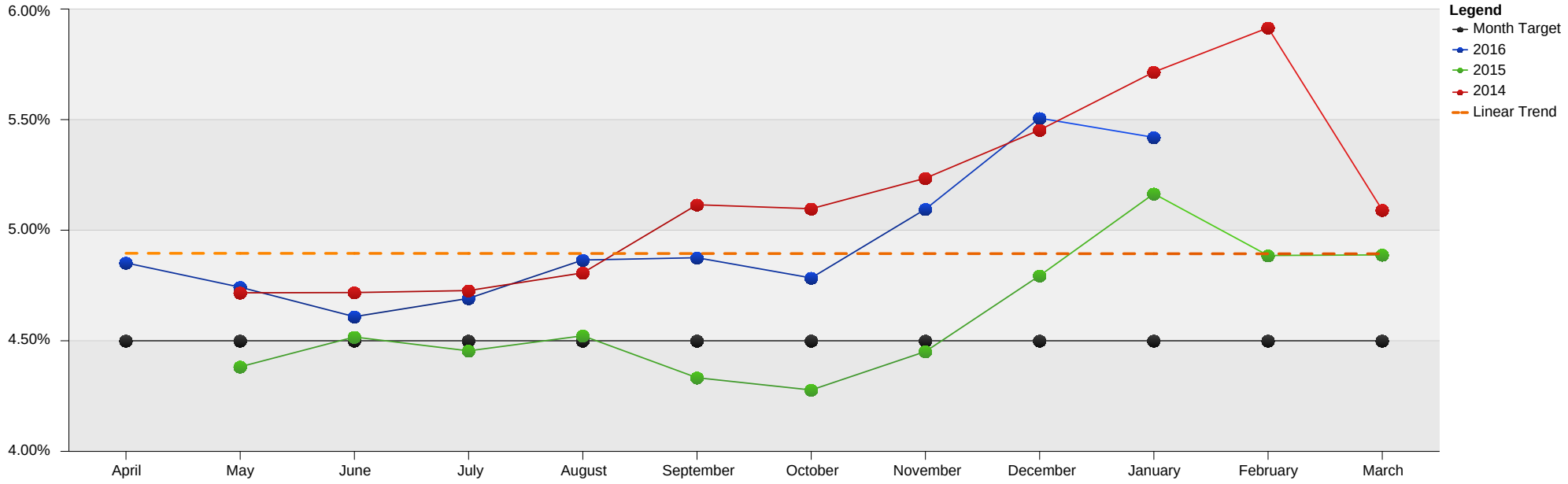


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with mandatory and statutory training (snapshot)	89.75%	89.75%	88.45%	88.45%	91.93%	91.93%	89.77%	89.77%	90.31%	90.31%	79.11%	79.11%

Narrative
The position for January 2017 is 89.75%. This is 5.25% lower than the target of 95%, however is a slight improvement on the position reported in December. Tees are below target but continue to perform above 90%. Durham and Darlington, North Yorkshire, Forensics and York and Selby are below 90%. York and Selby are achieving the lowest level at 79.11% but an improvement on previous months continues to be seen. The new staff dashboard described in KPI16 regarding the additional HR reports also relates to reports associated with mandatory training. Based on current trend and performance, there is a risk that we may not achieve the annual target of 95%.

Trust Dashboard Graphs for TRUST

18) Percentage Sickness Absence Rate (month behind)



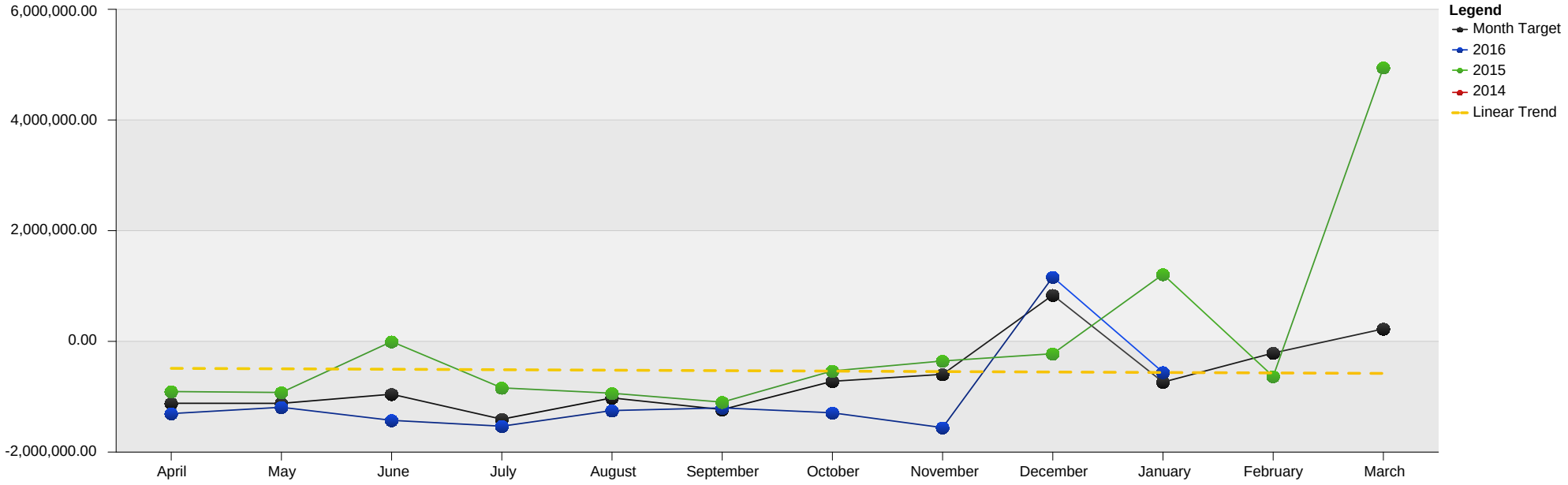
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	5.42%	4.94%	6.19%	5.53%	4.90%	5.15%	4.98%	4.35%	6.71%	5.61%	6.35%	5.45%

Narrative

The Trust position reported in January relates to the December sickness level. The Trust position reported in January 2017 is 5.43%, which is 0.93% worse than the Trust target of 4.50% but an improvement on the figure reported in December. However this figure is higher than that reported in January 2016, but in previous years a deterioration after December's position has been seen. The Trust position for the financial year to date is 4.94%, which is 0.44% worse than the target. None of the localities are meeting target. North Yorkshire reports the best position at 4.98%, however this is a reduction on December's position when the target was met. A sickness absence work stream has been established to focus on short term sickness absence. The working group will be responsible for reviewing the sickness absence audit tool, identifying trends, reviewing training needs of managers and where required providing intense support for services where short term absence is problematic. Results of sickness audits will be provided to Heads of Service and Directors of Operations. 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).Based on past and current performance there is a risk that we will not achieve the annual target of 4.50%.

Trust Dashboard Graphs for TRUST

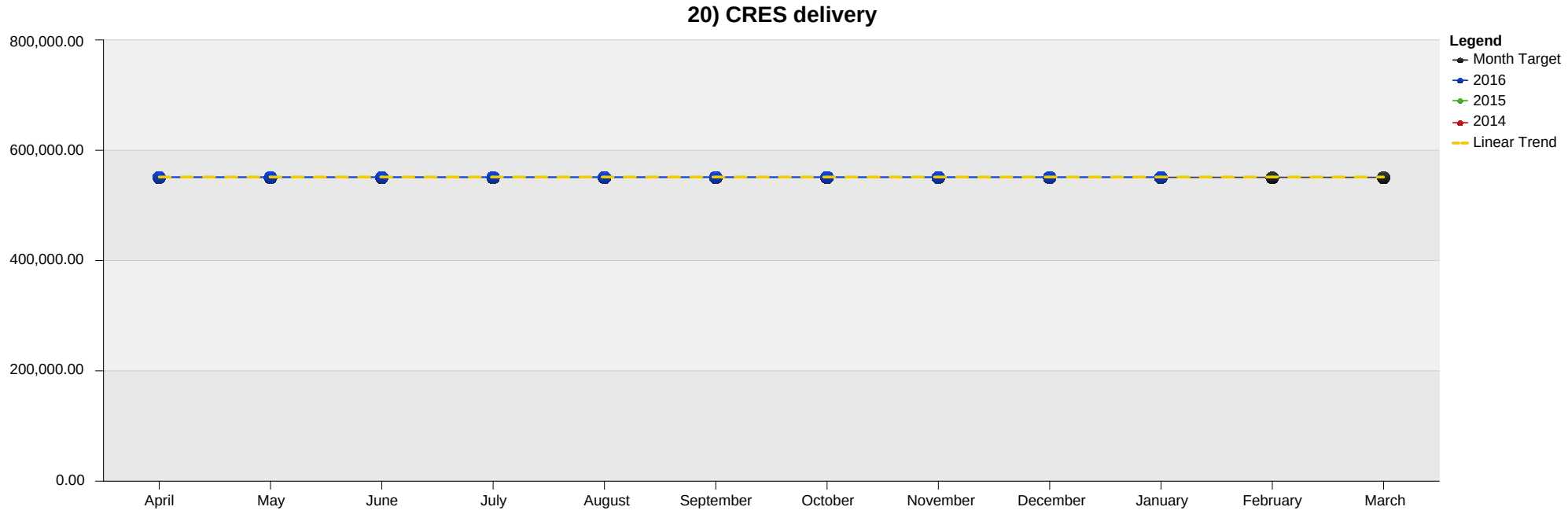
19) Delivery of our financial plan (I and E)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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)	-559,000.00	-10,155,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The comprehensive income outturn for the period ending 31 January 2017 is a surplus of £10,155k, representing 3.6% of the Trust's turnover. The Trust is ahead of plan largely due to a refund of historic National Insurance payments linked to widening access trainees, contract variations with commissioners and vacancies. Recruitment to posts is ongoing.

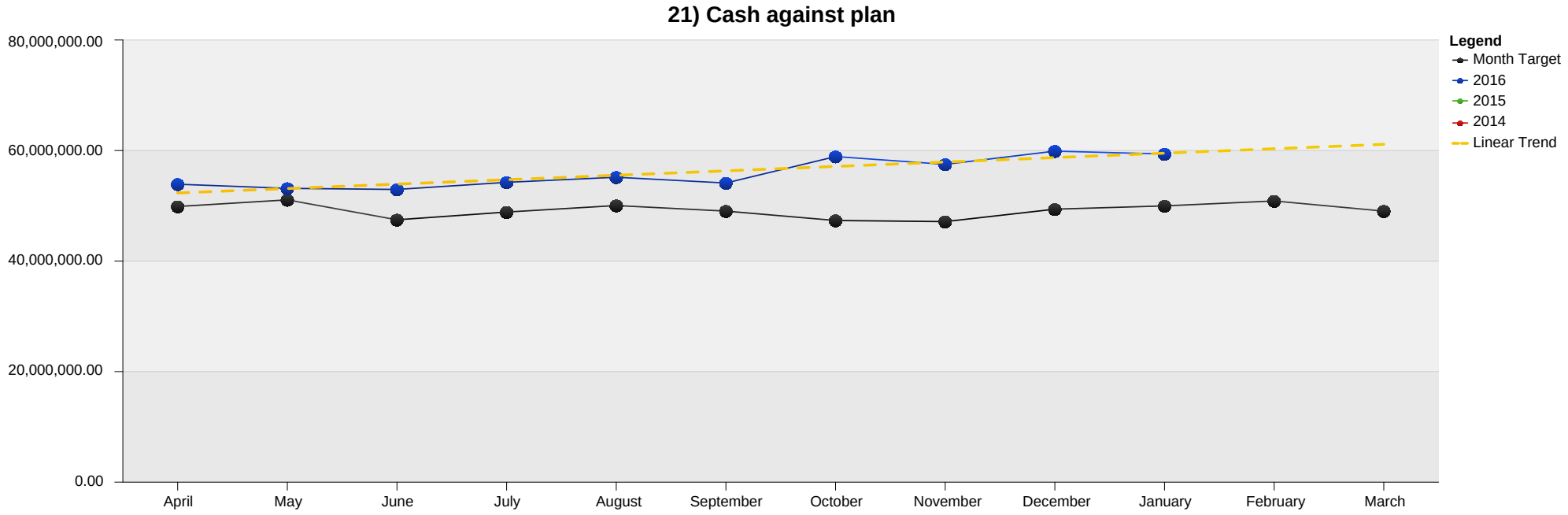
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	551,455.00	5,514,550.00	196,833.00	1,968,330.00	94,000.00	940,000.00	23,583.00	235,830.00	26,833.00	268,330.00		

Narrative
Total CRES delivery by the Trust for 31 January 2017 is £551,455. All localities continue to identify CRES schemes to ensure 100% is delivered recurrently in 2016/17.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	59,367,000.00	59,367,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
Total cash at 31 January 2017 is £59,367k and is ahead of plan largely due to planned delays in the capital programme and the Trusts surplus position. Capital expenditure is behind plan due to scheme delays, though schemes are progressing.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	January 2017												April 2016 To January 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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	15,586.00	17,368.00	3,770.00	3,946.00	3,832.00	4,178.00	3,696.00	4,420.00	1,170.00	1,226.00	3,118.00	3,596.00	153,852.00	165,402.00	37,212.00	39,450.00	37,824.00	38,676.00	36,488.00	40,898.00	11,556.00	11,826.00	30,772.00	34,512.00
2) Caseload Turnover	1.99%	-0.32%	1.99%	-0.80%	1.99%	0.80%	1.99%	0.04%	NA	NA	1.99%	-1.61%	1.99%	-0.32%	1.99%	-0.80%	1.99%	0.80%	1.99%	0.04%	NA	NA	1.99%	-1.61%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	89.20%	85.00%	93.21%	85.00%	93.70%	85.00%	93.02%	85.00%	NA	85.00%	67.65%	85.00%	94.02%	85.00%	93.00%	85.00%	96.33%	85.00%	95.80%	85.00%	NA	85.00%	87.79%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	23.00	50.00	8.00	18.00	6.00	11.00	6.00	5.00	NA	NA	3.00	14.00	232.00	314.00	80.00	79.00	63.00	76.00	63.00	75.00	NA	NA	27.00	70.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.35%	15.00%	7.69%	15.00%	4.84%	15.00%	6.88%	NA	NA	15.00%	11.11%	15.00%	7.53%	15.00%	7.02%	15.00%	7.19%	15.00%	7.18%	NA	NA	15.00%	11.21%
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	20.00	23.33	5.00	6.00	5.00	6.00	6.00	6.00	NA	NA	2.00	5.33	199.00	242.66	54.00	82.33	54.00	64.00	66.00	66.67	NA	NA	23.00	29.67

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	January 2017												April 2016 To January 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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%	84.33%	90.00%	82.89%	90.00%	98.01%	90.00%	68.56%	90.00%	99.25%	90.00%	70.62%	90.00%	85.36%	90.00%	81.27%	90.00%	96.80%	90.00%	74.92%	90.00%	99.56%	90.00%	70.33%
8) Percentage of appointments cancelled by the Trust	0.67%	0.66%	0.67%	0.70%	0.67%	0.52%	0.67%	0.93%	0.67%	0.21%	0.67%	0.50%	0.67%	0.73%	0.67%	0.88%	0.67%	0.58%	0.67%	0.95%	0.67%	0.16%	0.67%	0.49%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	29.05%	15.00%	19.44%	15.00%	11.39%	15.00%	52.63%	NA	NA	15.00%	50.00%	15.00%	22.79%	15.00%	20.55%	15.00%	15.12%	15.00%	34.57%	NA	NA	15.00%	27.20%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	91.02%	91.44%	90.79%	91.44%	94.06%	91.44%	94.04%	91.44%	75.93%	91.44%	97.33%	91.44%	92.04%	91.44%	93.71%	91.44%	92.82%	91.44%	92.84%	91.44%	79.77%	91.44%	91.24%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.67	1.00	0.74	1.00	1.16	1.00	0.74	1.00	0.00	1.00	0.00	10.00	7.23	10.00	4.14	10.00	5.51	10.00	11.78	10.00	24.53	10.00	10.14

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	January 2017												April 2016 To January 2017											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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%	93.66%	100.00%	94.19%	100.00%	97.13%	100.00%	92.92%	100.00%	93.50%	100.00%	90.47%	100.00%	93.66%	100.00%	94.19%	100.00%	97.13%	100.00%	92.92%	100.00%	93.50%	100.00%	90.47%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	17.86%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	17.09%	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%	87.67%	95.00%	85.37%	95.00%	94.32%	95.00%	82.46%	95.00%	91.96%	95.00%	77.84%	95.00%	87.67%	95.00%	85.37%	95.00%	94.32%	95.00%	82.46%	95.00%	91.96%	95.00%	77.84%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	89.75%	95.00%	88.45%	95.00%	91.93%	95.00%	89.77%	95.00%	90.31%	95.00%	79.11%	95.00%	89.75%	95.00%	88.45%	95.00%	91.93%	95.00%	89.77%	95.00%	90.31%	95.00%	79.11%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.42%	4.50%	6.19%	4.50%	4.90%	4.50%	4.98%	4.50%	6.71%	4.50%	6.35%	4.50%	4.94%	4.50%	5.53%	4.50%	5.15%	4.50%	4.35%	4.50%	5.61%	4.50%	5.45%

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	January 2017												April 2016 To January 2017									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	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)	-736,632.00	-559,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	-8,071,801.00	-10,155,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
20) CRES delivery	550,854.00	551,455.00	183,500.00	196,833.00	168,250.00	94,000.00	117,595.00	23,583.00	92,909.00	26,833.00			5,508,543.00	5,514,550.00	1,835,000.00	1,968,330.00	1,682,500.00	940,000.00	1,175,953.00	235,830.00	929,090.00	268,330.00		
21) Cash against plan	49,980,000.00	59,367,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	490,194,000.00	59,367,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Data Quality Scorecarrd 2016/17 (Reviewed October 2016)

Appendix B

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

Data Quality Scorecarrd 2016/17 (Reviewed October 2016)

Appendix B

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

Data Quality Scorecarrd 2016/17 (Reviewed October 2016)

Appendix B

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

Number of unexpected deaths and verdicts from the coroner April 2016 - March 2017

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes	1	1															1				**3**
Hanging					1												1				**2**
Suicides	2	1	2		2							1	2					1			**11**
Open			1																		**1**
Drug related death																					**0**
Drowning													1								**1**
Misadventure																					**0**
Awaiting verdict	5	3	6	1	6	1					1	1						1	2	1	**28**
Total	**8**	**5**	**9**	**1**	**9**	**1**	**0**	**0**	**0**	**0**	**1**	**2**	**3**	**0**	**0**	**0**	**2**	**2**	**2**	**1**	**46**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
5	4	3	8	4	3	1	6	7	5		

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
10	9	14	3	10

Number of unexpected deaths and verdicts from the coroner 2015 / 2016

This table has been included into this appendix for comparitive purposes only

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th February 2017**
TITLE:	**Strategic Direction Performance Report – Quarter 3 2016-17**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 3 (31st December 2016).

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

This report reflects that four of the Trusts five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. For Goal 3, it is noted that there are some improvements in both the Business Plan and KPI's, however the overall position still remains mixed.

Recommendations:

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

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**28th February 2017**
TITLE:	**Strategic Direction Performance Report – Quarter 3 2016-17**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 3 (31st December 2016).

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The 5 year targets for the Trust Strategic Direction Scorecard were agreed by the Board on the 18th August 2015.

3. KEY ISSUES:

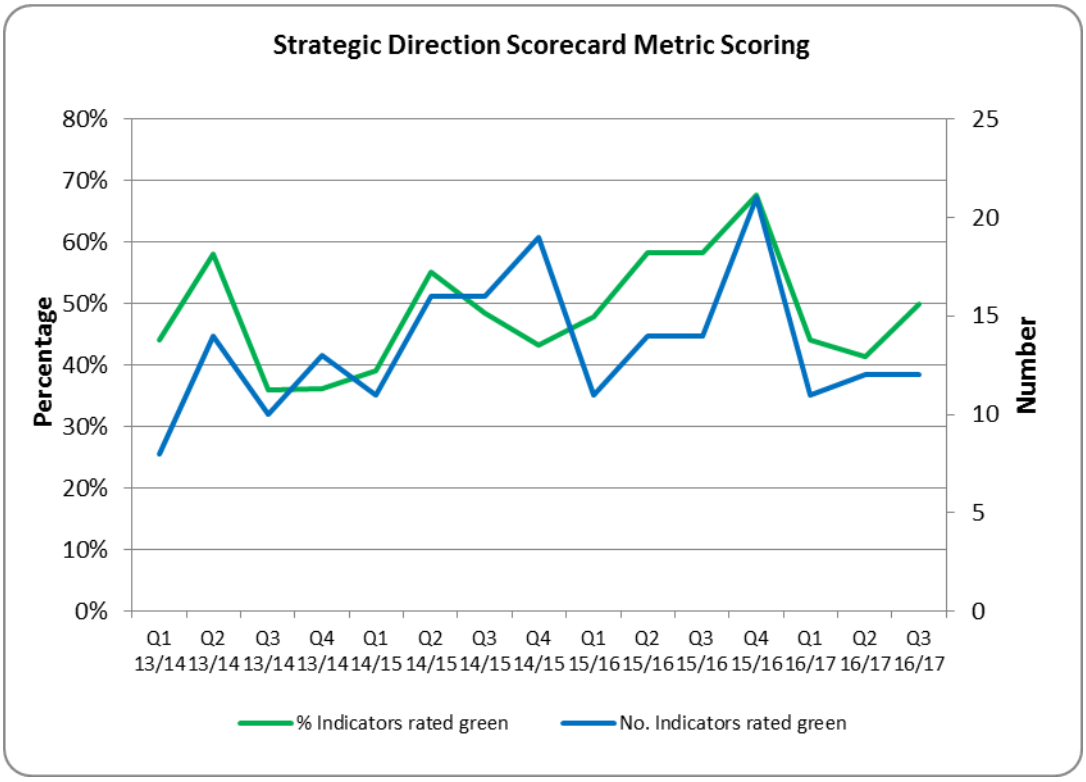
3.1 Trust Strategic Direction Scorecard

The Strategic Direction Scorecard is shown under each strategic goal with further detail, by exception, in Appendix 1.

The following table and graph provide a summary of the RAG ratings at quarter 3 compared to the position in the previous quarter and the previous financial years 2014/15 and 2015/16. The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics; however, quarter 3 shows an improvement on the percentage reported red in quarter 2 2015/16 (59%) but the number of indicators that can be RAG rated also reduced. The actual number of those rated green has in fact remained the same since last quarter. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

	2014/15		2015/16		Q1 2016/17		Q2 2016/17		Q3 2016/17		Q4 2016/17		2016/17 YTD	
	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	18	42%	21	66%	11	44%	12	41%	12	50%	0		12	41%
Indicators rated red	25	58%	11	34%	14	56%	17	59%	12	50%	0		12	41%
Indicators with no target	2		3		2		2		3		0		3	
Indicators currently under development/being finaliased	1		1		0		0		0		0		0	
Indicators where data is not yet available/not applicable in qtr	0		4		12		8		12		0		12	

The percentage is based on the number of indicators that can be RAG rated (24 for quarter 3).



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

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of 6 as at quarter 3, with 1 of those indicators showing an improvement on the quarter 2 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q3 Target 2016/17	Q2 2016/17	Quarter 3 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)									
1	Percentage of patients surveyed reporting their overall experience as excellent or good	>91.44%	92.17%	92.26%	⇧	>91.44%	92.34%	>15/16 out-turn= 91.37% tbc	>18/19 out-turn
2	Percentage of patients who have not waited longer than 4 weeks from "referral " to "assessment" for external and internal referrals	90.00%	85.09%	87.20%	⇧	90.00%	84.64%	90.00%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	84.39%	82.65%	⇩	85.00%	82.31%	85.00%	85.00%
4	The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)	Surveys: Top 20% of MH Trusts	Results delayed - now due in Q3	Better or About the Same as other Trusts	n/a	n/a	n/a	Surveys: Top 20% of MH Trusts	Surveys: Top 20% of MH Trusts
5	The Trust ranks in the top 10th percentile of all mental health Trusts for the NHS Staff Survey (annual)	n/a	Results due in Q4	Results due in Q4	n/a	n/a	n/a	Surveys: Top 10% of MH Trusts	Surveys: Top 10% of MH Trusts
6	Percentage of service users with a recovery focussed action plan (Adult Mental Health)	95.00%	92.05%	91.68%	⇩	95.00%	92.05%	95.00%	95.00%

Indicators of concern are:

- **KPI 2 - Percentage of patients who have not waited longer than 4 weeks from "referral" to "assessment" for external and internal referrals** – the Trust position for quarter 3 is 87.27% against a target of 90% which is an improvement on the quarter 2 position and is the best reported this financial year.

  Only Forensic Services (98.86%) and Teesside (97.04%) are reporting above target for quarter 3, and York & Selby are reporting the lowest performance at 71.90%.

  Within York and Selby there are a number of issues, relating to both data quality and capacity issues within the locality. Capacity issues are a particular concern in CAMHS and the MHSOP memory service, where there is the largest number of waiters. CAMHS have established a Single Point of Access for referrals and have established a team of CAMHS Hospital Liaison workers to release clinician capacity back in to the community teams. Some vacant posts have also been recruited to. An issue with the team set up on Paris has also been identified which is in the process of being addressed. MHSOP continue to review the pathway process as well as looking to recruit to the memory service to meet demand. An RPIW event took place in December 2016 which has evaluated processes for memory clinics.

  Within Durham and Darlington locality (82.40%), Children and Young People's Services (CYP) have continued to improve, following single point of access implementation.

  North Yorkshire locality (83.19%) continues to be impacted by a combination of staffing issues. The main areas of concern are within AMH, CAMHS as well as MHSOP Memory Service. NY have reviewed their service model via the Purposeful and Productive Community Services Programme (PPCS), to ensure capacity is distributed and this has worked within AMH where the crisis team has been assisting where possible. CAMHS has seen a significant improvement in their waiters recently, but there has been some sickness absence and a number of vacancies. A consultant vacancy in Northallerton will be filled at the end of January 2017 and interviews to other vacant posts have taken place. MHSOP continue to have capacity issues with an increase in referrals. Staff are to review the number of referrals against assessment slots to see what is manageable and what further action can be taken.

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

  KPI 3 – Percentage of patients reporting 'yes always' to the question 'did you feel safe on the ward?' – the Trust position for quarter 3 is 82.65%, which is slightly below the target of 85%. Only Teesside are above target, with Forensics and York and Selby reporting the lowest positions at

77.78% and 76.92% respectively. In terms of York & Selby the opening of Peppermill Court in October may improve the position in future quarters.

- **KPI 6 - Percentage of service users with a recovery focused action plan (Adult Mental Health)** – the Trust position for quarter 3 is 91.68% against a target of 95% which is a slight deterioration on the quarter 2 position of 92.05%.

  All localities are under performing, with Teesside and North Yorkshire only very slightly below target at 94.59% and 94.23%, respectively. Durham and Darlington are reporting at 88.61%. The following should be noted:

- There have been significant staffing issues experienced in some teams within Durham and Darlington locality which has impacted on performance into quarter 3. In addition, it has been identified that in one area the process had not been followed correctly which has now been addressed.

- Generally, there is an issue which has affected all localities, mainly in their Psychosis teams. In the model lines process recovery stars are to be completed within 12 weeks of first appointment, this can result in patients being seen as 'breaches' for some time, if they have been in service for less than this period of time. Therefore it is proposed that, the construction of the KPI be changed to include 'Number of service users open to psychosis/assertive outreach teams at quarter end, who have been in service for 12 weeks or more' **Board approval is sought to change this indicator**.

Other Points to note –

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

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 3 were rated green (91%) which is an improvement on the quarter 2 (73%) position.

There are 9% of the priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

The 9% represents 9 priorities / service developments. Of these:

- 2 required additional time within year (which has been agreed by EMT)
- 2 require additional time going beyond the current year (to be agreed by Board)
- 3 require removal from the current plan (to be agreed by Board)

- 1 priority / service development cannot yet request a change because a PM form / project plan is in development. (Knowledge Management System project)
- 1 priority / service development was awaiting approval of the project closure documentation (which has since been agreed by EMT)

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

3.2.3 Other Qualitative Intelligence

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

- The Trust has recently signed up to become a member of the Triangle of Care which brings together carers, service user and professionals. The Trust is committed to improving the experience of carers and all wards and crisis teams will be carrying out self-assessments over the next 12 months with the help of carers and carer organisations. They will review their practice in relation to the involvement and support for carers and develop plans for improvements

- Farnham Ward has achieved AIMS-WA (working age adult admissions wards) accreditation from the Royal College of Psychiatrists' Combined Committee for Accreditation (CCA).

- Having been shortlisted for four Royal College for Psychiatry awards, Trust staff have been successful in 3, two of which support Strategic Goal 1 - Excellent Services:

    - Experts by Experience - Service User/Patient Contributor of the Year

    - Liaison Psychiatry Team (North Tees) - Psychiatric Team of the Year for Older Age Adults

- The team at HMP Durham have received excellent verbal feedback following a visit from CQC. The CQC Inspector was impressed regarding the willingness of all mental health professionals to deal with all issues, and described the mental health service provided as 'Excellent' The Mental Health Model and range of providers and interventions was described as 'Very Good'.

3.2.4 In conclusion it can be seen for this strategic goal that the number of red KPIs remains unchanged but the improvement in the Business Plan and the significant qualitative intelligence, in terms of how services are improving, provides an overall positive position. However, further work is required around waiting times, patient experience and recovery focused action plans.

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

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of 8 as at quarter 3.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q3 Target 2016/17	Q2 2016/17	Quarter 3 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 2 (To continuously improve the quality and value of what we do)									
7	Number of outstanding action points for **more than 31 days** for Level 5 SIs and action points for safeguarding serious case reviews and domestic homicide reviews	0	19	23	⇩	0	19	0	0
8	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	15	19	⇩	0	15	0	0
9	Friends & Family Test - **Patient** Survey Question: "How likely are you to recommend our ward/services to friends and family if they needed similar care or treatment?"	>86.01%	86.14%	86.81%	⇧	>86.01%	86.28%	>15/16 out-turn= 86.01% tbc	> previous year out-turn
10	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	20.00%	0.00%	⇩	50.00%	16.67%	50.00%	>=75%
11	Percentage of staff reporting that they can 'contribute towards improvements at work'*	n/a	Results due in Q4	Results due in Q4	n/a	n/a	n/a	>2015/16 (79%) and in top 20%ile of MH/LD trusts tbc	> 2018/19 and in top 20%ile for MH/LD Trusts
12	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"	n/a	80.37%	No Staff FFT in Q3	n/a	>82.58%	80.71%	>15/16 out-turn= 82.58% tbc	> previous year out-turn
13	For Trust hospital sites with over 10 beds, the trust score for each category (Cleanliness, Food, Privacy & Dignity, Condition, Appearance & Maintenance, Dementia Friendly, Learning Disability) > national average PLACE (new PEAT) assessments.	n/a	50.00%	Assessment completed in Q2	n/a	80%	50.00%	80%	80%
14	Hospitality Assured Accreditation score*	n/a	81.10%	Assessment completed in Q2	n/a	82.00%	81.10%	82.00%	86.00%

Indicators of concern are:

- **KPI 7 - Number of outstanding action points on action plans for more than 31 days for Level 5 SI's and action points for safeguarding serious case reviews and domestic homicide reviews**– the Trust position for quarter 3 is 23 against a target of zero, which is a deterioration on the quarter 2 position. All relate to Level 5 SI's.

  The Patient Safety Team have had correspondence with all of the clinical services who have advised that they are in the process of implementing all of the identified action plans, however delays have been experience due to changes of staff within the directorates, in particular locality managers who were the action plan owners. We have implemented a process which will ensure these outstanding actions are continuously monitored and signed off as soon as possible.

- **KPI 8 - Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days** – the Trust position for quarter 3 is 19 against a target of zero, which is a deterioration on the quarter 2 position. All relate to Clinical Audit.

The 19 outstanding action points of more than 31 days at the end of quarter 3 are from 11 audits; 3 actions were past the target date by 206 days, 2 actions were past by 145 days, 3 actions were past by 115 days, 1 action was past by 114 days, 3 actions were past by 84 days, 1 action was past by 54 days and 6 actions were past by 53 days.

The leads/specialties are aware of these outstanding actions and are working to achieve implementation. Each Specialty has a clinical audit sub group which meets monthly, reviews outstanding actions and provides support to facilitate completion and sign off of the action point. Outstanding actions are also monitored each month by the Clinical Effectiveness Group and relevant actions escalated to Heads of Service/ Senior Managers. Outstanding actions are discussed with the Service Development Managers to facilitate completion and where appropriate any actions >90 days are escalated to the Quality Assurance Committee within the quarterly update report.

- **KPI 10 - Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication** – the Trust position for quarter 3 is 0% against a target of 50%, which is a deterioration on the quarter 2 position.

  There were 12 baseline assessment tools signed off by Clinical Effectiveness Group (CEG); however none were within 6 months of publication.

  The Trust has observed an increase in the number of NICE publications relevant for implementation since 2015. This has increased the number of baseline assessment tools (BATS) that services are required to complete. For many of the NICE guidance which are now issued, assessment of current levels of implementation can be complex. This is due to the fact that much of the guidance is across multiple Specialties and all Localities. Furthermore facilitating sign off of baseline assessments and action plans via Service Development Groups prior to presentation to the Clinical Effectiveness Group can also incur delays to the process.

  The Clinical Effectiveness Group monitor this KPI. Outstanding and overdue BATs are reviewed to identify any further support that can be assigned to assist delivery. In December 2016 the CEG requested that Leads for all overdue BATs be consulted regarding delays and return realistic dates for when these would be complete and presented for sign off. The large number of BATs presented to CEG during Quarter 3 reflects Leads addressing the overdue baseline assessments.

  Details of all 12 baseline assessment tool are given in Appendix 1.

3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 3 were rated green (95%) which is a slight improvement on quarter 2 (91%).

There were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.3.3 Other Qualitative Intelligence

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

- Peppermill Court in York reopened on Monday 3 October as a 24-bed adult inpatient assessment and treatment unit for the people of York and Selby. The refurbished unit is modern, light and airy and the male and female wards each have 12 single bedrooms and direct access to gardens. This unit brings adult inpatient beds back to York, which has been our priority since we took over services in October 2015.

- Teams in Hartlepool and Stockton won the MINDset Quality Improvement Award and also the Positive Practice Network award, for creating a model line for community psychosis.

3.3.4 In conclusion it can be seen for this strategic goal that taking into account the Business Plan and qualitative intelligence, the position remains positive. However further work is required around the number of outstanding action points for both level 5 SUI's and Clinical Audits, and the percentage of NICE guidance baseline assessments signed off within 6 months.

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

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 4 indicators rated red out of 12 as at quarter 3, with 2 of these indicators reporting an improvement on the quarter 2 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q3 Target 2016/17	Q2 2016/17	Quarter 3 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 3 (To recruit, develop and retain a skillled, compassionate and motivated workforce)									
15	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"	n/a	**68.15%**	No Staff FFT in Q3	n/a	>70.95%	**69.44%**	>15/16 out-turn= 70.95% tbc	> previous year out-turn
16	Percentage of medical students and junior doctors reporting satisfaction with their placement	88.00%	**88.89%**	**90.48%**	⇧	88.00%	**88.89%**	88.00%	90.00%
17	Percentage of positive nursing placement evaluations received	95.00%	**96.52%**	**96.10%**	⇩	95.00%	**95.89%**	95.00%	95.00%
18	Excess cost of employing medical agency versus substantive	£75,000	**£163,162**	**£130,794**	⇧	£150,000	**0**	**£300k**	zero
19	NHS Employers Assessment of Wellbeing	100%	**100.00%**	**100.00%**	⇔	100%	**100.00%**	100%	100%
20	Percentage of Culture Metrics showing improvement at year end*	n/a	**66.67%**	**no longer reported**	n/a	100%	**66.67%**	100%	100%
21	Percentage of positive staff responses for training/development evaluations received (data is a month behind	75.00%	**74.47%**	**74.90%**	⇧	75.00%	**74.16%**	75%	TBC
22	Quality of Appraisals	n/a	Results due in Q4	Results due in Q4	n/a	n/a	n/a	>15/16 out-turn= 3.36	>= 2018/19 & in top 20%
23	Percentage of medical staff successfully revalidated	100%	**100.00%**	**75.00%**	⇩	100%	**90.00%**	100%	100%
24	The variation in percentage responses to the questions in NHS Staff Survey of those who identified themselves as disabled compared to those who did not identified themselves as disabled*	n/a	Results due in Q4	Results due in Q4	n/a	n/a	n/a	n/a	TBC
25	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	50%	**18.18%**	**3.57%**	⇩	50.00%	**9.59%**	50.00%	80.00%
26	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	n/a	Results due in Q4	Results due in Q4	n/a	n/a	n/a	<2015/16 outturn (28%) & top 20%	< previous year out-turn

Indicators of concern are:

- **KPI 18 - Excess cost of employing medical agency versus substantive** - the Trust position for quarter 3 is £130,794, which is £55,794 worse than the target of £75,000 but an improvement on the quarter 2 position partially due to anticipated savings following the implementation of a managed agency provision from Retinue and the introduction of NHS Improvement price and wage caps.

  - There were 17 vacancies covered by agency as at the end of quarter 3 as detailed below:
    - Durham – Adults (2) MHSOP (1) and ALD (1)
    - Teesside - Adults (2)
    - North Yorkshire – Adults (2) and MHSOP (2)
    - Forensic Services – FLD (2)

- York and Selby – CAMHS (3) and MHSOP (2)

  - A further 2 agency staff were used in North Yorkshire to cover sickness (2 AMH and 1 CAMHS).

- **KPI 25 - Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above** – the Trust position for quarter 3 is 3.57% against a target of 50% which is a deterioration on the quarter 2 position. This relates to 1 advertised post with at least 2 internal candidates out of 28 advertised posts.

  Work is underway contacting appointing managers to discuss the lack of appointable candidates to Band 7 posts and above. The purpose is to establish why this is the case and what support can be offered to help attract candidates to these posts. Further to this there is a Kaizen event scheduled for March 2017 to review the role and function of the Talent Management Forum with the aim of embedding talent management fully into Directorates and localities. The Talent Management Board has also approved a revised action plan in November 2016. This talent management action plan has also been integrated into the leadership and management development strategy action plan, which will support the delivery of this indicator.

  Other Points to note -

- **KPI 20 – Percentage of Culture Metrics showing an improvement at year end** – at the Board meeting in November 2016, it was agreed that we would cease reporting culture metrics at organisational level, whilst we develop a new set of metrics which would then be reported in the Autumn. It is therefore proposed that we remove this indicator and Board are asked to support this proposal.

- **KPI 21 – Percentage of Staff Responses for training/development evaluations received -** The Trust position for the full quarter 3 position is not yet available, due to the evaluation being carried out by an external company. Therefore the November position is reported at 74.89% which reflects 2002 positive staff responses for training/development evaluations received out of 2673. This is 0.11% below the target of 75%.

3.4.2 Trust Business Plan

95% of the actions within the Business Plan which were due to be completed by the end of Q3 had been completed by 31st December 2016. This is an improvement on Q2, where only 87% of actions due to be completed by 30th September had been achieved.

However, 17% of the individual priorities in the current business plan are at high risk of failure to complete on time, within budget, or within the agreed scope. EMT have agreed those changes which do not move the end date into a new financial year, don't require additional resources above that which can be vired under delegated powers, and don't significantly change the expected deliverables. However, there are

14 remaining change requests for the Board to consider which are set out in Appendix 2.

3.4.3 Other Qualitative Intelligence

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

- Our staff Mindfulness Service won the Mental Wellbeing of Staff category at the Positive Practice Awards.
- Having been shortlisted for four Royal College of Psychiatry awards, Trust staff have been successful in 3, one of which supports Strategic Goal 3 - Workforce:
    - Dr Paul Blenkiron - Psychiatric Communicator of the Year

- To encourage health and wellbeing within the workforce and improve fitness across the Trust, a scheme has been introduced by the health and wellbeing team. They have a number has a number of pedometers available for use by staff in each locality across the Trust. The pedometers will record steps taken, distance covered and equivalent calories used, with prizes offered for those clocking up the most steps.

3.4.4 In conclusion it can be seen for this strategic goal that there has been an some improvement in both the Business Plan and KPI's, however, taking into account progress overall, the position remains mixed. In addition, the Trust will continue to benefit from an increased focus on talent management.

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

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing no indicators rated red at quarter 3.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q3 Target 2016/17	Q2 2016/17	Quarter 3 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 4 (To have effective partnerships with local, national and international organisations for the benefit of the communities we serve)									
27	Attendance rate at H&WB Boards	90%	81.82%	90.91%	⇧	90%	83.87%	90%	90%
28	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	100.00%	⇔	98%	100.00%	98%	98%
29	Proportion of student nursing placements provided as a % of placements requested	90%	100.00%	99.04%	⇩	90.00%	99.79%	90.00%	90.00%
30	R&D Outcomes - Annual number of recruits to National Institute of Health Research studies supported by TEWV R&D staff	n/a	468	161	⇩	n/a	698	453	10% increase year on year
31	R&D Outcomes - Annual external R&D income (including external grants and commercial income)	n/a	£161,696	£117,715	⇩	n/a	£419,366	£678,014	10% increase year on year
32	Corporate Governance Statement signed off annually by Board with no conditions* and Monitor Governance Risk Rating maintained at 'GREEN' each quarter	Signed & Green	n/a	No longer reported	n/a	Signed & Green	n/a	Signed & Green	Signed & Green

Points to note –

- **KPI 32 – Corporate Governance Statement** - Following the introduction of the Single Oversight Framework, the Trust is no longer required to submit a Corporate Governance Statement. Board agreed to longer report this indicator pending notification of any further requirements from NHS Improvement. It will therefore be removed from future reports. Board are asked to support this proposal.

3.5.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 3 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.5.3 Other Qualitative Intelligence

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

- The Trust has been successful, working in partnership with Northumberland, Tyne and Wear NHS Foundation Trust (NTW), in being awarded an extension to the current veterans' mental health services contract. This is in anticipation of a further procurement coming some time later on this year. Plans have been put in place to prepare a tender response to retain this important service within this partnership arrangement.

- TEWV is one of the organisations to trial secondary mental health providers managing care budgets for tertiary mental health services (in our case CAMHS tier 4 services for the North East and North Yorkshire). From 1st October 2016 and for the rest of this financial year we will be doing this in 'shadow form' (responsibility and accountability remains with NHS England). A programme board has been set up to oversee this which has representation from NHS England, all the clinical commissioning groups (CCGs) within the patch and key people from the Trust. It is being managed by the Tees locality although all children and young people's services across all localities will be involved.

- North Yorkshire IAPT in partnership with Maternity Services at Harrogate District Hospital have been shortlisted for a Royal College of Midwives award. An innovative partnership has been formed which provides mental health support for expectant and new mothers. The objectives of the project are to increase accessibility for women in the perinatal period with depression and /or anxiety disorders and to build relationships between midwives and mental health staff to improve the referral process and increase the number of midwifery referrals into the team. The award winners will be announced in March 2017.

- Health & Justice North West have undertaken a procurement for procuring health services for a cluster of prisons, Spectrum submitted a bid, identifying TEWV as a sub contractor for the mental health element for HMP's Preston, Lancaster Farms and Kirkham. Spectrum were notified in November that this bid had been successful. The plan is for initial mobilisation in January with a full commencement date of 1st April, 2017.

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

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

3.6.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated red out of 7 as at quarter 3, which is a deterioration on the quarter 2 position.

TRUST STRATEGIC DIRECTION SCORECARD 2016/17									
	Indicator	Q3 Target 2016/17	Q2 2016/17	Quarter 3 Actual 2016/17	Change on previous quarter/year	YTD Target 2016/17	FYTD 16/17 Actual	Annual Target 2016/17	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 5 (To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve)									
33	Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)	37.50%	71.43%	71.43%	⇔	37.50%	71.43%	<37.50% tbc	<=6.25%
34	Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard	75%	75.00%	75.00%	⇔	75.00%	79.17%	75%	TBC
35	Percentage change in income for Trust contracted services compared to previous year	1.10%	6.83%	7.40%	⇧	1.10%	6.83%	1.10%	Better than deflator
36	Reference Cost Index score for in-scope PbR Services	<=95	97	100	⇩	<=95	97	<=95 TBC	TBC
37	Reference Cost Index score for out of scope PbR Services	<=95	86	88	⇩	<=95	86	<=95 TBC	TBC
38	EBITDA **	6.29%	8.64%	11.86%	⇧	7.48%	8.64%	6.33%	8.00%
39	Good Corporate Citizenship audit scores*	n/a	Due in Q4	Due in Q4	n/a	n/a	n/a	65.00%	75.00%

Indicators of concern are:

- **KPI 33 - Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)** – the Trust position for quarter 3 is 71.43% which is worse than the target of 37.50% and is consistent with the quarter 2 position.

This accounts for 10 metrics out of 14 that are reporting red; however, of these 6 have shown an improvement on quarter 2. Those showing a slight deterioration are the patients recorded on PARIS for which accommodation status and ethnicity are missing, No CPA level recorded and the percentage of records submitted through MHSDS with a valid ethnicity code. There is a data quality action plan which is underway led by the Information Department with the clinical services to address the data quality issues. This is monitored at Trust Data Quality Group and at Trust Performance Improvement Group on a monthly basis.

- **KPI 36 Reference Cost Index Score for in-scope PbR services** – the Trust position is 100 against a target of less than 95.

  Reference Costs are measured against all other Mental Health providers within the NHS. Although we have a target of 95, the national averages and Reference Cost Index (RCI) are influenced by all other providers submissions therefore their relative position will affect ours. The in scope RCI has increased relative to the position of other organisations.

3.6.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 3 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.6.3 Other Qualitative Intelligence

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

- NHS England made £25m available for CAMHS nationally to be spent in 2016/17, in which all four localities were successful in their bids:
  - Durham and Darlington – 7 staff will commence to focus on reducing waits for ASD assessment which was highlighted as being a large proportion of the 12 week+ waiters. This is to be funded within current resources; however the Trust has submitted a bid for £150k non-recurrent funds to support this work.
  - Teesside – received £146k, some of which will be used to support IAPT services within CAMHS
  - North Yorkshire – Received £183k to focus on a number of areas, including IAPT, Early Intervention (GP Surgery Clinics) and improving Single Point of Access processes through increased admin;
  - York and Selby – Received £136k focussing on increasing capacity to reduce waiting times and securing suitably qualified staff to support the new Single Point of Access service offer, accelerate implementation of wave 6 CYP IAPT training.

- TEWV have submitted a bid to continue to run the northern Mental Health Act panel doctor approval service. Notification was received in October that this bid was successful.

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

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:**
There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled'. This will be reported on in quarter 4.

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

5. RISKS:

There are no identified risks associated with this paper.

6. CONCLUSIONS:

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

This report reflects that four of the Trusts five goals are in a positive position, whilst still acknowledging that there is work to do to improve some KPI's. For Goal 3, it is noted that there are some improvements in both the Business Plan and KPI's, however the overall position still remains mixed.

Overall the scorecard position has improved slightly against the percentages reported in both quarter 1 2016/17 and quarter 2 2016/17. However, the actual number of those rated green has remained static since last quarter. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

7. RECOMMENDATIONS:

Board of Directors are asked to:

- Approve the changes to the Trust Business Plan detailed in Appendix 1.
- Approve the suggested amendment for key performances indicators and targets referenced in section 3.2.1 (KPI 6).
- Approve the suggested cessation of key performances indicators referenced in sections 3.4.1 (KPI 20) and 3.5.1 (KPI 32).

Sharon Pickering
Director of Planning, Performance & Communications

Background Papers:

Board requests for changes:

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
1.6	Deliver agreed service developments - **Eating Disorder Inpatient Service - re-tender** (ends Q4 16/17)	Durham and Darlington	AMH	**Eating Disorder inpatient service -** to respond to the expected re-tender	Tender submission completed in line with quality requirements and timescale	~~16/17 Q1~~ 16/17 Q4	Jo Dawson		Commissioners have given no indication that this service will be subject to tender **Trust Board are therefore requested to approve the removal of this priority.**
1.6	Deliver agreed service developments - **Review of LD Community teams - Phase 3** (ends Q4 16/17)	Durham and Darlington	ALD	Development of community infrastructure - action plan developed	Action plan agreed with Local Authority	16/17 Q3	Fran Bergin		This work has been re-scoped and as a result there are specific actions and timescales to address this priority in the D&D 2017/18 Business Plan. Plan. **Trust Board are therefore requested to approve the removal of this priority.**
				Development of community infrastructure	Action plan implemented	16/17 Q4		**N/A**	
1.6	Deliver agreed service developments - **Review of Respite Services** (ends Q1 16/17)	Tees	LD	Respond to commissioning intentions following the review of Respite Services	Once commissioning intentions are received, respond as required	16/17 Q1	Paul Ellis		Commissioner led review and consultation exercise now to take place to inform procurement in 17/18. Will be taken forward in next year's plan. **Trust Board are therefore requested to approve the removal of this priority.**
1.6	Deliver agreed service developments - **Development of a model for Early**	Tees	CYP Tier 2 and 3	Develop a model for Early Intervention	Project brief approved by appropriate governance body	~~15/16 Q2~~ ~~15/16 Q3~~ ~~15/16 Q4~~ 16/17 Q2	Chris Davis		**Trust Board are requested to remove this priority** as work needs to be undertaken to

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
	Intervention for children (ends Q4 16/17)			Develop a model for Early Intervention	Business case and implementation plan approved by appropriate governance body	~~15/16 Q3~~ ~~15/16 Q4~~ ~~16/17 Q1~~ 16/17 Q4		**N/A**	collect baseline data on early years both internally and externally. The view is to include in next year's Tees Locality Business plan once an evidence base has been formed.
				Develop a model for Early Intervention	If business case approved, implementation in line with project plan	In line with project timescales		**N/A**	
1.6	Deliver agreed service developments - **Hambleton and Richmondshire Community Services Resource Centre** (ends Q4 16/17)	North Yorkshire	AMH / MHSOP	Review previous Business Case for reprovision of Community Services Resource Centre in Hambleton and Richmondshire	Produce report/revised Business Case for EMT	16/17 Q4	Adele Coulthard	**N/A**	This is now being taken forward as part of the Hambleton and Richmondshire Service Review - a working group is being set up specifically to look at this work stream. **Board are asked to remove this priority as it is being progressed through a priority in the 17/18-19/20 Trust Business Plan.**
1.6	Deliver agreed service developments - **Develop Urgent Care Pathway for all of North Yorkshire in response to CCG requests** (ends Q1 17/18)	North Yorkshire	AMH / MHSOP / CYP Tier 3	Implement agreed Service Specification across all of North Yorkshire	Standard work developed and implemented using QIS methodology	16/17 Q2	AMH Head of Service / Liz Herring / Jan McLauchlan		Draft all age specification now received by commissioners – meetings continue to agree the final document through contracts however a final completion date is unknown at this time. The standard work has

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
									been developed through the SWR pilot – there will be a learning event in February that will start the spread of the triage and assessment tool.
				Implement agreed Service Specification across all of North Yorkshire	Project Close Down Report (PM4) presented to EMT	16/17 Q3			Discussed at LMGB with revised dates agreed to be Q3 17/18 with funding to be determined. **Trust Board are requested to approve the extension of this action to Q3 17/18.**
				Implement agreed Service Specification across all of North Yorkshire	Evaluation Report (PM5) presented to EMT	17/18 Q1		**N/A**	**Due to the above request, Trust Board are requested to extend the timescales of this action to Q1 18/19.**
1.6	Deliver agreed service developments - **Explore potential to develop Single Point(s) of Access for AMH and MHSOP in North Yorkshire** (ends Q2 17/18)	North Yorkshire	AMH / MHSOP	If scope approved, produce Business Case	Business Case agreed at EMT	16/17 Q2	Adele Coulthard		Not now being progressed as a LMGB priority. Services will support the single e-Referral documentation in the first instance. The ability to manage all referrals into NY via a single point of referral was not considered by LMGB as a sensible way forward. LMGB agreed was that each service would consider the single referral
				Implement preferred option as detailed in Business Case	Project Close Down Report agreed at EMT	16/17 Q4		**N/A**	
				Produce Project Evaluation Report	Project Evaluation Report presented to EMT	17/18 Q2		**N/A**	

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
									points per locality linked with the move towards single referral proforma into service – meaning those with low volume referrals (CAMHS & LD) already have it in place. AMH model community teams will accommodate a single referral document into service **Trust Board are therefore requested to approve the removal of this priority.**
1.6	Deliver agreed service developments – **Rostering** (ends Q3 16/17)	York and Selby	MHSOP	Implementation of 12 hour rostering system across MHSOP inpatient services	Implementation of roster complete	16/17 Q3	Brian Coupe		The implementation of 12 hour rostering across MHSOP inpatient services is part of the Service CRES plan for 2016/12017/18. In order to implement 12 hour rostering, the Service has submitted a QIA to EMT and Board to seek approval of the roster change. In line with the CRES/QIA timescales, the QIA will be signed off in Q4 16/17. **Trust Board are requested to extend the**

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
									timescale of this action to Q2 17/18 to allow for consultation.
1.6	Deliver agreed service developments - **Future in Mind** (ends Q3 16/17)	York and Selby	CYP (Tier 1-3)	Provision of an identified mental health worker in every state school in York & Selby, to upskill school staff, deliver group interventions and emotional wellbeing intervention	Mental Health Workers in post for every school	16/17 Q3	Carol Redmond		Following NHSE approval for transformation plan, City of York Council has been awarded this project and will now employ the MHW within the schools. The Locality CAMHS service will provide clinical supervision to MHW as part of the project. **Trust Board are therefore requested to approve the removal of this priority.**

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
				Develop a seamless pathway with an agreed shared care transition plan that is multiagency, collaborative and recover focus	Pathway agreed and implement				City of York Council are re-organising their Children services to ensure synergies of services across the City of York boundaries. As well as CYC re-organising services, North York CAMHS service are reviewing their SPA for Children. In order to maintain synergies with both CYC and North Yorkshire, the Service are requesting an extension to Q1 17/18. **Trust Board are requested to extend the timescale of this action to Q1 17/18.**
1.5	Ensure our current approach to addressing the physical healthcare needs of our patients is embedded and developed further (ends Q4 17/18)	Nursing and Governance	All	Implementation of physical health care works streams into community services - in line with Community Productivity roll out	Implementation plan for each locality developed and delivered.	16/17 Q3	Alexia Hardy		At the time of developing these metrics it was felt it was appropriate to produce implementation plans for localities. However, as a result of community scoping activity (visits to 40 community teams) the themes identified are out-with the scope and control of this project and fit more closely with PPCS (due to the requirement of

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
									investment, resources, training needs). **Trust Board are therefore requested to approve the removal of this priority.**
3.5	Develop a new staff engagement plan (ends Q4 16/17)	Human Resources	NA	Develop a Extending working lives procedure	Procedure presented and approved by EMT	16/17 Q3	David Levy		We are currently awaiting the results of the Extending Working Lives research study conducted by Leicester University which was due to be received by September 2016. Visit planned at Leicester University with research lead on the 23rd January 2017. **EMT are requested to extend the timescales of this action to Q4 16/17.**
				Develop a staff engagement plan	Plan presented and approved by EMT	16/17 Q3			Plan to be presented to EMT on the 25th January 2017.
				Develop and deliver with legal advisors a *discrimination in*	Programme delivered in all 5 localities and evaluation	16/17 Q4		**N/A**	The focus in 2017/18 now needs to be upon managers receiving whistleblowing training

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
				employment awareness raising programme for managers	report completed				from the newly appointed Freedom to Speak Up Guardian. Due to this, there is a concern about the impact of both sets of training being delivered to the same audience in the same year, feasibility of combining the delivery of training will be considered. **Trust Board are requested to extend the timescale of this action to Q4 17/18.**
1.6	Deliver agreed service developments - **Enhancing Paris and integrating other systems to support the delivery of care (Paris Programme)** (ends Q4 16/17)	Information	N/A	Implement programme as per approved programme plan	Programme Implemented	16/17 Q4	Sue Whitehead	**N/A**	Head of Information visited OMT to discuss PARIS in November, further discussions required later in January 2017. This Programme may be superseded by the exemplar bid. Further support and embedding training continues through January 2017 and into February 2017 but due to staff availability additional sessions still need to be booked in to capture maximum staff. There, the overall status of this priority remains red. In September, a PM2a programme change form was approved at EMT which changed the timescale of some of the milestones within the programme. This however does not take into account the further milestones that do not have any timescale attached to

Bus Plan Ref	Priority Title and overall status	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
									them as they will be completed upon implementation of the current 'live' actions. **Therefore, Trust Board are requested to extend the timescales of this programme to Q1 17/18, however, a further request may be required should the Programme be superseded by the exemplar bid.**

ITEM NO. 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th February 2017**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**28th February 2017**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
281	31.1.17	Extension to Standstill Agreement in relation to the Roseberry Park PFI scheme.	Brent Kilmurray, Chief Operating Officer Phil Bellas, Trust Secretary
282	3.2.17	Licence to underlet relating to Huntington House, Jockey Lane, York.	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
283	3.2.17	Licence to carry out works relating to Huntington House, Jockey Lane, York.	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
284	3.2.17	Underlease to an existing lease relating to land on the north side of Jockey Lane, York.	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
285	3.2.17	Lease relating to Huntington House, Jockey Lane, York.	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary

286	14.2.17	Extension to Standstill Agreement in relation to the Roseberry Park PFI scheme.	Brent Kilmurray, Chief Operating Officer Phil Bellas, Trust Secretary
287	17.2.17	TP1 form (transfer of part of registered title) relating to land at Roseberry Park, Marton Road, Middlesbrough	Colin Martin, Chief Executive Brent Kilmurray, Chief Operating Officer
288	17.2.17	Licence for fitting-out works relating to Coatham Road Health Centre, Coatham Road, Redcar	Drew Kendall, Interim Directors 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 (October 2015)
Seals Register

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28 February 2017**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

2 policies that have undergone full review and require ratification:

- HR-0013-v7 Human Rights, Equality and Diversity Policy (Appendix 2)
- CORP-0052-v3 Equality Analysis Policy (Appendix 3)

1 policy that underwent minor amendment:

- MHA-0010-v2(2) Community Treatment Order (CTO) Policy

3 policies that require an extension to the review date:

- CLIN-0011-v6 Advance decisions to refuse treatment and statements made in advance
- CLIN-0073-v2 MAPPA Policy
- CLIN-0031-v4(2) Preceptorship Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT on 1 February 2017

DATE:	**28 February 2017**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

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

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

3. KEY ISSUES:

3.1 The following have undergone full review and require ratification:

HR-0013-v7 Human Rights, Equality and Diversity Policy
Review date: 01 February 2018

This policy has undergone full review in line with legislative requirements including the Mental Health Act Code of Practice. The Code requires that this policy undergoes annual review.

CORP-0052-v3 Equality Analysis Policy
Review date: 01 February 2020

This policy ensures Trust policies, strategies, functions and services etc. meet the requirements of the Equality Act 2010, with a specific focus on the Public Sector Equality Duty. The policy and the supporting guidance have undergone full review in line with legislation and best practice.

3.2 The following underwent minor amendment:

MHA-0010-v2(2) Community Treatment Order (CTO) Policy
Review date: 7 April 2017

This policy is currently under full review. In the interim, a minor change has been made changing the title from Supervised Community Treatment Order Policy. The amended title meets the requirements of the Mental Health Act Code of Practice 2015 and is how the policy is more commonly known among staff.

3.3 The following have undergone full review but require no changes. The review date is therefore to be extended 3 years.

IT-0010-v4 Information Security and Risk Policy
Review date: 01 February 2020

3.4 The following require an extension to the review date:

CLIN-0011-v6 Advance decisions to refuse treatment and statements made in advance
Review date: 07 April 2017

CLIN-0073-v2 MAPPA Policy
Review date: 30 April 2017

CLIN-0031-v4(2) Preceptorship Policy
Review date: 30 June 2017

Both of the above documents have been extended while the revised drafts undergo consultation.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

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

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meeting on 1 February 2017 have been presented for ratification.

7. RECOMMENDATIONS:

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

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