AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS THURSDAY 19TH JULY 2018
VENUE: THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON
AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	Declarations of Interest.		
Item 2	Chairman's Report.	**Chairman**	**Verbal**
Item 3	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.35 am)

Item 4	To receive and note the report of the Guardian of Safe Working.	**Dr. Whaley to attend**	**Attached**
Item 5	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 6	To consider the six monthly Nurse Staffing Report.	**EM**	**Attached**
Item 7	On the recommendation of the Resources Committee to approve and ratify the Trust's 2017/18 Workforce Race Equality Scheme (WRES) and associated action plan.	**DL**	**Attached**
Item 8	To consider a report on an analysis of the Trust's gender pay gap and potential actions which could be taken to close it.	**DL**	**Attached**
Item 9	To approve the revised Leadership and Management Development Strategy.	**DL**	**Attached**
Item 10	To receive and note the annual report on Directors' visits.	**DB**	**Attached**
Item 11	To consider any matter of urgency arising from the meeting of the Mental Health Legislation Committee held on 12th July 2018.	**RS/EM**	**Verbal**

Performance (10.45 am)

Item 12	To consider the summary Finance Report as at 30th June 2018 and to approve the Quarter 1, 2018/19 submission to NHS Improvement.	**PM**	**Attached**
Item 13	To approve the revised key performance indicators for the Strategic Direction Performance Report scorecard.	**SP**	**Attached**

Governance (11.00 am)

Item 14	To receive and note a report on the Trust's position against the Single Oversight Framework at Quarter 1, 2018/19.	**PB/SP**	**To follow**
Item 15	To consider a report on the review of the operational arrangements of the Mental Health Legislation, Quality Assurance and Resources Committees.	**PB**	**Attached**

Items for Information (11.15 am)

Item 16	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 17 To note that the next meeting of the Board of Directors will be held on Tuesday 25th September 2018 in the Board Room, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.20 am)

Item 18 **The Chairman to move:**

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

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

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

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

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

(a) the free and frank provision of advice, or

(b) the free and frank exchange of views for the purposes of deliberation, or

(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
13th July 2018

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

ITEM NO. 4

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**July 2018**
TITLE:	**Guardian of safe Working Quarterly Report**
REPORT OF:	**Julian Whaley, Guardian of Safe Working**
REPORT FOR:	**Assurance**

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

Executive Summary:

This paper outlines the ongoing work of the 'Guardian of Safe Working' as part of the 2016 Terms and Conditions for Junior Doctors and identifies issues that have arisen for the Trust.
It is the responsibility of the Guardian of Safe Working to provide a Quarterly report to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.
The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017 and most of our trainee workforce are now on this contract. Mandated monitoring processes have not identified any breaches to terms and conditions of service requiring the levy of a fine. Processes allow identification of concerns which are being appropriately addressed and where necessary, changes implemented.

Recommendations:

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

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

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

Regular Commitments of the Guardian to support this agenda includes:

1. Quartely Junior Doctor Forums and 7 Locality Junior Doctor Forums.
2. Attendance at Trust Medical Education meetings and Local Negotiating Committee
3. Membership & engagement of regional (2) and national forums.
4. Junior Doctor induction sessions
5. Process for 1:1 meeting offer with Junior Doctors.
6. Regular sessions on Junior Doctor Teaching Programmes

3. KEY ISSUES:

I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified timeframes. High levels of exception reports relate to the high degree of variation in out of hours non-resident on call rota work and there is some increase in doctors reporting for late finishes. I am satisfied that all

doctors are being paid for the work they are undertaking but further assurance will be sought that agreement for time off in lieu is achieved when this is the agreed outcome. There has been no justification to levy a fine on any department within the organisation.
Over recent months there has been a sustained increase in workload in South Durham. As a result, the schedule is changed from August to resident with the transfer of one junior doctor from North to South Durham. Also, there has been a persistent vacancy issue in the in-patient service and significant concerns have been raised by a junior doctor; this has necessitated a coordinated response from medical staffing and operational services to ensure appropriate additional support. It is important that we continue to highlight the importance of the exception reporting system in identifying changes in work pattern and not leaving Junior Doctors open to criticism for failing to speak out.
There are anticipated difficulties in Harrogate from August; all posts will be filled but not all on the rota or full-time. Assurance has been given that the rota will not reduce below the revised schedule of 1 in 6 and there will be a mandated half day post on-call to ensure no 48 hour breach.
There have been some difficulties with the need to complete manadated training prior to joining rotas, leading to a need to 'front-load' rotas at the start of new rotations; an initiative to complete training prior to starting in return for a half-day will help with this.
Rota monitoring in Scarborough has led to a work schedule change with an additional 1 hour enhanced-hours payment which should lead to reduction in exception reporting.
Teesside is planning to trial the use of an on-call tablet with a task manager system, which will aid coordination and identify appropriateness of antisocial hours work.
I am hopeful that a single cost code for Junior Doctors calling a taxi can be obtained to simplify process and make it less likely that a doctor will risk driving home when potentially too tired.
North Durham are trialling 'Commicare' in support of safe lone working for the junior workforce.
A number of national publications (BMA Rest & Facilities Charter / RCPsych Trainee-led Review / NHS I 8 High Impact Actions) have been helpful in identifiying issues for trainees and these have been considered in the Junior Doctor Forum and have led to a number of positive actions across the Trust, including the development of a survey, leadership events, sponsorship of training, careers events and a proposal for a number of workstreams via Medical Development. It is important that we consider how all Quality Improvement work both engages with and impacts on Junior Doctors.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety,GoodGovernance, Staffing and Duty of Candour. This report evidences maintenance of these standards. I have recently met with CQC in this role.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board is aware of the cost considerations

of rota designs and the need to ensure appropriate workloads for junior doctors within a model that makes effective use of the whole workforce.

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

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

4.4 **Equality and Diversity:**

The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity is co-opted to the quarterly trustwide Junior Doctor Forum and E&D is a standing agenda item. A Champion of Flexible Working is also in post.

4.5 **Other implications:**

GMC surveys have placed our organisation as one of the best training providers for junior doctors in the country. Historically our training schemes have achieved outstanding results in Royal College of Psychiatrists membership examinations. It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.
Recruitment into Psychiatry remains a key concern nationally.

5. RISKS:

Failure to provide systemic solutions in ensuring Junior Doctor duties are not quantitatively or qualitatively onerous will lead to significant cost and reputational risk, impacting on all areas highlighted in section 4. I am satisfied that the systemic processes outlined within this report provide assurance of interventions to mitigate potential risks highlighted.

7. CONCLUSIONS:

The organisation continues to comply with the 2016 Junior Doctor Contract and junior doctors are appropriately submitting exception reports which are being handled appropriately. There are no immediate safety concerns.
Rotas with high levels of antisocial hours activity have been identified and appropriate systems and processes are in place including schedule revisions to best meet the needs of junior doctors and the Trust as a whole.
The organisation continues to work both systemically and individually on issues arising from vacancies.

7. RECOMMENDATIONS:

The Board are asked to read and scrutinise this report.

Author, Julian Whaley
Title: Guardian of Safe Working

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

High level data

Number of doctors / dentists in training (total):	76
Number of doctors / dentists in training on 2016 TCS (total):	60
Number of clinical supervisors	68
Amount of time available in job plan for guardian to do the role:	2 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors: trainee	0.25 PA per

Exception reports (with regard to working hours) from 1st April 2018 up to 31st June 2018

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	N/A	N/A	N/A	N/A
F1 – South Durham	0	17	17	0
F2 - Teesside & Forensic Services Juniors	0	0	0	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	2	2	0
CT1-2 –North Durham	0	4	4	0
CT1-2 – South Durham	0	57	57	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	0	0	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	3	3	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Total	**0**	**83**	**83**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	2	2	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	4	4	0
South Durham Juniors	0	42	42	0
North & South Durham Senior Registrars	0	0	0	0
Total	**0**	**48**	**48**	**0**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Locality	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
Teesside & Forensic Juniors	Registrars/ GP Reg/ F2s/ Trust Doctors			1B	
Teesside & Forensic Senior Registrars	Senior Registrars			1C	
Teesside CAMHS	Senior Registrars			1C	
Durham & Darlington CAMHS	Senior Registrars			1B/ 1A	
South Durham Juniors	Registrars/ GP Reg/ F2s/ Trust Doctors			1C	
South Durham Senior Registrars	Registrars			1C	
North Durham Juniors	Registrars/ GP Reg/ F2s/ Trust Doctors			1B	
North Durham Senior Registrars	Senior Registrars			1C	

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Teessside & Forensic Services	Trust Doctor	New	No	40	38	0	38	1 F2 vacancy from April and 1 trust doctor who could not do on-calls for a period of time
	GP Registrar	New	Not known					
	CT3	New	Yes					
	MTi	New	No					
	MTi	New	Unknown					
	F2	New	Unknown					
	CT3	Old	Not known					
	CT1	New	Not known					
	CT3	Old	Yes					
	CT3	Old	Yes					
	CT1	New	Yes					
	Trust Doctor	New Trust Dr	No					
	CT2	New	Not known					
	Trust Doctor	New	No					
	GP Registrar	New	Not known					
North Durham	Specialty Doctor	SAS doctor	No	14	14	0	14	1 F2 vacancy from April and 1 due to pregnancy
	CT3	Old	No					
	CT2	New	No					
	Trust Doctor	New	Unknown					
	GP Reg	New	Unknown					
	Specialty Doctor	SAS doctor	Unknown					
	Trust Doctor	New	Unknown					
South Durham	CT3	Old	Unknown	24	24	0	24	1 vacancy, 1 long term sickness and on-call restrictions of existing trainees
	CT2	New	Unknown					
	Specialty Doctor	SAS Doctor	No					
	CT3	Old	Yes					
	Specialty Doctor	SAS Doctor	Yes					
	Trust Doctor	New	Yes					
	CT3	Old	Unknown					
	CT2	New	Unknown					
	Specialty Doctor	SAS Doctor	No					
	CT3	Old	Unknown					
Total				**78**	**76**	**0**	**76**	**6**

Narrative around Exception Reporting

Durham & Darlington

There were 81 exception reports raised during that period for the Durham & Darlington locality. This includes data from 4 rotas – South Durham junior doctors, North Durham junior doctors, South Durham senior registrars and North Durham senior registrars. There were 4 exception reports raised from the North Durham junior doctors over the reported period and the remaining were from the South Durham junior doctors. The majority of the exception reports were in relation to additional plain and enhanced time worked whilst on-call. 39 exception reports from the South Durham locality were in relation to late finishes and extensions of the normal working day and on some occasions due to missed breaks. 5 exception reports were logged as educational exception reports. The South Durham rota is currently nonresident but due to the business and intensity of the on-calls, the trust following discussions with the trainees has agreed to implement a resident on-call rota for the South Durham locality from August 2018.

Teesside

There were 2 exception reports raised during that period for the Teesside locality. This included data from 3 rotas – Teesside junior doctors, Teesside senior registrars and Teesside CAMHS senior registrars. Both exceptions were raised from the junior doctor rota and were in relation to claiming enhanced time whilst on non-resident on-call.

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

High level data

Number of doctors / dentists in training (total):	54
Number of doctors / dentists in training on 2016 TCS (total):	50
Number of clinical supervisors	47
Amount of time available in job plan for guardian to do the role:	2 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors:	0.25 PA per trainee

Exception reports (with regard to working hours) Up to from 1st April 2018 up to 31st June 2018

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - Northallerton	No F2 Doctors in North Yorkshire			
F2 - Harrogate				
F2 - Scarborough				
F2 - York	0	2	2	0
CT1-2 - Northallerton	0	11	11	0
CT1-2 - Harrogate	0	20	20	0
CT1-2 - Scarborough	0	22	22	0
CT1-2 - York	0	6	6	0
CT3/ST4-6 – Northallerton	0	1	1	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	9	9	0
CT3/ST4-6 – York	0	0	0	0
Trust Doctors - Northallerton	0	15	15	0
Trust Doctors - Harrogate	0	7	7	0
Trust Doctors - Scarborough	0	13	13	0
Trust Doctors - York	0	0	0	0
Total	**0**	**106**	**106**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	27	27	0
Harrogate	0	27	27	0
Scarborough	0	44	44	0
York	0	8	8	0
Total	**0**	**106**	**106**	**0**

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Northallerton	Trust Dr	New	No	2	2	0	2	Sickness
	CT3	Old	Yes					
Harrogate	CT3	Yes	Yes	13	11	0	11 + consultants acted down on 2 occasions	Trust Doctor doing reduced number of on calls/ Paternity Leave/ Sickness
	CT1	Yes	No					
	Specialty Dr	No	Yes					
	Specialty Dr	No	Yes					
	CT1	Yes	Unknown					
	Trust Doctor	New	Unknown					
	Trust Doctor	New	No					
Scarborough	Specialty Dr	NA	Yes	12	12	0	12	O.8 CT/0.5 GP/Trust Doctor of the rota from 24.4.18
	CT1	Yes	Yes					
	CT3	Yes	Yes					
York & Selby	CT1	New	Unknown	40	38	3	35	To cover X2 Trust doctor posts due to start in Feb but withdrew. Also x1 doctor off on-calls for health reasons and x1 doctor off on-calls following long term sick who
	Specialty Doctor	N/A	Yes					
	Trust Doctor	New	Unknown					
	CT2	New	Unknown					
	F2	New	Unknown					
	Trust Doctor	New	Unknown					
	Trust Doctor	New	Unknown					
	ST4	New	Unknown					
	GP	New	Unknown					
	Trust Doctor	New	Unknown					
	GP	New	Unknown					

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
								only re-joined in June.
Total				**67**	**63**	**3**	**62**	**0**

Narrative around Exception Reporting

Harrogate:
Non-resident rota - Doctors receive payment for 4 additional hours at plain rate and 1 additional hour at enhanced rate in their work schedule. The majority of exceptions were due to doctors working more hours than in their work schedules. 8 exceptions were due to working during the enhanced hours period. However 13 exceptions were due to late finishes to the normal working day from one Trust Doctor who was in her first post in the UK and one Registrar.

Scarborough:
Non-resident rota - Doctors receive payment for 2 additional hours at plain rate in their work schedule. The majority of exceptions related to working more hours than in their work schedule. 34 exceptions were due to working during the enhanced hours period. A recent monitoring exercise has shown that the work schedule should be reviewed to include 1 hour paid at enhanced rate.

Northallerton:
Non-resident rota - Doctors receive payment for 2 additional hours at plain rate in their work schedule. The majority of exceptions related to working more hours than in their work schedule. 17 exceptions were due to working during the enhanced hours period. However 4 exceptions were due to a late finish to the normal working day.

York:
Exceptions were raised due to a doctor working late and a doctor claiming he had to miss teaching to provide locum cover, having not informed medical staffing he had teaching when he volunteered to cover that day. Two were to claim payment for two locum shifts. One was due to a trainee having to stay late for a supervision session. A further two were due to a trainee having to stay late to treat a patient. There was also an exception due to trainee rep attending junior doctor forum on a non-working day that was advised by the Associate Director of Medical Development to exception report to claim payment for this.

ITEM NO. 5

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Thursday, 19 July 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Assurance statement pertaining to the QuAC meeting held on 05 July 2018:

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 Forensic and Durham and Darlington services and top issues and concerns
- Patient Safety Group
- CQC compliance Report
- Safeguarding & Public Protection
- NHSI: Patient Safety Alert: Resources to support the safe adoption of the revised early warning score (NEWS2)
- NHSI: How to understand and improve patient safety incident reporting to the National Reporting and Learning System (NRLS)
- Presentation on Restraint and Physical Intervention in CAMHS Tier 4 services

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 05 July 2018.
- Note the confirmed notes of the meeting held on 07 June 2018 (Annex 1).
- Note the recommendation to consider at a future Board Seminar the use of Restraint and Physical interventions in CAMHS Tier 4 Services.

MEETING OF:	**Board of Directors**
DATE:	**Thursday, 19 July 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting held on 05 July 2018.

2. BACKGROUND INFORMATION AND CONTEXT

This report provides assurance to the Board on the Trust's compliance with CQC fundamental standards and other quality requirements.

These assurances are based on regular reporting from the clinical governance infrastructure which includes the Locality Management Governance Boards (LMGBs) together with the corporate assurance working groups of the Committee.

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principal risks and concerns, together with assurances and progress from Forensic and Durham and Darlington Services.

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

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

4.1 FORENSIC SERVICES LMGB

The Committee received the LMGB report for Forensic Services.

The top three issues highlighted were:

- Cancelled patient leave – this continues to be monitored in daily clinical huddles and re-provided where possible.

- Healthy Eating Kaizen Event – where the service is developing a strategy to reduce the levels of obesity among the forensic population as 86% are currently classed as overweight or obese. Positive feedback was provided by the CQC inspector who attended the event.

- Triangle of Care – where the National Secure Carers toolkit has been recently launched which includes good practice from TEWV Forensic Services. This will continue to be developed to support carers.

4.2 **DURHAM AND DARLINGTON SERVICES LMGB**

The Committee received the LMGB report for Durham and Darlington.

The top areas of concern highlighted were:

- Out of locality bed pressures with growing concerns around staff morale and job satisfaction.

- Bed management over the weekends – with an increase of 34% admissions across Lanchester Road and West Park in May 2018. A Kaizen event has been planned.

- Utilising the segregation policy in Adult Learning Disabilities – a patient is currently being managed in inpatients from York who was transferred from PICU and they have caused extensive damage to the physical environment and upset patients. As a result Ramsey Ward has been opened to accommodate this individual.

4.3 Patient Safety

The Committee received the Patient Safety Report for the period 1 to 30 April 2018, including appendices on:

(1) Information on reflections on recent serious incidents Directors panels – June 2018;
(2) Risks associated with the use of illicit substances in inpatient settings;
(3) Example of intoxication test in MH assessment.

The Board is asked to note:

- The Patient Safety Group has reviewed all relevant Trust Patient Safety activities in line with the Group's terms of reference. Any issues have been documented and are being progressed by appropriate leads.

- The only matter of risk highlighted in this report is the complexity of establishing an effective mortality review group, in the absence of clear national guidance for mental health and learning disability providers, which could divert valuable resources from within the Patient Safety function.

4.4 Safeguarding and Public Protection

The Committee discussed the exception report for Safeguarding and Public Protection.

The Board is to note:

- A lot of the work of the Safeguarding Team outlined in the report continues as in previous months with ongoing serious case reviews.

- A joint targeted inspection (JTAI) commenced in Durham on 10 July 2018 on domestic abuse. This will involve preparation for multi-agency case file audits with practitioners and managers and practitioner focus groups to follow the journey of a child through services.
- Risks continue around not meeting the agreed trajectories for Safeguarding Children Level 3 training, which although improving, could lead to contractual penalties if we do not reach the 98% target.

Assurance was provided that the Trust is meeting its legal requirements for safeguarding adults and children within the current legislative framework.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 Compliance with CQC Requirements Report

The Committee received a verbal update from the Director of Quality Governance.

The key matters to note are:

- The letters of feedback received from the CQC regarding each core service have been mostly positive.
- The well led inspection will commence on the 23 July 2018, a briefing pack has been sent round to the relevant people and mock interviews will take place before this to assist people with their preparations.

5.2 NHSI: Patient Safety Alert: Resources to support the safe adoption of the revised Early Warning Score (NEWS2).

The Board is asked to note:

- This Patient Safety Alert was presented to the QuAC at its meeting held on 7 June 2018 as an appendix to the Patient Safety Report and it was agreed to discuss it further at the July 2018 QuAC meeting.(minute 18/76 refers)
- The Alert has been released for the attention of all acute and ambulance Trusts, however TEWV recognises the benefits of mirroring this work.
- Consideration has been given to any actions for the Trust to take forward in response to the Alert and these will be followed up by Physical Health and Wellbeing Group.

5.3 NHSI: How to understand and improve your patient safety incident reporting to the National Reporting and Learning System (NRLS).

The Board is asked to note:

- This NHS Improvement publication is intended to be used by the Trust to better understand incidents that are reported to NRLS
- The publication was presented to the QuAC at its meeting held on 7 June 2018 (minute 18/76 refers) as an appendix to the Patient Safety Report and it was agreed to discuss it further at the July 2018 QuAC meeting.
- The Trust has been positively highlighted as having a good reporting culture for reporting incidents as evidenced by the significant increase.

5.4 Restraint and Physical Interventions in CAMHS Tier 4 Services.

The Committee received a presentation on Restraint and Physical Interventions following agreement at the 3 May 2018 QuAC meeting (minute 18/64 refers).

The Committee expressed ongoing concerns around the high numbers of physical interventions, emergency sedation and medication and wanted to gain a deeper understanding of the issues.

Members discussed the complexities of having the appropriate staffing levels and the need for standardised and more detailed incident reporting and felt that this matter would benefit from being considered at a future Board Seminar.

Recommended to the Board: *that the issues around Restraint and Physical interventions in CAMHS Tier 4 Services be considered at a future Board Seminar.*

5.6 **Exceptions to report to the Board**

There are no exceptions to escalate to the Board.

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

There were no issues that will impact on the Trust's strategic or operational risks.

6. IMPLICATIONS

6.1 **Quality**

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

6.2 **Financial/value for money**

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

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

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

6.4 **Equality and Diversity**

There are no issues to note.

7. CONCLUSIONS

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

8. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) *Note the issues raised at the Quality Assurance Committee meeting on 05 July 2018.*
(ii) *Note the confirmed minutes of the meeting held on 07 June 2018.*
(iii) *Support the recommendation to consider the use of Restraint and Physical interventions in CAMHS Tier 4 Services at a future Board Seminar.*

Jennifer Illingworth
Director of Quality Governance
19 July 2018

Annex 1

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 7 JUNE 2018, IN THE BOARDROOM 2, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Mr Colin Martin, Chief Executive
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr Richard Simpson, Non-Executive Director
Mr David Brown, Acting Chief Operating Officer
Mrs Shirley Richardson, Non-Executive Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing
Mrs Karen Atkinson, Head of Nursing, Teesside
Dr Suresh Babu, Clinical Director, Durham and Darlington
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Leanne McCrindle, Head of Quality Governance and Compliance
Mr Tim Cate, Director of Operations, North Yorkshire
Mrs Emma Haimes, Head of Data Quality and Patient Experience
Mr Dominic Gardner, Director of Operations, Teesside
Dr Steve Wright, Deputy Medical Director for North Yorkshire
Mr Stephen Davison, Lead Nurse, Nursing and Governance
Mr Chris Williams, Chief Pharmacist
Mrs Linda Parsons, Associate Director of Operational Services, Estates and Facilities

18/71 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Dr Ahmad Khouja, Medical Director, Mrs Jennifer Illingworth, Director of Quality Governance and Dr Lenny Cornwall, Deputy Medical Director.

18/72 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 03 May 2018 were agreed as true and correct, subject to a typographical error to minute18/53: action log item 18/06 to include minute number 18/60.." and signed by the Chairman.

18/73 ACTION LOG

The Committee discussed the QuAC Action Log, noting the following updates:

18/40 Undertake some analysis of potential inconsistency between the outcomes of Trust peer reviews and MHA reviews.
Mrs Illingworth noted that this work was underway to align the two more closely.
Completed

18/64 Undertake some work around the high numbers of rapid tranquilisation in CAMHS and incidents of restraint.
It was noted that this information would come back to the 5 July 2018 QuAC meeting as a presentation.
Completed

18/59 CQQ preparation: briefing pack for Non-Executive Directors.
It was noted that this would be circulated in the next week.

Completed

18/74 NORTH YORKSHIRE SERVICES LMGB REPORT

The Committee received and noted the North Yorkshire Services LMGB Report.

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

(1) A recent increase in unexpected deaths in Scarborough.
A thematic review of serious incidents in North Yorkshire had been undertaken and the resulting action plans were being taken forward. A clinically led task force would concentrate over the next six months on the lessons learned.

The serious incident reports revealed that three of the serious incidents had a root cause, three cases had contributory findings and there were 54 care/service delivery problems, with 104 contributory factors.

The Committee agreed that an update on this serious matter would be brought back to the 4 December 2018 QuAC meeting.

Action: Mr T Cate

(2) MHSOP Transformation.
A workshop had been held with Harrogate staff to discuss the impact of service changes and there were concerns over the risk of staff disengagement. Continued support would be given to staff through communication and participation in the process going forward.

(3) CAMHS – challenges with meeting the eating disorder waiting times and access standards. A medic post remained vacant and there were challenges to recruitment generally, in particular at Scarborough.

18/75 TEES SERVICES LMGB REPORT

The Committee received and noted the Tees Services LMGB Report.

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

- Medical recruitment in CYP (Community), MHSOP and Adult Directorates.
- Sustained high levels of occupancy in Adult Acute Inpatient Services and MHSOP.
- The ongoing problem regarding the lack of nursing home accommodation for older people with a learning disability.

Following discussion it was noted that:

- There were ongoing issues and repercussions for patients and staff caused by the use of illicit substances in inpatient areas.
- There were risks to patients and staff at the Ridings with fighting outside the building and drug users leaving needles in the driveway. This has been escalated to the Head of Estates and Facilities.
- There were occasional reports of Blik alarms not working, which would be reported to the Chief Executive.

- The medication errors reported in the strategy scorecard had been moved to weekly reporting to monitor more closely.

18/76 PATIENT SAFETY GROUP REPORT

The Committee received and noted the following reports:

(i) Assurance Report of the Patient Safety Group;
(ii) Patient Safety Quality Report for the period 1 to 31 March 2018;
(iii) Patient Safety Annual Report 2017/18;
(iv) Positive and Safe Annual Report.

Following discussion it was agreed that the following information would be discussed in more detail at the 5 July 2018 QuAC meeting:

(1) NHSI: Patient Safety Alert: Resources to support the safe adoption of the revised Early Warning Score (NEWS2).

(2) NHSI: How to understand and improve your patient safety incident reporting to the National Reporting and Learning System (NRLS). This recent NRLS report allows Trusts to better understand incident reporting with comparisons with previous years. The results for the Trust were positive in that reporting incidents continued to increase over the reporting period.

In addition:

(3) NHS Improvement: A Just Culture.
Further work would be undertaken by the Patient Safety Group to see how this could fit with what the Trust already does and to identify any potential gaps and a paper would be presented to the 5 September 2018 QuAC meeting.

Action: Mrs J Illingworth

18/77 PATIENT EXPERIENCE GROUP REPORT

The Committee received and noted the following reports:

(i) Assurance Report of the Patient Experience Group;
(ii) Patient and Carer Experience Team Annual Report 2017/18;
(iii) PALS and complaints Annual Report 2017/18.

Arising from the reports it was noted that whilst the number of complaints had risen, a large proportion of them were not upheld. There had been a rise in complaints from MP's and constituents and these were locality specific featuring issues such as the waiting times for autism assessments in Durham and also complaints from York.

It was pleasing to note however, that through recent initiatives there had been improvements around the waiting times and assessment for autism.

Assurance was provided to the Committee that there were robust systems in place for monitoring patient and carer feedback and that timescales and compliance rates for the review of complaints and collection of patient experience data were mostly being met.

Following discussion it was agreed that future reports should include rolling averages for the data sets of information in order that comparisons could be made with previous years.

Action: Mrs J Illingworth

18/78 SAFEGUARDING & PUBLIC PROTECTION REPORT

The Committee received and noted the Exception Report for Safeguarding and Public Protection and the six monthly Safeguarding and Public Protection Report.

Arising from the reports it was noted that:

- There had been an increase in the number of serious case reviews resulting in some recommendations for the Trust following a domestic homicide in Redcar. Improvements were being made with communication between GPs and community mental health teams.

- Compliance around training for Safeguarding levels 1-3 had made some improvements, however there was a risk of not meeting the level 3 training with the possibility of contractual penalties. Level 3 was currently 88% compliant against the target of 98%. This had now been included as part of the daily management within teams with weekly visibility at OMT level.

- There had been a reduction over the last year in the contacts with the Trust's Safeguarding Adult Team, whereas contacts with the Safeguarding Children Team had increased and the Trust would be working with the Multi-Agency Hub (MASH) in Durham to look at the reasons behind this.

Assurance was provided to the Committee that the Trust continued to meet its legal requirements for safeguarding adults and children within the current legislative framework.

18/79 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:

- The CQC inspection would commence on 23 July 2018 and preparatory activities were well underway.
- Peer review inspections had been suspended following 57 that had taken place since July 2017.
- There had been close down of the CQC action plan following the 2017 inspection.
- There had been four CQC MHA inspections since May 2018 with the reports not yet received with one report received for Rowan Ward, MHSOP, North Yorkshire with commonly identified themes such as care plans, restrictive practices and capacity assessments.

18/80 INFECTION, PREVENTION AND CONTROL

The Committee received and noted the following reports:

(i) Quarterly Infection, Prevention and Control Report for period 1 January to 31 March 2018;

(ii) Infection, Prevention and Control Annual Report 2017/18;
(iii) Infection, Prevention and Control Annual Programme 2018/19.

Arising from the reports it was noted that:

- There had been poor compliance scores for ADL kitchens in some Wards following patient cooking sessions and Hotel Services had been informed.
- Some Wards and sites had failed to achieve the required National Standard of Cleanliness. The IPC Committee had worked through the top 10 reasons for these failings, following which a Kaizan event had been held to look at making improvements.
- The water quality in two Ward areas would be monitored closely and managed by the Water Safety Group.
- The IPC Annual Report and IPC Programme would be published on the Trust website in accordance with the Health and Social Care Act.

Assurance was provided to the Committee that there was a good level of monitoring being received by the IPC in relation to compliance with the Health and Social Care Act 2008 and CQC fundamental standards with identified risks being managed appropriately.

18/81 DRUG AND THERAPEUTICS REPORT

The Committee received and noted the Drug and Therapeutics Report and the Medicines Optimisation Annual Report for 2017/18.

Arising from the reports it was noted that:

(1) There had been good progress made with the six pharmacy and medicines optimisation work streams that provide a framework to support the implementation of NICE Medicines Optimisation guidance.
(2) Medicines reconciliation had improved from 80% to 90% by ensuring that this was undertaken at the time of admission. This represented 97% of the eligible patients admitted for more than 24 hours.
(3) Monitoring of fridge temperatures had made significant improvements with recordings every day up from 57% to 88% and days missed across the Trust down from 88 to 21.

Following discussion it was noted that the rationale for using the drug Clonazepam to treat aggression in PICU's was due to it being a longer acting drug with less peaks and troughs.

Members of the Committee welcomed the two page Annual report for 2017/18, which set out concisely the good levels of improvement and assurance for the last year.

18/82 HEALTH, SAFETY, SECURITY AND FIRE REPORT

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

Arising from the report it was noted that:

(1) It had been disappointing to see an increase in sharp incidents, which related to patients using their own needles. This would be monitored more closely.
(2) There had been an improvement to 100% returns as at 31 March 2018 for workbook audits with all areas being compliant.

(3) There had been 343 smoking related incidents reported in 2017/18, compared to 198 in 2016/17.
On this matter it was noted that 22 of these incidents were patients activating the fire alarm and that one individual could be responsible for numerous incidents.

Following discussion members queried whether there had been any improvement with smoking incidents on Kirkdale Ward, which had gone up from 22 to 75 in 2017/18.
Mrs Parsons undertook to look at the detail behind these figures and report back to the Committee in December 2018.

Action: Mrs L Parsons

18/83 CLINICAL AUDIT AND EFFECTIVENESS REPORT

The Committee received the Clinical Audit and Effectiveness Report.

Arising from the report it was noted that:

(1) There had been a marginal decline in the year end position of completed audits at 82.76% (72/87), however this was due to capacity issues in Quarter 1 and 2 from 2017, which were now fully resolved.

(2) Clinical audit of Restraint in Tier 4 CAMHS was showing red status, 0-49% compliance, which is due to a disparity between incident reports and what is written in the clinical record. Assurance was provided that this is being addressed and some improvements have already been made around the recording process.

18/84 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

The Committee was notified of a Patient Safety Alert received from NHS Improvement around the insertion of nasogastric tubes.

Mrs Moody undertook to report any resulting actions for the Trust to pick up to the 5 July 2018 meeting.

Action: Mrs E Moody

18/85 ANY MATTERS DISCUSSED TO BE ESCALATED TO THE BOARD OF DIRECTORS THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS.

The Committee noted that there were no issues that could impact on the Trust's risks.

18/85 ANY OTHER BUSINESS

There was no other business to discuss.

18/87 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 5 July 2018, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.30pm

ITEM 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**19th July 2018**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

The purpose of the report is to advise the Board of a 6 monthly review (1st December 2017 to 31st May 2018) of in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) and in line with the NQB Guidance.

The 'Right Staffing' (previously known as 'Safe Staffing') programme board has been established to oversee a work plan to ensure the Trust has robust systems and processes in place to assure them that there is sufficient capacity and capability to provide high quality care to patients. Right Staffing is one of the strategic business priorities for the trust board and a Right Staffing programme manager has now been appointed and the workstreams have been developed.

In conclusion, the following is of relevance:

- Results from the Trust wide inpatient establishment review exercise resulted in significant investment by the Trust to support acute AMH staffing to ensure equitable care hours per patient day across the Trust in these areas.
- Changes to numbers of staff in post can be observed as follows:
  - Durham & Darlington – a reduction of both registered and unregistered nurses can be observed. The reduction is not isolated to one particular area but across the service.
  - An increase in registered nurses can be observed with the Forensic Services. A reduction of unregistered nurses can also be observed; the reduction is linked to the closure of Clover/Ivy in line with the transforming care agenda and is therefore planned changes.
  - North Yorkshire – an increase of registered nurses and a reduction of unregistered nurses can be observed. This is across the service and is not isolated to one particular team.
  - Within Teesside a reduction of both registered and unregistered nurses can be observed. This is largely attributable to the closure of Wingfield Ward.
  - A reduction of both registered and unregistered nurses can be observed within York and Selby.

The largest reduction of both staff groups is apparent within Oak Rise as a result of a change of shift patterns.

- In line with 'NQB guidance for Right Skills', the paper sets out a number of development programmes in place to enhance the skills of our workforce.

- Regarding staffing activity, the 6 month average shows:
  - The actual hours worked exceeding the planned hours across all months. The gap between planned and actual is reducing and future establishment reviews will consider the gap further. All metrics are reporting above the 89.9% tolerance.
  - Talbot Direct Care was highlighted as having the lowest fill rate for unregistered nurses on nights of 21.8% and relates to the to the transfer of the package of care to a private provider.
  - The Orchards (NY) was cited as having the second lowest fill rate for registered nurses on nights of 60.6%. This is linked to the HealthRoster system not reflecting the current budgeted establishment. The system change has been made and will be effective from 28th May 2018.
  - Sickness is the biggest factor impacting on staffing with 41 wards (this is a reduction of 3 when compared to the previous 6 month report). Agency usage (22 wards) and Maternity (12 wards) were cited as the second and third highest.
  - 12,995 additional duties were created with a reason of 'enhanced observations'. This is an increase of 1,937 duties when compared to the previous 6 month report. The 12,995 additional duties created equate to 137,007 hours an increase of 31,366 hours when compared to the previous 6 month period.
  - Acomb Garth was cited as the highest user of additional duties with a reason of 'enhanced observations'.
  - Bank usage greater than 25% equated to 9 wards in 3 separate localities. Clover/Ivy is the highest user with a bank fill rate of 37.9%.
  - Agency usage related to 22 wards in 5 separate localities. Acomb Garth had the highest with an agency usage rate of 53.4%.
  - The majority of inpatient wards are using overtime to fill shifts however, those in excess of 4% equates to 26 wards. Forensic Services are using the most overtime whilst York and Selby are using the least.
  - There are 48 wards from all localities that have utilised bank, agency and overtime within the reporting period.

- Triangulation of quality data over the 6 month average:
  - 109 incidents were raised during the reporting period citing concerns with staffing levels. This is a decrease of 2 when compared to the previous 6 month report (111 incidents raised).
  - Triangulation of SIs, level 4 incidents, level 3 self-harm, complaints and incidents control and restraint with bank usage and the fill rates did not highlight any correlations between these strands of data.
  - Triangulation of falls that have resulted in significant harm, pressure ulcers, medication errors, breaks not taken, with that of bank usage and the fill rate indicators. From this it is not possible to draw any meaningful conclusions from this data for the period of this report.
  - In terms of patient, staff and carer feedback an analysis of the data from complaints, friends and family test and compliments has been undertaken but there were no specific issues raised with regards to staffing levels.

- The Right Staffing programme will develop a ward dashboard of quality nursing indicators. An interim approach being utilised within the trust is the use of 9 quality nursing indicators and the monthly performance report out at EMT.
- From the 1st April 2018 the Trust was required to submit care hours per patient day alongside its current fill rate return. The CHPPD across all inpatient areas was 10.3 (3.8 registered nurses and 6.5 healthcare assistants) with an inpatient average of 14.3 CHPPD. Page 25 of the report breaks this down by locality and by the benchmarking groups. Attached at appendix 6 and 7 is the 6 month Care Hours per Patient Day.

Recommendations:

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

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

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of a 6 monthly review (1st December 2017 to 31st May 2018) in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) following the format of the new NQB 2016 Guidance.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Further to the emergent lessons from the Francis review there were a number of issues raised about the impact of the nurse staffing arrangements upon the poor quality of care and increased patient mortality exposed in that organisation. It is well accepted that safe and sustainable staffing is fundamental to good quality care however this includes many variables beyond numbers of staff.

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing/Nurse-staffing). The full monthly data set of day by day staffing for each of the 72 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

2.3 The 'Right Staffing' programme board will consider the broader multidisciplinary workforce whilst continuing to ensure the Trust has robust systems and processes in place to assure them that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards / clinical areas day or night, every day of the week as appropriate. This is being led by the Director of Nursing supported by the programme manager in adopting the new Trust programme approach.

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

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

2.5 The national work stream looking at service specific guidance has recently published specific guidance for Learning Disability and Mental Health. The guidance considered within the trust Right Staffing programme to support and direct its work streams.

2.6 Right Staffing is one of the strategic business priorities for the Trust Board, accordingly the Executive Management Team have approved the Right Staffing Programme that will manage the implementation of the NQB guidance in addition to the broader aspects of the workforce identified in 2.4 of this report

3.0 TRIANGULATED APPROACH TO STAFFING DECISIONS:

3.1 Right Staff

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

3.1.2 Results from the Trust wide inpatient establishment review exercise resulted in significant investment by the Trust to support in acute AMH staffing in the 20 bedded units to provide equitable care hours per patient day across the Trust in these areas.

The Trust is currently participating in the national Mental Health Acuity and Dependency Development Group (NHSi and HEE) to test the Mental Health Optimal Staffing Tool (MHOST). This is an evidenced based tool that has been further developed by Dr Keith Hurst from the previous 2015 version known as the “Hurst Tool”. The MHOST is currently only available for inpatient services, although a community version is under development. The MHOST is expected to be published nationally later in the year.

A standardised operating procedure, currently under development, for establishment reviews within the trust will utilise the MHSOT to support this review process. The phased approach in the programme plan will accommodate the availability of the MHSOT accordingly. Consideration will be given towards the potential for using the Allocate Safecare module to support this.

3.1.3 As an interim approach the budgeted staffing establishments as at 1st December 2017 and the 31st May 2018 have been obtained from HealthRoster and have been used to compare the actual establishments in post. Attached at appendix 2 of this report is the full breakdown by ward and locality. The key points are as follows:

- Durham & Darlington – registered nurses in post has decreased by 4.6 WTE and a reduction of 7.1 WTE unregistered nurses. The reduction of both staff groups is across the service and not isolated to one particular area.
- Forensic Services – registered nurses in post has increased by 5.5 WTE and a reduction of 13.3 WTE for unregistered nurses. The reduction of unregistered nurses can largely be attributable to the closure of Clover/Ivy in line with the transforming care agenda and are therefore planned changes.

- North Yorkshire – registered nurses in post has increased by 1.2 WTE and a reduction of 6.6 WTE unregistered nurses. The reduction of unregistered nurses can be observed across the service and not isolated to one particular area.
- Teesside – registered nurses in post has reduced by 3.9 WTE and 5.5 WTE less unregistered nurses. The closure of Wingfield Ward has accounted for an element of the reduction of staff in post.
- York and Selby – registered nurses in post have decreased by 1.2 WTE and a reduction of 4.0 WTE unregistered nurses is also visible across the service. Oak Rise has had a significant reduction of registered nurses equating to 4.1 WTE and 2.3 WTE unregistered nurses. The reduction in staffing is as a result of a change of shift pattern to long days during the reporting period.
- Across all inpatient areas, this has resulted in a decrease of approximately 3 registered nurses and a reduction of 36.5 WTE unregistered nurses in post.

The trust is participating in a national collaborative programme, the aim of which is to increase the retention of clinical staff, in particular registered nurses, led by NHS-I. The emphasis on retention highlights that there may be diminishing returns with efforts to focus on recruitment of staff, and that in any event patient safety may be improved incrementally with more experienced staff being retained within an organisation. The emphasis is on improving internal support, well-being, internal development routes and offering career options which increase the likelihood of retaining such staff. The Trust appears in cohort three of this scheme, indicating relatively low levels of concern by comparison with the early cohorts, and our data in this topic are seen as comparing well with peer mental health trusts. There have been meetings to review progress with NHS-I representatives at which positive overall feedback on the trusts position and work in progress has been received. The Trust was required to submit an action plan by 4th July describing a small number of key focus issues to improve our retention of staff, with a one year timeline for initial implementation and review.

3.2 Right Skills

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

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

3.2.3 There was 1 ward within the Trust who in May 2018 is reporting less than 75% compliance for mandatory training at the time of writing the report, as follows:

WARD	May 2018
Rowan Lea	73.79%

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

- **Framework for inpatient HealthCare Assistants** - All new starters from April 2012 have been recruited utilising the HCA Framework and options were presented to existing staff. A database of all Trainee HCA's and the existing HCA workforce is held by the Workforce Department and collates all of the training activity. This approach is a key ingredient in preparing potential candidates for further professional training in line with some of the initiatives below, in addition to its own intrinsic value in staff development and patient care. Since April 2018 we have recruited 624 trainee HCA's with 424 having fully completed the full HCA framework with the remainder still ongoing and in progress. All competencies assigned to existing staff only, 110 competencies remain outstanding but this is a daily reducing figure against their required completion date.

- **Nursing Associate Band 4 roles** - These new roles will in future be regulated by the Nursing and Midwifery council, as a new member of the nursing family. The Trust currently has two cohorts of ten Associates in training. The most recent cohort had their training funded from the Apprenticeship levy. The NMC are consulting on the proposed regulatory framework and have set out the required Standards of Proficiency. Internally the Trust is reviewing procedures such as medication administration to ensure these are compliant with guidance when the first Associates qualify and take up posts, with the first candidates being available from April 2019. The right staffing programme will be considering the number and location of required Associate Nurses and working closely with the PPCS programme regarding associated skill mix issues within the Role Development workstream.

- **Apprenticeship Pre-Registration Training** - The apprenticeship route into nurse training is now approved nationally at level 6. Locally we are engaging with Sunderland University, who are a relatively new entrant into the pre-registration field for us and are among the approved local pilot providers of nursing apprenticeships along with other local institutions. Alongside this we are also considering the potential to expand our use of the Open University distance learning approach which is now commissioned as an Apprenticeship approach. This will enable the Trust to make effective use of its levy while contributing to the development of staff and widening access to trust training, with

these staff being more likely to be retained in the future workforce. This forms part of our approach to diversify the range of training providers to attract the widest range of candidates of different backgrounds, and in particular to increase the number of our existing care staff who we can develop into registered nurses. A paper will be considered by EMT later this month with regards to numbers of staff the organistaion want to train and how backfill costs will be managed.

- **Diversifying the range of training providers** - As noted above, we are actively seeking to extend our partnerships with local Higher Education Institutes, this includes: Sunderland on new apprenticeship approaches to nurse training. Sunderland are also introducing new Mental health and Learning Disabilty nursing pre-registration courses in partnership with the trust and NTW NHS Trust which is due to commence this year. The Trust is to receive 30 additional new registered mental health nurses and 10 learning disability nurses per year. This introduces a new participant into the arena and can potentially lead to placement pressures which will require careful management, but is seen to be especially positive in the northern part of the Trust.

  Coventry University, have now developed an adult nursing branch at their new campus in Scarborough, and are interested in potentially extending this into a mental health cohort from next year. The Trust will provide short term support placements for the adult branch to improve joint working and health promotion while we work on a Mental Health specific programme.

- **Out of Hours nursing support – the Duty Nurse Co-ordinator** – 13 additional band 6 posts have been approved and funded by the trust to commence the roll out of the Duty Nurse Coordinator which will provide enhanced support and professional nursing advice out of hours, nights and weekends. This was a key element of phase one of the phased approach recommended in the evidence based establishment report presented to this role is expected to be will be fully embedded across all localities by September 2018. Teesside and forensic services are currently fully operational; Durham and Darlington to follow by August 2018; and with North Yorkshire and York & Selby expecting to also be ready by September 2018. Early feedback has been very positive with regard to managing bed pressures and providing support for effective staffing.

- **Support for Learning Disability Nurse training** - We are aware that both of the two main Higher Education Institutes in the area, Teesside University and York University, have in the recent past received very low numbers of student nurse applications for Learning Disability training, which threatened the viability of the training courses in both cases. The Trust remains a major employer of learning disability nurses despite the service re-modelling underway. A proposal was approved by EMT to directly support a small cohort of ten suitable internal candidates to take up Learning Disability Nurse training at the local HEI's. The ten applicants took up their places in January 2018 with secondment agreements in place at a fixed mid-point Band 3. There are indications informally that the position at Teesside may be slightly better this year, and the Trusts support in maintaining the programmes has been recognised within this.

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

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

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

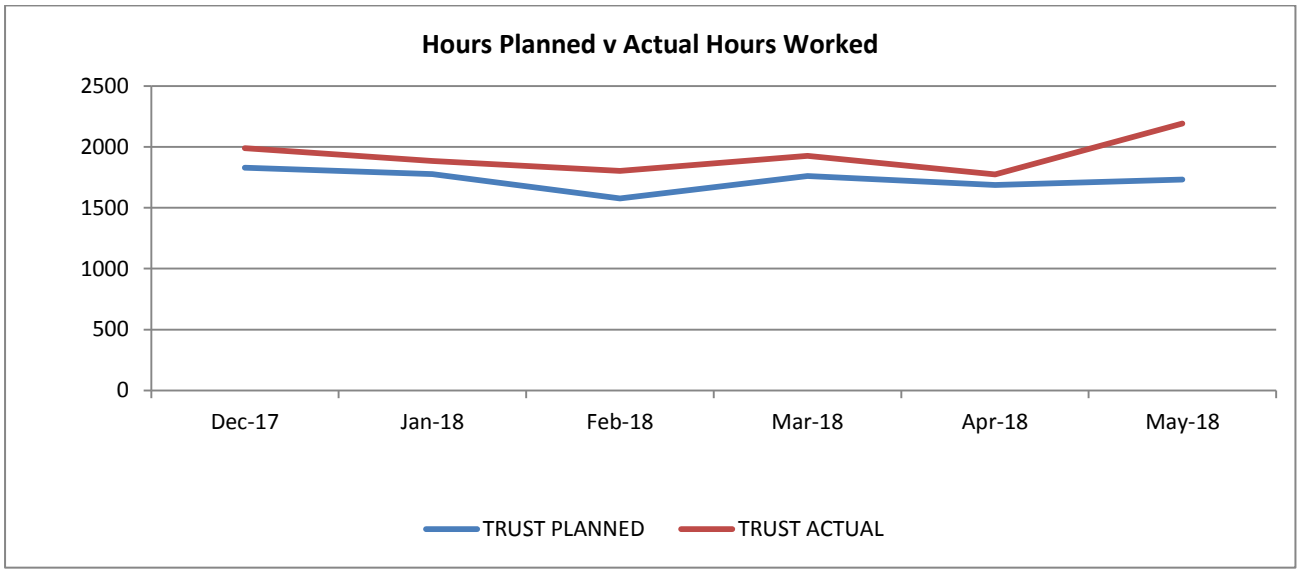
3.2.6 The trust has a long established approach to continuous improvement and the Right Staffing programme identifies key interdependencies with Purposeful Productive Community Service (PPCS), Model Wards, Recovery and Digital Transformation programmes in addition to Human Resources, Organisational Development,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

3.3 Right place and right time

3.3.1 The NQB guidance states that Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring

clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

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



3.3.3 It is important to highlight that at no point during the 6 month review did the actual hours match the planned, and that the actual hours were always in excess of planned hours rather than in deficit. However, the gap between the planned and actual hours has shown an overall reduction from the previous 6 months despite the rise shown in May 2018. The establishment reviews will consider this gap between actual and planned hours in conjunction with the utilisation of temporary staffing. The programme will address this and will be further informed by new NHSI guidance for making effective use of staff banks.

3.3.4 Appendix 3 of the report shows the average fill rate (1st December 2017 to 31st May 2018) for both days and nights for both registered and non-registered staff. The 6 monthly position shows that there were 23 (32%) fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts. In terms of unregistered nurses this equated to 7 (10%) fill rates below 89.9%. This shows that although the trust usually meets its planned staffing numbers there is often a deficit of the planned skill mix from registered to non-registered. This presents risks in terms of CQC compliance and limits the quality and safety of interventions that can be offered from a registered nursing perspective. This should improve with recent investment in registered nursing posts and the focus on recruitment and retention.

3.3.5 In terms of the night time shifts the 6 monthly position shows that there were 7 (10%) fill rates of less than 89.9% (shown as red) for registered nurses and health care assistants there were 5 (7%) fill rates ward who had a fill rate below 89.9%.

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

Month	Actual Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Dec-17	93.80	↓	110.80	↓	100.30	↓	122.20	↓
Jan-18	95.60	↑	110.90	↑	99.90	↓	122.70	↑
Feb-18	94.20	↓	118.30	↑	101.60	↑	125.80	↑
Mar-18	93.40	↓	115.10	↓	99.90	↓	126.90	↑
Apr-18	98.40	↑	116.30	↑	103.40	↑	128.40	↑
May-18	98.10	↓	115.00	↓	102.70	↓	127.50	↓

From the table it is important to highlight the following:

- All fill rate indicators are within the 89.9% tolerance.
- The average fill rate for registered nurses on day shifts has improved from 93.8% in December 2017 when compared to 98.1% in May 2018 (4.3% increase).
- The average fill rate for health care assistants on day shifts has increased from 110.8% in December 2017 when compared to 115.0% in May 2018 (4.2% increase).
- The average fill rate for registered nurses on night shifts has increased from 100.3% in December 2017 when compared to 102.7% in May 2018 (2.4% increase).
- The average fill rate for health care assistants on night shifts has increased from 122.2% in December 2017 when compared to 127.5% in May 2018 (5.3% increase).

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3.3.7 The overall total red rated occurrences utilising the average fill rate (i.e. less than 89.9%) was 40 occurrences. The table below shows the breakdown by locality:

Locality	Total Number of Red Occurrences	Trend on previous 6 months
Durham & Darlington	10	↑ (7)
Teesside	11	↓ (13)
North Yorkshire	2	↓ (7)
Forensic Services	14	↓ (17)
York and Selby	3	↓ (4)

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

3.3.8 The 6 month average highlights Talbot Direct Care (Durham & Darlington, CYPS) as having the lowest fill rate of 21.8% for unregistered nurses on nights. The low fill rate is as a result of transferring the package of care to a private provider. Any shortfall was being provided for by either the Holly Unit, the ward manager or a member of the community team.

3.3.9 The second lowest fill rate utilising the 6 month average highlights The Orchards NY (North Yorkshire) with a fill rate of 60.6% for registered nurses on Nights. This is linked to the HealthRoster system not reflecting the current budgeted establishment. The required changes to the electronic system have been implemented and will be visible from the 28th May 2018 roster.

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

- 41 wards who had sickness absence rates greater than 5% loss of actual hours
- 22 wards who had agency usage greater than 4% of actual hours worked
- 12 wards who had maternity absence greater than 5% loss of the actual hours
- 10 wards who had vacancies greater than 10% loss of actual hours
- 9 wards who had bank usage greater than 25% of actual hours worked

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

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

Month	Number of duties	Number of Hours
December	1,937	20,518
January	1,876	19,970
February	1,886	20,052
March	2,470	26,116
April	2,354	24,923
May	2,472	25,428
TOTAL	**12,995**	**137,007**

- This table highlights that the number of additional duties being created with a reason of 'enhanced observations' within the trust is increasing (1,937 duties created in December 2017 compared to 2,472 in May 2018)

- 12,995 additional duties/shifts were created within the reporting period this is an increase of 2,810 duties when compared to the previous 6 month period.

- The 12,995 additional duties/shifts created equates to 137,007 hours within the reporting period this is an increase of 31,366 hours when compared to the previous 6 month period. This equates to an average shift length of 10.5 hours per additional duty/shift created (an increase of 0.1 hours when compared to the previous 6 month period). Using 12 hour shifts, this would equate 155,940 additional hours worked (18,933 more than the 137,007 that was actually worked).

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

Locality	Ward / Team	Number of Duties	Number or Hours
York & Selby	Acomb Garth	1371	15427
Teesside	Westerdale South	1327	14570
Teesside	Newberry Centre	820	7580
Teesside	Westwood Centre	740	8354
Forensics	Mandarin	705	7598
Forensics	Merlin Ward	602	6590
Forensics	Northdale Centre	568	5062
Forensics	Harrier/Hawk	437	4522
Forensics	Clover/Ivy	405	4229
Forensics	Kestrel/Kite.	403	3818
	TOTAL	**7378**	**77751**

3.3.14 Further analysis of the usage of 'enhanced observations' in relation to budgeted establishments is required to fully understand the level of clinical need, practices at ward level and to seek an effective solution to bank usage. Right Staffing has facilitated the liaison with peers who have participated in the NHSI observation collaborative to better understand the benefits of zonal engagement and observation practices to support effective utilisation of staff to better support service users and deliver high quality care. Senior staff from Acomb Garth and Westerdale South has participated in this exercise, the outcomes of which will be presented to the Right Staffing Programme Board for consideration of utilising in the Trust. This will form an ongoing and key part of the proposed work plan for right staffing programme.

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

Locality	Ward Name	Hours	Bank Usage
Forensics	Clover / Ivy	9916.74	37.9%
Forensics	Mandarin	8172.68	34.6%
Teesside	Westerdale South	13981.49	32.4%
Durham & Darlington	Birch Ward	5686.30	27.9%
Forensics	Merlin	7502.25	27.6%
Durham &Darlington	Maple	4618.00	27.1%

Durham &Darlington	Hamsterley	5684.18	26.4%
Forensics	Mallard	5687.21	26.0%
Forensics	Harrier / Hawk	6793.50	25.7%

- This equates to 9 wards in 3 separate localities.

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

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

Locality	Ward Name	Hours	Agency Usage
York and Selby	Acomb Garth	18779.00	53.4%
North Yorkshire	Cedar	6350.00	31.0%
York and Selby	Cherry Tree House	4785.83	22.8%
Teesside	Westerdale South	8535.00	19.8%
York and Selby	Meadowfields	3678.73	18.9%
Teesside	Westerdale North	3289.50	15.1%
North Yorkshire	Rowan Ward	2386.45	13.4%
North Yorkshire	Ayckbourn Danby Ward	1615.00	10.6%
York and Selby	Oak Rise	2308.83	10.3%
North Yorkshire	Springwood	2085.50	10.1%
North Yorkshire	Rowan Lea	2156.42	9.1%
York and Selby	Minster Ward	1503.00	8.8%
Forensics	FLD Eagle ASD	303.75	7.1%
Durham & Darlington	Elm Ward	1190.08	6.4%
Teesside	The Evergreen Centre	1737.00	5.6%
North Yorkshire	Ward 15	858.25	5.5%
Teesside	Bedale Ward	1295.50	5.0%
Durham &Darlington	Hamsterley	1024.28	4.8%
Forensics	Eagle / Osprey	507.25	4.7%
Durham & Darlington	Birch Ward	899.67	4.4%
Durham & Darlington	Maple	707.33	4.2%
York and Selby	Ebor Ward	653.75	4.1%

- This equates to 22 wards in 5 separate localities.

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

Locality	Ward Name	Hours	Overtime

Durham & Darlington	Holly	893.95	10.8%
Teesside	Baysdale	1242.33	8.4%
North Yorkshire	Ward 14	1115.35	7.5%
Teesside	Bankfields Court Unit 2	1082.19	7.2%
Durham & Darlington	Talbot Direct Care	362.03	6.6%
Teesside	Aysgarth	852.10	6.5%
Forensics	Harrier / Hawk	1679.34	6.3%
Forensics	Oakwood	718.34	6.1%
Teesside	Newberry Centre	1822.48	6.1%
Teesside	Westwood Centre	2091.40	5.9%
York and Selby	Minster Ward	990.50	5.8%
Durham & Darlington	Primrose Lodge	873.00	5.5%
North Yorkshire	Ayckbourn Danby Ward	825.90	5.4%
York and Selby	Cherry Tree House	1053.92	5.0%
North Yorkshire	The Orchards (NY)	640.35	5.0%
Forensics	Northdale Centre	1505.09	5.0%
Durham & Darlington	Bek-Ramsey Ward	1190.50	5.0%
Forensics	Nightingale	795.83	4.8%
North Yorkshire	Springwood	967.02	4.7%
Forensics	Lark	747.82	4.5%
Forensics	Newtondale	1074.20	4.5%
Forensics	Clover / Ivy	1120.59	4.3%
Forensics	Jay Ward	751.30	4.2%
Forensics	Swift Ward	782.35	4.2%
Teesside	Bedale Ward	1049.68	4.1%
Teesside	Thornaby Road	1242.42	10.7%

- The majority of the inpatient wards across the trust are using overtime.
- Forensic Services are using the most overtime (14,703) whilst York & Selby are using the least (3,340).
- There are 48 wards who have utilised bank, agency and overtime within the reporting period as outlined below:

Locality	Ward Name	Overtime Usage Vs Actual Usage	Agency Usage Vs Actual Usage	Bank Usage Vs Actual Usage
North Yorkshire	Danby Ward	5.4%	10.6%	7.4%
North Yorkshire	Esk Ward	1.9%	2.1%	11.2%
Teesside	Bedale Ward	4.1%	5.0%	15.9%
Teesside	Bilsdale	1.9%	1.4%	5.6%
Durham and Darlington	Birch Ward	3.7%	4.4%	27.9%
Teesside	Bransdale	1.0%	1.6%	7.7%
Durham and Darlington	Cedar	1.8%	0.5%	21.1%
North Yorkshire	Cedar (NY)	2.6%	31.0%	7.0%
York and Selby	Ebor Ward	2.7%	4.1%	10.7%
Durham and Darlington	Elm Ward	1.6%	6.4%	24.0%

Durham and Darlington	Farnham Ward	2.5%	2.0%	8.1%
Teesside	Kirkdale	3.1%	0.6%	21.7%
Teesside	Lustrum Vale	3.4%	1.0%	17.3%
Durham and Darlington	Maple	2.9%	4.2%	27.1%
York and Selby	Minster Ward	5.8%	8.8%	6.9%
Teesside	Overdale	2.4%	1.5%	3.8%
Durham and Darlington	Primrose Lodge	5.5%	0.3%	15.4%
Teesside	Stockdale	1.7%	2.6%	6.6%
North Yorkshire	The Orchards (NY)	5.0%	0.6%	6.7%
Durham and Darlington	Tunstall Ward	1.3%	1.7%	2.0%
North Yorkshire	Ward 15	1.2%	5.5%	24.4%
Durham and Darlington	Willow Ward	2.6%	1.3%	15.7%
Teesside	Newberry Centre	6.1%	3.1%	8.9%
Teesside	The Evergreen Centre	2.5%	5.6%	9.4%
Forensics	Clover / Ivy	4.3%	0.9%	37.9%
Forensics	Eagle / Osprey	3.4%	4.7%	16.2%
Forensics	FLD Eagle ASD	2.9%	7.1%	8.8%
Forensics	Kestrel / Kite.	3.4%	0.4%	24.6%
Forensics	Langley	1.8%	0.4%	20.1%
Forensics	Northdale Centre	5.0%	1.3%	22.1%
Forensics	Oakwood	6.1%	1.0%	20.3%
Forensics	Thistle	2.9%	0.3%	9.7%
Durham and Darlington	Bek-Ramsey Ward	5.0%	1.8%	7.1%
York and Selby	Oak Rise	2.5%	10.3%	13.2%
York and Selby	Acomb Garth	0.5%	53.4%	7.7%
Durham and Darlington	Ceddesfeld	3.3%	3.2%	8.1%
York and Selby	Cherry Tree House	5.0%	22.8%	11.7%
Durham and Darlington	Hamsterley	2.5%	4.8%	26.4%
York and Selby	Meadowfields	0.7%	18.9%	12.1%
Durham and Darlington	Oak Ward	3.3%	1.4%	14.4%
Durham and Darlington	Roseberry Wards	0.3%	0.7%	11.2%
North Yorkshire	Rowan Lea	3.8%	9.1%	10.5%
North Yorkshire	Rowan Ward	1.7%	13.4%	12.3%
North Yorkshire	Springwood	4.7%	10.1%	15.0%
North Yorkshire	Ward 14	7.5%	0.5%	2.3%
Teesside	Westerdale North	1.2%	15.1%	5.6%
Teesside	Westerdale South	0.4%	19.8%	32.4%
Durham and Darlington	Harland Rehab Ward	3.9%	1.5%	12.7%

- There are no wards that are appearing as ‘red’ across overtime, agency and bank.

3.4 Patient outcomes, people productivity and financial sustainability

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

3.4.2 In turning to the triangulation of staffing data with other safety indicators. Appendix 5 provides an overview of all quality indicators for all inpatient wards. Firstly there were 13 SI's that occurred in in-patient areas within the 6 month period.

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

No. of SIs	Ward	Bank Usage	Staffing Fill Rate			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Danby Ward	7.4%	88.8%	81.4%	108.0%	108.7%
2	Bilsdale	5.6%	108.1%	112.8%	129.1%	118.1%
1	Elm Ward	24.0%	93.2%	101.2%	101.8%	123.0%
2	Farnham Ward	8.1%	106.2%	97.5%	114.2%	104.9%
2	Overdale	3.8%	106.3%	103.3%	118.5%	111.8%
1	Bankfields Unit 3	6.9%	87.6%	97.5%	98.5%	96.9%
1	Cherry Tree House	11.7%	110.1%	82.7%	102.5%	167.2%
1	Rowan Lea	10.5%	91.0%	107.6%	117.8%	117.7%
2	Rowan Ward	12.3%	93.8%	101.9%	116.9%	125.5%

- From those wards that did have an SI within the reporting period all had either a 'green' or 'amber' rating for their bank usage.
- There were 4 fill rate indicators that reported as 'red' – Danby Ward, Bankfields Unit 3 and Cherry Tree; with all remaining indicators reporting as either 'green' or 'blue'

The Patient Safety investigation team have been asked to specifically consider staffing levels and skill mix in relation to their investigation of inpatient SI's to support more robust triangulation of staffing data and aid root cause analysis. During the reporting period there were 2 cases reviewed at Directors Panel which highlighted a contributory finding regarding staffing:

- 2018-3650 - following a fall which resulted in a fractured neck of femur. The case highlighted agency workers and their competency.

- 2018-1835 - recorded against the Psychosis Team in Durham. The case highlighted concerns with regards to capacity within the team as well as sufficient numbers of staff.

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

3.4.3 There were a total of 6 Level 4 incidents that occurred within the reporting period. These are summarised below utilising the bank fill rate and staffing fill rates as comparative data:

No. of L4 Incidents	Ward	Bank Usage	Staffing Fill Rate			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Elm Ward	24.0%	93.2%	101.2%	101.8%	123.0%
1	Farnham Ward	8.1%	106.2%	97.5%	114.2%	104.9%
1	Overdale	3.8%	106.3%	103.3%	118.5%	111.8%
1	Cherry Tree	11.7%	110.1%	82.7%	102.5%	167.2%
1	Rowan Lea	10.5%	91.0%	107.6%	117.8%	117.7%
1	Rowan Ward	12.3%	93.8%	101.9%	116.9%	125.5%

- From those wards that did have a L4 incident within the reporting period all had a 'green' or 'amber' rating for their bank usage.
- There was only 1 fill rate indicator reporting as 'red' – Cherry Tree; all others reported as either 'green' or 'blue'.

3.4.4 There were 39 level 3 self-harm incidents occurred within the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No. of L3 (Self Harm) Incidents	Ward	Bank Usage	Staffing Fill Rate			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Danby Ward	7.4%	88.8%	81.4%	108.0%	108.7%
1	Esk Ward	11.2%	81.3%	99.9%	127.7%	102.0%
6	Cedar	21.1%	117.5%	113.1%	85.1%	78.0%
8	Cedar (NY)	7.0%	106.2%	105.9%	110.0%	115.8%
2	Elm Ward	24.0%	93.2%	101.2%	101.8%	123.0%
3	Lustrum Vale	17.3%	93.9%	101.4%	124.8%	110.0%
1	Maple	27.1%	85.8%	99.1%	123.1%	115.3%
1	Stockdale	6.6%	119.0%	117.2%	115.0%	110.5%
2	Tunstall Ward	2.0%	112.0%	99.6%	102.7%	109.1%
5	Ward 15	24.4%	85.9%	103.5%	122.9%	104.0%
2	Newberry Centre	8.9%	106.7%	136.0%	141.0%	195.3%
1	Talbot Direct Care	0.0%	53.7%	94.9%	27.6%	21.8%
2	The Evergreen Centre	9.4%	80.8%	108.5%	114.8%	125.5%
1	Westwood Centre	3.5%	93.1%	99.2%	160.9%	209.7%
1	Clover / Ivy	37.9%	94.9%	126.4%	103.7%	180.0%
1	Thistle	9.7%	83.1%	104.2%	100.9%	97.0%
1	Roseberry Wards	11.2%	100.8%	101.9%	101.6%	103.5%

- From the 39 level 3 self-harm incidents this equated to 17 wards across 4 localities.
- North Yorkshire had the highest number of level 3 incidents in the reporting period with 15 incidents in total.
- Cedar NY had the highest number of level 3 incidents across the reporting period with 8 incidents.
- 2 out of 17 wards reported as 'red' for their bank usage whilst all the others reported either as 'amber' or 'green'.
- There were 12 fill rate indicators that reported as 'red' whilst the others all reported as either 'green' or 'blue'.

3.4.5 There were 24 complaints raised during the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No. of Complaints	Ward	Bank Usage	Staffing Fill Rate			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Ayckbourn Esk Ward	11.2%	81.3%	99.9%	127.7%	102.0%
1	Bedale Ward	15.9%	93.4%	79.2%	140.1%	174.8%
2	Bransdale	7.7%	118.0%	116.3%	119.9%	118.7%
3	Cedar	21.1%	117.5%	113.1%	85.1%	78.0%
1	Cedar (NY)	7.0%	106.2%	105.9%	110.0%	115.8%
2	Elm Ward	24.0%	93.2%	101.2%	101.8%	123.0%
1	Kirkdale	21.7%	89.2%	100.2%	102.0%	104.0%
2	Maple	27.1%	85.8%	99.1%	123.1%	115.3%
2	Minster Ward	6.9%	88.1%	101.9%	110.8%	106.2%
1	Stockdale	6.6%	119.0%	117.2%	115.0%	110.5%
1	Tunstall Ward	2.0%	112.0%	99.6%	102.7%	109.1%
1	Ward 15	24.4%	85.9%	103.5%	122.9%	104.0%
1	Newberry Centre	8.9%	106.7%	136.0%	141.0%	195.3%
1	Harrier / Hawk	25.7%	93.4%	107.3%	119.9%	150.3%
1	Kestrel / Kite.	24.6%	93.8%	104.9%	111.9%	143.8%
1	Merlin	27.6%	115.0%	100.3%	133.4%	178.4%
2	Cherry Tree House	11.7%	110.1%	82.7%	102.5%	167.2%

- None of the complaints raised cited issues with staffing levels or skill mix. However, there were 2 complaints that did raise concerns with regards to staff attitude being negative (Elm Ward, Durham and Darlington; and Harrier, Forensic Services).
- Durham and Darlington locality had the highest number of complaints in the reporting period with 8 complaints raised.
- From those that had complaints raised 3 wards reported as 'red' for bank usage whilst the remaining wards reported either as 'amber' or 'green'
- 9 fill rate indicators were reporting as 'red' with 7 of these relating to registered nurses. All other metrics are reporting as either 'green' or 'blue'.

3.4.6 The Trust's Positive and Safe team continues to focus on high users of control and restraint. A high proportion of the Trust usage of prone and other forms of restraint is

related to a small number of wards, and individual patients within those wards, and the various factors which may be contributing to this form part of the positive and safe remit.

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

Ward	Locality	Bank Usage	Incidents of restraint			
			Incidents	PRO Used	Other	Restraint Total
Newberry Centre	Teesside	8.9%	937	5	1240	1245
The Evergreen	Teesside	9.4%	801	31	1185	1216
Sandpiper Ward	Forensics	15.3%	415	13	897	910
Westwood Centre	Teesside	3.5%	192	2	290	292
Clover / Ivy	Forensics	37.9%	171	8	347	355
Acomb Garth	York and Selby	7.7%	158		224	224
Westerdale South	Teesside	32.4%	158		161	161
Cedar	Durham and Darlington	21.1%	149	11	249	260
Springwood	North Yorkshire	15.0%	107		145	145
Bek-Ramsey Ward	Durham and Darlington	7.1%	100	13	141	154
Bankfields Unit 3	Teesside	6.9%	71		112	112

The Newberry Centre had 937 incidents requiring the use of restraint during the reporting period. This equated to 1245 restraints of which 5 was recorded as 'Prone'.

- 2 of the wards identified within the top 10 had a 'red' rating for their bank usage whilst the others reported as either 'amber' or 'green'.

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

Ward	Staffing Fill Rate			
	RN Days	RN Nights	HCA Days	HCA Nights
Newberry Centre	106.7%	136.0%	141.0%	195.3%
The Evergreen	80.8%	108.5%	114.8%	125.5%
Sandpiper Ward	99.0%	94.5%	104.8%	137.7%
Westwood Centre	93.1%	99.2%	160.9%	209.7%
Clover / Ivy	94.9%	126.4%	103.7%	180.0%
Acomb Garth	95.6%	116.2%	206.9%	319.8%
Westerdale South	93.6%	80.1%	254.4%	373.2%
Cedar	117.5%	113.1%	85.1%	78.0%
Springwood	86.4%	102.4%	112.6%	164.2%
Bek-Ramsey Ward	136.9%	100.7%	110.3%	101.9%
Bankfields Unit 3	87.6%	97.5%	98.5%	96.9%

3.4.9 The use of Prone restraint will continue to be monitored within the Positive and Safe team and monthly within the Right Staffing reports, however, it is worth highlighting that during

the reporting period there were 117 episodes of Prone used. This is an increase of 33 when compared to the previous 6 month report.

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

The 9 indicators include:

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

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

3.4.12 Falls that have resulted in significant harm for all inpatient services have been examined. Within the reporting period there have been a total of 4 incidents across 4 wards. The ward and teams that these each relate to are as follows:

Locality	Speciality	Ward / Team	Number of incidents
Teesside	Adults	Overdale	1
York and Selby	MHSOP	Cherry Tree House	1
North Yorkshire	MHSOP	Rowan Lea	1
North Yorkshire	MHSOP	Rowan Ward	1

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

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

    - Cherry Tree had one fill rate indicator that reported as 'red' for RN on nights. All other fill rate indicators reported as either 'green' or 'blue'.
    - All wards are reporting as either 'amber or green' for bank usage
    - All wards with the exception of Overdale are reporting as 'red' for agency usage
    - With the exception of Cherry Tree all wards are reporting as 'green' for overtime.

3.4.13 Data in relation to pressure ulcers was obtained covering the reporting period. There were 3 incidents reported across 3 wards as follows:

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

- 2 of the 3 incidents occurred within older people's service which would be expected.
- In turning to the triangulation of staffing data:

    - Oak Ward had 1 fill rate indicator that reported as 'red', all other fill rate indicators reported as either 'green' or 'blue'.
    - Oak Ward are reporting as 'amber' for bank usage whilst Mallard reported 'red' and Rowan Lea reported as 'green'.
    - Agency workers were utilised within Oak Ward and Rowan Lea.
    - Overtime was worked across all of the wards listed.

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

3.4.15 There were 449 incidents of medication errors reported within the reporting period across 64 wards. The top 6 wards are shown as follows:

Locality	Specialty	Ward / Team	Number of incidents
York and Selby	Adults	Minster	41
York and Selby	Adults	Ebor Ward	24
Teesside	Adults	Lustrum Vale	22
Forensics	FMH	Linnet	21
Forensics	FLD	Northdale	20
Forensics	FMH	Sandpiper	17

- Ebor and Minster have 1 fill rate indicator reporting as 'red'. All other fill rate indicators are reporting as either 'green' or 'blue'.
- Bank usages across all wards listed in the Top 6 are reporting as 'green' or 'amber' for their bank usage.
- Agency worked was only undertaken within 4 of the wards listed. Ebor and Minster are reporting as 'red' for agency usage.
- Overtime working occurred within all of the wards listed.

3.4.16 In terms of shifts worked without a break there were 2,525 shifts worked within the reporting period where breaks were not given. The top 5 wards were as follows:

Ward	No of eligible shifts	No. of eligible shifts without breaks 01/12/17 to 31/05/18	% of shifts without break	Days without breaks	Nights without break
Newberry Centre	3822	568	14.86%	381	187
Evergreen Centre	3400	121	3.56%	114	7
Minster Ward	1765	107	6.06%	71	36
Clover/Ivy	2299	106	4.61%	84	22
Mallard Ward	2064	94	4.55%	81	13

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

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

Ward Name	Staffing Fill Rate - Day - Registered Nurses	Staffing Fill Rate - Night - Registered Nurses	Staffing Fill Rate - Day - Unregistered Nurses	Staffing Fill Rate - Night - Unregistered Nurses	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours
Newberry Centre	106.7%	136.0%	141.0%	195.3%	8.9%	3.1%	6.1%
Evergreen Centre	80.8%	108.5%	114.8%	125.5%	9.4%	5.6%	2.5%
Minster Ward	88.1%	101.9%	110.8%	106.2%	6.9%	8.8%	5.8%
Clover / Ivy	94.9%	126.4%	103.7%	180.0%	37.9%	0.9%	4.3%
Mallard	103.3%	118.9%	106.6%	156.5%	26.0%	0.0%	3.3%

- There are 2 fill rate indicators' that are reporting as 'red' and are in relation to registered nurses on days. All other indicators are reporting as either 'green' or 'blue'
- There are 2 wards listed as reporting as 'red' for bank usage whilst all the others are reporting either 'amber' or 'green'
- 4 of the 5 wards have utilised agency workers
- All wards listed have utilised overtime.

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

3.5 Reporting, investigating and acting on incidents

3.5.1 The NQB guidance advises NHS providers to follow best practice guidance in the investigation of all patient safety incidents, including root cause analysis for serious incidents. As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified. In addition NHS providers should consider reports of the 'red flag' issues suggested in the NICE guidance, and any other incident where a patient was or could have been harmed, as part of the risk management of patient safety incidents. Incidents must be reviewed alongside other data sources, including local quality improvement data (e.g. for

omitted medication) clinical audits or locally agreed monitoring information, such as delays or omissions of planned care. Furthermore, NHS providers should actively encourage all staff to report any occasion where a less than optimal level of suitably trained or experienced staff harmed or seems likely to harm a patient. These locally reported incidents should be considered patient safety incidents rather than solely staff safety incidents, and they should be routinely uploaded to the National Reporting and Learning System.

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

3.5.3 It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. Within the reporting period there were 109 incidents raised citing issues with staffing. This is a decrease of 2 when compared to the previous 6 month report. The incidents citing staffing problems were from across the following localities which may demonstrate the increased focus on appropriate escalation:

Locality	Number of incidents raised	Trend on previous 6 month
North Yorkshire	36	↑ (25)
Durham & Darlington	14	↓ (19)
Teesside	17	↓ (18)
Forensics	28	↓ (31)
York and Selby	14	↓ (18)

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

- 110 incidents citing staffing levels as the reason 46 night shifts 64 day shift. Of the 110 incidents 94 (85%) related to inpatient areas.

Key themes:

- 58% (64) incidents citing staffing levels were for day duty
- Forensic services at Roseberry Park accounted for 33% (30) of all incidents citing staffing levels
- North Yorkshire accounted for 40% (36) of all incidents.
- Moving staff around to cover shortfalls on other wards
- Enhanced observations increasing staffing requirements
- During the period 1st December 2017 to 31st May 2018 there were 12 incidents (13%) reported where staff did not turn up for a shift and no notice was given.
- Sickness is reported to have caused issues across the trust.

Issues reported:

- Observations not carried out
- Breaks not being taken
- Staff and patient safety compromised

- Unable to respond to alarms raised on adjoining wards
- Wards not running on required staffing levels
- Patient activities being cancelled
- Perimeter and safety checks not being carried out.
- Bedroom checks not carried out.

The trust adopted an escalation process to ensure a standard approach was adopted across the Trust and a timely response to ensure patient safety is not compromised. The escalation process has been reviewed as part of the Right Staffing programme to ensure that it is delivering what it was intended to do since its introduction and that the outcome of the 'incident' is reported through Datix. Monthly monitoring of this occurs within the monthly Safe Staffing reports and is highlighted to Heads of Nursing.

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

3.6 Patient, staff and carer feedback

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

3.6.2 A further analysis of the 24 complaints has been undertaken to identify whether there were any specific issues rose citing staffing levels. The review concluded that there were no complaints raised citing concerns with staffing levels or skill mix. There were however, 2 complaints that did highlight concerns with regards to negative staff attitude.

3.6.3 In addition analysis has been undertaken with regards to patient and carer feedback that has been submitted in relation to the friends and family test. In April 2017 the Trust introduced a new system (Meridian) to capture the friends and family test and a new question was introduced; is there anything we could do to make the service better? 183 comments were received that suggested more staff was required within our inpatient wards trust wide to support further activities including supporting leave and enhance communication.

3.6.4 The trust receives compliments and these are captured and published via the weekly e-Bulletin. A total of 162 compliments were received during the reporting period specifically in relation to highlighting a number of individuals and commend the work they have undertaken. These compliments cover all localities. From the total number of compliments there was nothing highlighted that was specific to actual staffing levels.

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

3.7 Care hours per Patient Day (CHPPD)

3.7.1 From April 2018, all MH trusts reported CHPPD for the first time to NHS Improvement. This is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. Work has begun to consider appropriate application of this metric in other healthcare groups such as allied health professionals (AHP's). We will be submitting pilot data in relation to AHP's that are rostered in TEWV in July 2018.

3.7.2 This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight. The CHPPD across all inpatient areas was 10.3 (3.8 registered nurses and 6.5 healthcare assistants) with an inpatient average of 14.3 CHPPD. This can be broken down by locality as follows:

Locality	Care Hours per Patient Day		
	Registered Nurse	Healthcare Assistants	Overall
Durham & Darlington	3.0	4.3	7.3
Forensics	5.3	10.7	16.0
North Yorkshire	3.3	4.8	8.1
Teesside	3.4	6.2	9.5
York & Selby	7.1	10.6	17.6

This can be further examined by looking at the benchmarking groups as follows:

Speciality	Registered Nurses	Healthcare Assistants	Overall
Acute	3.02	4.1	7.1
Adult LD	9.06	17.89	27.0
Child LD	13.0	15.7	28.7
Eating Disorders	3.0	6.4	9.5
Forensic LD	8.1	12.4	20.5
High Dependency	3.1	5.2	8.3
Locked Rehab	2.9	5.4	8.4
Long Term Complex continuing care	3.6	3.6	7.2
Low Secure	4.1	6.7	10.8
Medium Secure	3.8	6.8	10.6
Older Adults Acute	3.6	6.7	10.2
Other Specialist MH Beds	6.1	10.5	16.5
PICU	9.4	14.6	23.9
TIER 4	6.7	9.9	16.6

3.7.3 Appendix 6 shows the CHPPD covering the reporting period and Appendix 7 shows this graphically.

3.7.4 It is important to highlight that the NQB guidance states that CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. This will be further developed as part of the Right Staffing Programme and will be considered in more detail within the 6 monthly safe staffing report.

3.8 LD Staffing Guidance "An improvement resource for learning disability services (2018) NQB

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

3.8.2 Further guidance for mental health services; 'Safe sustainable and productive staffing, an improvement resource from mental health services' (2018) is now also available. As with previous guidance this is structured around the three NQB themes of right staff, right shills, right place and time, and highlights the need to undertake evidence – based workforce planning including strategic establishment reviews. The review requires a combination of professional judgment and evidence based tools, with the Hurst tool remaining the recommended format. It makes the following recommendations which Boards should seek assurance on:

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

- **Right Skills:**
  - The organisation has processes to identify, analyse and implement evidence-based practice across services.
  - Where new care models are developed, a clear plan exists to support staff so that the change takes place safely and affordably.
  - There are clear plans to evaluate the changes and both are reviewed.
  - The organisation takes an evidence-based approach to support efficient and effective team working.

- The organisation has systems and processes to promote staff's physical and emotional wellbeing and prevent fatigue and burnout.
- The organisation has a strategy for retaining staff, which clearly states learning and development opportunities for all staff groups and plans for attracting, recruiting and retaining staff, aligned with the workforce plan.

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

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

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. We are continuing to monitor via the Right Staffing work stream the emerging issue of qualified day cover to further understand this and the use of the evidence based tools to review nursing establishments.

4.3 Legal and Constitutional (including the NHS Constitution):

The Care Quality Commission and NHS England have set regulatory and contractual requirements that the Trust ensures adequate and appropriate staffing levels and skill mix to deliver safe and effective care. Inadequate staffing can result in non-compliance action and contractual breach. The March 2013 NHS England and CQC directives set out specific

requirements that will be checked through inspection and contractual monitoring as they are also included in standard commissioning contracts.

The Trust has complied with these directives to date.

4.4 Equality and Diversity:

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

4.5 Other implications:

There are no other implications identified

5.0 RISKS:

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

6.0 CONCLUSIONS:

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

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

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

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

7.0 RECOMMENDATIONS:

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

Emma Haimes, Head of Quality Data and Patient Experience – June 2018
Stephen Scorer, Associate Director of Nursing
Joe Bergin, Right Staffing Programme Manager
Elizabeth Moody, Director of Nursing and Governance

Budgeted and Actual Staffing Establishments in WTE

Appendix 1

Locality	WARD	Speciality	Establishment at 01/12/17				Establishment at 31/05/2018				Comparison 01/12/2017 to 31/05/2018 Budget v Actual WTE hours			
			Registered Staff		Unregistered Staff		Registered staff		Unregistered staff		Registered Staff		Unregistered Staff	
			Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
Durham & Darlington	Cedar Ward	Adults	15.30	16.60	14.80	12.00	14.30	15.60	14.80	14.20	-1.00	-1.00	0.00	2.20
	Birch Ward	Adults	9.60	11.10	14.30	12.70	8.60	11.90	14.30	11.00	-1.00	0.80	0.00	-1.70
	Primrose Lodge	Adults	9.60	6.80	11.40	12.00	8.60	7.80	11.40	11.00	-1.00	1.00	0.00	-1.00
	Willow Ward	Adults	9.60	10.60	12.40	11.50	8.60	6.60	12.40	11.60	-1.00	-4.00	0.00	0.10
	Maple Ward	Adults	9.60	10.30	11.40	12.60	8.60	10.30	11.40	11.20	-1.00	0.00	0.00	-1.40
	Elm Ward	Adults	9.60	7.80	12.40	12.40	8.60	8.70	11.40	10.80	-1.00	0.90	-1.00	-1.60
	Farnham Ward	Adults	9.60	8.60	11.40	11.00	8.60	8.60	11.40	8.80	-1.00	0.00	0.00	-2.20
	Tunstall Ward	Adults	9.60	10.40	11.40	11.10	8.60	10.40	11.40	11.10	-1.00	0.00	0.00	0.00
	Holly Unit	CYPS	5.60	6.60	5.60	4.80	5.60	4.80	5.60	5.60	0.00	-1.80	0.00	0.80
	Bek, Ramsey	LD	9.60	8.60	22.90	23.30	8.60	9.60	22.90	22.00	-1.00	1.00	0.00	-1.30
	Ceddesfeld Ward	MHSOP	8.60	8.20	13.20	15.50	8.60	8.80	13.20	15.70	0.00	0.60	0.00	0.20
	Hamsterley Ward	MHSOP	9.60	9.40	13.20	13.10	8.60	8.40	13.20	10.80	-1.00	-1.00	0.00	-2.30
	Oak Ward	MHSOP	9.60	8.80	12.40	13.30	8.60	7.80	12.40	13.50	-1.00	-1.00	0.00	0.20
	Roseberry Wards	MHSOP	8.60	7.70	12.40	11.00	8.60	7.60	12.40	11.90	0.00	-0.10	0.00	0.90
Forensics	Clover/Ivy	Forensics LD	8.10	7.00	20.20	16.00	8.10	8.90	20.20	16.10	0.00	1.90	0.00	0.10
	Thistle Ward	Forensics LD	10.70	7.00	14.80	13.90	10.70	8.00	14.80	13.90	0.00	1.00	0.00	0.00
	Northdale Centre	Forensics LD	8.10	10.00	26.80	21.20	8.10	10.00	26.80	21.50	0.00	0.00	0.00	0.30
	Oakwood	Forensics LD	9.10	6.10	6.60	8.00	9.10	6.50	6.60	8.00	0.00	0.40	0.00	0.00
	Eagle/Osprey	Forensics LD	9.10	5.70	17.50	14.20	0.00	0.00	0.00	0.00	-9.10	-5.70	-17.50	-14.20
	Eagle ASD	Forensics LD	0.00	0.00	0.00	0.00	6.00	3.80	6.00	6.00	6.00	3.80	6.00	6.00
	Harrier/Hawk	Forensics LD	8.10	6.80	20.20	17.00	8.10	8.80	20.20	18.00	0.00	2.00	0.00	1.00
	Langley Ward	Forensics LD	8.10	7.00	8.30	7.00	8.10	7.00	8.30	7.00	0.00	0.00	0.00	0.00

	Kestrel/Kite	Forensics LD	8.10	8.70	22.00	20.90	8.10	8.70	22.00	22.00	0.00	0.00	0.00	1.10
	Brambling Ward	Forensics MH	8.10	8.00	13.20	14.00	8.10	7.90	13.20	11.10	0.00	-0.10	0.00	-2.90
	Jay Ward	Forensics MH	8.10	7.90	13.20	13.90	8.10	7.90	13.20	12.40	0.00	0.00	0.00	-1.50
	Sandpiper Ward	Forensics MH	10.70	9.90	17.10	18.50	10.70	13.10	17.10	18.40	0.00	3.20	0.00	-0.10
	Merlin	Forensics MH	10.70	8.90	15.30	15.10	10.70	9.80	15.30	15.10	0.00	0.90	0.00	0.00
	Swift Ward	Forensics MH	8.10	7.80	15.30	16.60	8.10	8.60	15.30	15.50	0.00	0.80	0.00	-1.10
	Lark	Forensics MH	8.10	8.00	13.20	13.40	8.10	8.00	13.20	12.90	0.00	0.00	0.00	-0.50
	Kirkdale Ward	Forensics MH	8.10	9.90	15.30	13.80	8.10	8.90	15.30	13.80	0.00	-1.00	0.00	0.00
	Mallard Ward	Forensics MH	8.10	8.20	15.30	15.80	8.10	6.80	15.30	14.70	0.00	-1.40	0.00	-1.10
	Mandarin	Forensics MH	8.10	8.70	13.20	15.30	8.10	8.80	13.20	13.00	0.00	0.10	0.00	-2.30
	Nightingale Ward	Forensics MH	8.10	8.90	13.20	14.50	8.10	8.50	13.20	14.40	0.00	-0.40	0.00	-0.10
	Linnet Ward	Forensics MH	8.10	8.30	13.20	13.00	8.10	9.20	13.20	13.80	0.00	0.90	0.00	0.80
	Newtondale Ward	Forensics MH	10.70	10.90	17.90	16.80	10.70	10.00	17.90	18.00	0.00	-0.90	0.00	1.20
North Yorkshire	The Orchards	Adults	11.40	11.60	5.40	4.70	11.40	9.90	5.40	6.60	0.00	-1.70	0.00	1.90
	Danby Ward	Adults	8.10	5.00	10.70	11.00	8.10	8.00	10.70	11.00	0.00	3.00	0.00	0.00
	Esk Ward	Adults	11.10	7.40	10.70	10.90	12.10	6.40	10.70	9.90	1.00	-1.00	0.00	-1.00
	Ward 15 Friarage	Adults	10.10	7.00	10.70	11.50	10.60	7.50	10.70	9.70	0.50	0.50	0.00	-1.80
	Cedar Ward (NY)	Adults	10.10	8.20	15.20	13.50	10.10	7.40	15.20	11.00	0.00	-0.80	0.00	-2.50
	Ward 14	MHSOP	9.10	7.70	10.00	9.40	9.10	7.70	10.00	8.50	0.00	0.00	0.00	-0.90
	Rowan Ward	MHSOP	9.90	9.30	12.70	10.40	9.69	8.30	12.70	10.10	-0.21	-1.00	0.00	-0.30
	Springwood	MHSOP	9.10	6.40	12.50	11.40	9.10	8.60	12.50	12.60	0.00	2.20	0.00	1.20
	Rowan Lea	MHSOP	9.10	9.00	17.90	17.90	9.10	9.00	17.90	14.70	0.00	0.00	0.00	-3.20
Teesside	Bedale Ward	Adults	8.20	10.00	13.70	14.10	8.20	11.00	13.70	14.70	0.00	1.00	0.00	0.60
	Bilsdale Ward	Adults	9.20	11.80	11.00	13.60	9.20	9.60	11.00	11.70	0.00	-2.20	0.00	-1.90
	Bransdale Ward	Adults	9.20	10.60	10.00	12.90	9.20	9.00	10.00	13.10	0.00	-1.60	0.00	0.20
	Overdale Ward	Adults	9.20	9.60	11.00	7.60	9.20	8.60	11.00	11.20	0.00	-1.00	0.00	3.60
	Stockdale Ward	Adults	9.20	10.20	11.00	12.80	9.20	9.20	11.00	13.50	0.00	-1.00	0.00	0.70
	Lincoln Ward	Adults	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Lustrum Vale	Adults	10.30	9.70	11.00	10.30	10.80	13.70	11.00	10.50	0.50	4.00	0.00	0.20

	Baysdale	CYPS	7.70	6.30	12.70	12.50	7.70	5.30	12.70	15.10	0.00	-1.00	0.00	2.60
	Newberry Centre	CYPS	13.02	18.90	15.22	19.90	65.70	20.10	15.20	20.80	52.68	1.20	-0.02	0.90
	The Evergreen Centre	CYPS	14.50	17.30	18.70	29.80	15.30	19.70	18.70	21.20	0.80	2.40	0.00	-8.60
	Westwood Centre	CYPS	17.10	16.40	16.40	22.80	17.10	17.40	16.50	27.10	0.00	1.00	0.10	4.30
	Thornaby Road	LD	3.80	4.00	11.90	9.70	3.80	4.00	11.90	9.00	0.00	0.00	0.00	-0.70
	Aysgarth	LD	6.00	6.00	11.50	10.30	6.00	5.00	11.50	9.30	0.00	-1.00	0.00	-1.00
	Bankfields Court Flats	LD	21.90	26.80	67.80	51.80	21.90	26.80	67.80	51.80	0.00	0.00	0.00	0.00
	Bankfields Court Unit 2	LD												
	Bankfields Court Unit 3	LD												
	Bankfields Court Unit 4	LD												
	The Lodge	LD												
	Wingfield Ward	MHSOP	8.80	5.60	9.10	6.10	0.00	0.00	0.00	0.00	-8.80	-5.60	-9.10	-6.10
	Westerdale South	MHSOP	8.70	15.30	11.00	18.60	8.70	14.90	11.00	18.60	0.00	-0.40	0.00	0.00
	Westerdale North	MHSOP	9.70	15.50	11.00	14.20	9.70	15.80	11.00	13.90	0.00	0.30	0.00	-0.30
York & Selby	Ebor Ward	Adults	9.40	9.10	11.70	9.60	9.40	9.40	11.70	10.10	0.00	0.30	0.00	0.50
	Minster Ward	Adults	10.40	8.90	11.70	8.80	10.40	8.90	11.70	9.80	0.00	0.00	0.00	1.00
	Cherry Tree House	MHSOP	11.70	8.50	14.50	13.20	12.40	10.70	14.50	11.20	0.70	2.20	0.00	-2.00
	Oak Rise	ALD	9.40	11.70	21.20	15.00	9.40	7.60	21.20	12.70	0.00	-4.10	0.00	-2.30
	Acomb Garth	MHSOP	11.00	7.80	13.50	14.80	11.00	8.20	13.50	14.20	0.00	0.40	0.00	-0.60
	Meadowfields	MHSOP	9.30	7.80	14.50	11.20	9.30	7.80	14.50	10.60	0.00	0.00	0.00	-0.60

Average fill rate covering the period of 1st December 2017 to 31st May 2018

Appendix 2

Ward Name	Locality	Speciality	Bed Numbers (MAY)	6 Months - 1st December 2017 to 31st May 2018					
				Registered Average %		Unregistered Average %		Bank Usage vs Actual Hours	
				Day	Night	Day	Night	Hours	% against Actual Hours
Ayckbourn Danby Ward	North Yorkshire	Adults	11	88.8%	81.4%	108.0%	108.7%	1122.25	7.4%
Ayckbourn Esk Ward	North Yorkshire	Adults	11	81.3%	99.9%	127.7%	102.0%	1829.25	11.2%
Bedale Ward	Teesside	Adults	10	93.4%	79.2%	140.1%	174.8%	4110.58	15.9%
Bilsdale	Teesside	Adults	14	108.1%	112.8%	129.1%	118.1%	998.25	5.6%
Birch Ward	Durham and Darlington	Adults	15	69.3%	101.8%	122.4%	140.6%	5686.30	27.9%
Bransdale	Teesside	Adults	14	118.0%	116.3%	119.9%	118.7%	1345.75	7.7%
Cedar	Durham and Darlington	Adults	10	117.5%	113.1%	85.1%	78.0%	5611.01	21.1%
Cedar (NY)	North Yorkshire	Adults	14	106.2%	105.9%	110.0%	115.8%	1432.92	7.0%
Ebor Ward	York and Selby	Adults	12	88.5%	100.4%	99.4%	101.9%	1732.50	10.7%
Elm Ward	Durham and Darlington	Adults	20	93.2%	101.2%	101.8%	123.0%	4444.99	24.0%
Farnham Ward	Durham and Darlington	Adults	20	106.2%	97.5%	114.2%	104.9%	1333.17	8.1%
Kirkdale	Teesside	Adults	16	89.2%	100.2%	102.0%	104.0%	4031.75	21.7%
Lustrum Vale	Teesside	Adults	20	93.9%	101.4%	124.8%	110.0%	3075.50	17.3%
Maple	Durham and Darlington	Adults	20	85.8%	99.1%	123.1%	115.3%	4618.00	27.1%
Minster Ward	York and Selby	Adults	12	88.1%	101.9%	110.8%	106.2%	1168.00	6.9%
Overdale	Teesside	Adults	18	106.3%	103.3%	118.5%	111.8%	650.25	3.8%
Primrose Lodge	Durham and Darlington	Adults	15	80.2%	100.1%	117.8%	100.0%	2458.83	15.4%
Stockdale	Teesside	Adults	18	119.0%	117.2%	115.0%	110.5%	1174.00	6.6%
The Orchards (NY)	North Yorkshire	Adults	10	88.6%	60.6%	105.2%	133.7%	856.00	6.7%
Tunstall Ward	Durham and Darlington	Adults	20	112.0%	99.6%	102.7%	109.1%	340.00	2.0%
Ward 15	North Yorkshire	Adults	12	85.9%	103.5%	122.9%	104.0%	3834.75	24.4%
Willow Ward	Durham and Darlington	Adults	15	88.6%	103.4%	149.1%	107.6%	2748.50	15.7%
Baysdale	Teesside	CYPS	6	114.5%	102.3%	108.2%	101.9%	901.21	6.1%
Holly	Durham and Darlington	CYPS	4	158.3%	136.3%	161.4%	199.0%	835.69	10.1%
Newberry Centre	Teesside	CYPS	14	106.7%	136.0%	141.0%	195.3%	2663.72	8.9%
Talbot Direct Care	Durham and Darlington	CYPS	1	53.7%	94.9%	27.6%	21.8%	0.00	0.0%
The Evergreen Centre	Teesside	CYPS	16	80.8%	108.5%	114.8%	125.5%	2888.49	9.4%
Westwood Centre	Teesside	CYPS	12	93.1%	99.2%	160.9%	209.7%	1221.50	3.5%
Clover / Ivy	Forensics	Forensics LD	10	94.9%	126.4%	103.7%	180.0%	9916.74	37.9%
Eagle / Osprey	Forensics	Forensics LD	10	69.0%	107.5%	74.1%	88.8%	1735.25	16.2%

FLD Eagle ASD	Forensics	Forensics LD	1	102.9%	101.1%	116.1%	96.3%	373.92	8.8%
Harrier / Hawk	Forensics	Forensics LD	10	93.4%	107.3%	119.9%	150.3%	6793.50	25.7%
Kestrel / Kite.	Forensics	Forensics LD	16	93.8%	104.9%	111.9%	143.8%	6261.31	24.6%
Langley	Forensics	Forensics LD	10	80.9%	99.7%	109.4%	100.0%	2547.00	20.1%
Northdale Centre	Forensics	Forensics LD	12	95.8%	113.7%	117.7%	106.7%	6674.98	22.1%
Oakwood	Forensics	Forensics LD	8	85.5%	100.0%	163.6%	100.1%	2374.00	20.3%
Thistle	Forensics	Forensics LD	5	83.1%	104.2%	100.9%	97.0%	1683.76	9.7%
Brambling	Forensics	Forensics MH	13	102.3%	105.0%	115.4%	128.9%	4011.50	21.0%
Jay Ward	Forensics	Forensics MH	5	93.3%	106.4%	104.9%	114.2%	2105.57	11.9%
Lark	Forensics	Forensics MH	17	97.6%	103.4%	100.6%	94.4%	2090.00	12.6%
Linnet Ward	Forensics	Forensics MH	17	90.7%	104.7%	107.0%	101.7%	1470.33	8.5%
Mallard	Forensics	Forensics MH	14	103.3%	118.9%	106.6%	156.5%	5687.21	26.0%
Mandarin	Forensics	Forensics MH	16	92.9%	111.7%	155.0%	185.3%	8172.68	34.6%
Merlin	Forensics	Forensics MH	10	115.0%	100.3%	133.4%	178.4%	7502.25	27.6%
Newtondale	Forensics	Forensics MH	20	108.2%	92.0%	103.7%	129.5%	5012.59	20.8%
Nightingale	Forensics	Forensics MH	16	88.0%	101.1%	99.7%	98.4%	1787.20	10.9%
Sandpiper Ward	Forensics	Forensics MH	8	99.0%	94.5%	104.8%	137.7%	3730.75	15.3%
Swift Ward	Forensics	Forensics MH	10	98.1%	103.0%	96.8%	109.1%	1838.50	9.8%
Aysgarth	Teesside	LD	6	95.0%	99.8%	98.6%	100.1%	1839.97	14.0%
Bankfields Court Flats	Teesside	LD	6	113.1%	116.3%	80.6%	97.5%	635.79	5.3%
Bankfields Court Unit 2	Teesside	LD	5	114.7%	96.9%	108.5%	127.3%	2353.37	15.6%
Bankfields Court Unit 3	Teesside	LD	6	87.6%	97.5%	98.5%	96.9%	957.59	6.9%
Bankfields Court Unit 4	Teesside	LD	6	102.8%	143.3%	88.4%	85.6%	1108.50	8.9%
Bek-Ramsey Ward	Durham and Darlington	LD	11	136.9%	100.7%	110.3%	101.9%	1700.16	7.1%
Oak Rise	York and Selby	LD	8	110.7%	105.5%	93.3%	109.8%	2952.14	13.2%
The Lodge	Teesside	LD	1	80.1%	88.2%	70.8%	79.2%	91.17	1.0%
Acomb Garth	York and Selby	MHSOP	14	95.6%	116.2%	206.9%	319.8%	2723.40	7.7%
Ceddesfeld	Durham and Darlington	MHSOP	15	92.2%	100.6%	124.9%	118.9%	1640.16	8.1%
Cherry Tree House	York and Selby	MHSOP	18	110.1%	82.7%	102.5%	167.2%	2456.50	11.7%
Hamsterley	Durham and Darlington	MHSOP	15	95.7%	100.5%	144.3%	139.3%	5684.18	26.4%
Meadowfields	York and Selby	MHSOP	14	93.7%	98.2%	103.6%	145.7%	2347.70	12.1%
Oak Ward	Durham and Darlington	MHSOP	12	87.0%	101.7%	102.4%	102.2%	2291.98	14.4%
Roseberry Wards	Durham and Darlington	MHSOP	15	100.8%	101.9%	101.6%	103.5%	1816.32	11.2%
Rowan Lea	North Yorkshire	MHSOP	20	91.0%	107.6%	117.8%	117.7%	2493.56	10.5%
Rowan Ward	North Yorkshire	MHSOP	16	93.8%	101.9%	116.9%	125.5%	2177.25	12.3%
Springwood	North Yorkshire	MHSOP	14	86.4%	102.4%	112.6%	164.2%	3086.75	15.0%
Ward 14	North Yorkshire	MHSOP	10	86.9%	101.2%	102.7%	99.5%	346.00	2.3%

Westerdale North	Teesside	MHSOP	20	**110.7%**	**109.5%**	**122.7%**	**153.7%**	1221.17	5.6%
Westerdale South	Teesside	MHSOP	14	**93.6%**	**80.1%**	**254.4%**	**373.2%**	13981.49	32.4%
Harland Rehab Ward	Durham and Darlington	Rehab	1	**109.2%**	**100.4%**	**96.5%**	**99.4%**	1668.50	12.7%
Kiltonview	Teesside	Day Unit	0	**108.7%**		**87.3%**		1398.67	12.3%
The Orchard	Teesside	Day Unit	0	**92.2%**		**97.6%**		876.33	16.0%
Thornaby Road	Teesside	Day Unit	5	**103.9%**		**125.7%**	**101.4%**	406.25	3.5%

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

Ward Name	Locality	Speciality	Bed Numbers (May)	Overtime		Agency		Bank		Maternity		Sickness		Vacancies	
				Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours
Danby Ward	North Yorkshire	Adults	11	825.9	5.4%	1615.0	10.6%	1122.3	7.4%	0.0	0.0%	1505.0	9.9%	1256.3	8.2%
Esk Ward	North Yorkshire	Adults	11	314	1.9%	339.0	2.1%	1829.3	11.2%	607.5	3.7%	833.5	5.1%	1826.3	11.2%
Bedale Ward	Teesside	Adults	10	1049.68	4.1%	1295.5	5.0%	4110.6	15.9%	0.0	0.0%	679.0	2.6%	378.8	1.5%
Bilsdale	Teesside	Adults	14	345	1.9%	253.0	1.4%	998.3	5.6%	30.0	0.2%	1118.5	6.3%	720.0	4.0%
Birch Ward	Durham & Darlington	Adults	15	753.17	3.7%	899.7	4.4%	5686.3	27.9%	1743.0	8.5%	980.0	4.8%	1380.0	6.8%
Bransdale	Teesside	Adults	14	172.6	1.0%	274.0	1.6%	1345.8	7.7%	337.5	1.9%	812.5	4.7%	851.3	4.9%
Cedar	Durham & Darlington	Adults	10	471.33	1.8%	120.0	0.5%	5611.0	21.1%	0.0	0.0%	1291.5	4.8%	956.3	3.6%
Cedar (NY)	North Yorkshire	Adults	14	532.81	2.6%	6350.0	31.0%	1432.9	7.0%	975.0	4.8%	617.0	3.0%	4121.3	20.1%
Ebor Ward	York and Selby	Adults	12	428.5	2.7%	653.8	4.1%	1732.5	10.7%	0.0	0.0%	758.0	4.7%	1860.0	11.5%
Elm Ward	Durham & Darlington	Adults	20	291.43	1.6%	1190.1	6.4%	4445.0	24.0%	37.5	0.2%	2290.0	12.3%	581.3	3.1%
Farnham Ward	Durham & Darlington	Adults	20	404.5	2.5%	336.2	2.0%	1333.2	8.1%	0.0	0.0%	1013.5	6.1%	768.8	4.7%
Kirkdale	Teesside	Adults	16	579.4	3.1%	119.3	0.6%	4031.8	21.7%	1061.3	5.7%	2445.0	13.2%	1215.0	6.6%
Lustrum Vale	Teesside	Adults	20	603.03	3.4%	179.5	1.0%	3075.5	17.3%	937.5	5.3%	1221.8	6.9%	903.8	5.1%
Maple	Durham & Darlington	Adults	20	490.51	2.9%	707.3	4.2%	4618.0	27.1%	564.0	3.3%	3358.5	19.7%	945.0	5.5%
Minster Ward	York and Selby	Adults	12	990.5	5.8%	1503.0	8.8%	1168.0	6.9%	0.0	0.0%	965.0	5.7%	1803.8	10.6%
Overdale	Teesside	Adults	18	416.8	2.4%	264.5	1.5%	650.3	3.8%	334.5	1.9%	120.0	0.7%	701.3	4.1%
Primrose Lodge	Durham & Darlington	Adults	15	873	5.5%	39.9	0.3%	2458.8	15.4%	0.0	0.0%	3597.5	22.6%	270.0	1.7%
Stockdale	Teesside	Adults	18	309.35	1.7%	460.0	2.6%	1174.0	6.6%	1736.0	9.8%	2136.5	12.0%	390.0	2.2%
The Orchards (NY)	North Yorkshire	Adults	10	640.35	5.0%	72.0	0.6%	856.0	6.7%	792.0	6.2%	1027.3	8.0%	720.0	5.6%
Tunstall Ward	Durham & Darlington	Adults	20	228.53	1.3%	298.7	1.7%	340.0	2.0%	0.0	0.0%	406.5	2.4%	727.5	4.3%
Ward 15	North Yorkshire	Adults	12	186.9	1.2%	858.3	5.5%	3834.8	24.4%	0.0	0.0%	1090.0	6.9%	948.8	6.0%
Willow Ward	Durham & Darlington	Adults	15	460.37	2.6%	225.7	1.3%	2748.5	15.7%	0.0	0.0%	1307.5	7.5%	746.3	4.3%
Baysdale	Teesside	CYPS	6	1242.33	8.4%	0.0	0.0%	901.2	6.1%	0.0	0.0%	902.3	6.1%	397.5	2.7%
Holly	Durham & Darlington	CYPS	4	893.95	10.8%	0.0	0.0%	835.7	10.1%	270.0	3.2%	923.7	11.1%	217.5	2.6%
Newberry Centre	Teesside	CYPS	14	1822.48	6.1%	926.9	3.1%	2663.7	8.9%	435.0	1.5%	2654.7	8.9%	12401.3	41.7%
Talbot Direct Care	Durham & Darlington	CYPS	1	362.03	6.6%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	3225.0	59.1%
Evergreen Centre	Teesside	CYPS	16	781.7	2.5%	1737.0	5.6%	2888.5	9.4%	1722.3	5.6%	3634.2	11.8%	573.8	1.9%
Westwood Centre	Teesside	CYPS	12	2091.4	5.9%	0.0	0.0%	1221.5	3.5%	992.5	2.8%	546.5	1.5%	562.5	1.6%
Clover / Ivy	Forensics	Forensics LD	10	1120.59	4.3%	240.8	0.9%	9916.7	37.9%	453.8	1.7%	2261.0	8.6%	2040.0	7.8%

Eagle / Osprey	Forensics	Forensics LD	10	365.83	3.4%	507.3	4.7%	1735.3	16.2%	675.0	6.3%	296.8	2.8%	1413.8	13.2%
FLD Eagle ASD	Forensics	Forensics LD	1	122	2.9%	303.8	7.1%	373.9	8.8%	0.0	0.0%	22.5	0.5%	165.0	3.9%
Harrier / Hawk	Forensics	Forensics LD	10	1679.34	6.3%	0.0	0.0%	6793.5	25.7%	0.0	0.0%	1117.7	4.2%	1905.0	7.2%
Kestrel / Kite.	Forensics	Forensics LD	16	854.22	3.4%	101.3	0.4%	6261.3	24.6%	337.5	1.3%	2239.8	8.8%	1155.0	4.5%
Langley	Forensics	Forensics LD	10	227.25	1.8%	45.0	0.4%	2547.0	20.1%	0.0	0.0%	1652.0	13.1%	986.3	7.8%
Northdale Centre	Forensics	Forensics LD	12	1505.09	5.0%	405.8	1.3%	6675.0	22.1%	300.0	1.0%	1302.0	4.3%	3202.5	10.6%
Oakwood	Forensics	Forensics LD	8	718.34	6.1%	112.5	1.0%	2374.0	20.3%	682.5	5.8%	1790.0	15.3%	787.5	6.7%
Thistle	Forensics	Forensics LD	5	492.82	2.9%	56.3	0.3%	1683.8	9.7%	0.0	0.0%	192.3	1.1%	1728.8	10.0%
Brambling	Forensics	Forensics MH	13	156	0.8%	0.0	0.0%	4011.5	21.0%	138.8	0.7%	972.8	5.1%	645.0	3.4%
Jay Ward	Forensics	Forensics MH	5	751.3	4.2%	0.0	0.0%	2105.6	11.9%	11.3	0.1%	713.0	4.0%	468.8	2.6%
Lark	Forensics	Forensics MH	17	747.82	4.5%	0.0	0.0%	2090.0	12.6%	412.5	2.5%	718.5	4.3%	967.5	5.8%
Linnet Ward	Forensics	Forensics MH	17	515.9	3.0%	0.0	0.0%	1470.3	8.5%	1316.3	7.6%	671.0	3.9%	258.8	1.5%
Mallard	Forensics	Forensics MH	14	723.4	3.3%	0.0	0.0%	5687.2	26.0%	0.0	0.0%	1541.7	7.0%	753.8	3.4%
Mandarin	Forensics	Forensics MH	16	690.13	2.9%	0.0	0.0%	8172.7	34.6%	0.0	0.0%	1915.3	8.1%	922.5	3.9%
Merlin	Forensics	Forensics MH	10	798.15	2.9%	0.0	0.0%	7502.3	27.6%	0.0	0.0%	153.8	0.6%	1635.0	6.0%
Newtondale	Forensics	Forensics MH	20	1074.2	4.5%	0.0	0.0%	5012.6	20.8%	1530.0	6.3%	1389.3	5.8%	836.3	3.5%
Nightingale	Forensics	Forensics MH	16	795.83	4.8%	0.0	0.0%	1787.2	10.9%	110.0	0.7%	1634.3	9.9%	963.8	5.9%
Sandpiper Ward	Forensics	Forensics MH	8	582.93	2.4%	0.0	0.0%	3730.8	15.3%	157.5	0.6%	1378.5	5.6%	322.5	1.3%
Swift Ward	Forensics	Forensics MH	10	782.35	4.2%	0.0	0.0%	1838.5	9.8%	1766.3	9.4%	716.3	3.8%	450.0	2.4%
Aysgarth	Teesside	LD	6	852.1	6.5%	0.0	0.0%	1840.0	14.0%	0.0	0.0%	1454.8	11.1%	570.0	4.3%
Bankfields Flats	Teesside	LD	6	430.75	3.6%	0.0	0.0%	635.8	5.3%	0.0	0.0%	456.5	3.8%	0.0	0.0%
Bankfields Unit 2	Teesside	LD	5	1082.19	7.2%	0.0	0.0%	2353.4	15.6%	220.0	1.5%	754.9	5.0%	663.8	4.4%
Bankfields Unit 3	Teesside	LD	6	396.57	2.9%	0.0	0.0%	957.6	6.9%	0.0	0.0%	1707.0	12.3%	225.0	1.6%
Bankfields Unit 4	Teesside	LD	6	419.66	3.4%	0.0	0.0%	1108.5	8.9%	0.0	0.0%	408.0	3.3%	0.0	0.0%
Bek-Ramsey Ward	Durham & Darlington	LD	11	1190.5	5.0%	439.7	1.8%	1700.2	7.1%	525.0	2.2%	2589.0	10.8%	637.5	2.7%
Oak Rise	York and Selby	LD	8	554.99	2.5%	2308.8	10.3%	2952.1	13.2%	0.0	0.0%	1646.8	7.4%	1980.0	8.9%
The Lodge	Teesside	LD	1	260.09	2.9%	0.0	0.0%	91.2	1.0%	0.0	0.0%	87.5	1.0%	0.0	0.0%
Acomb Garth	York and Selby	MHSOP	14	177.8	0.5%	18779.0	53.4%	2723.4	7.7%	634.0	1.8%	2484.0	7.1%	2265.0	6.4%
Ceddesfeld	Durham & Darlington	MHSOP	15	677.09	3.3%	643.5	3.2%	1640.2	8.1%	0.0	0.0%	1386.3	6.8%	405.0	2.0%
Cherry Tree House	York and Selby	MHSOP	18	1053.92	5.0%	4785.8	22.8%	2456.5	11.7%	1133.5	5.4%	2201.0	10.5%	2167.5	10.3%
Hamsterley	Durham & Darlington	MHSOP	15	531.83	2.5%	1024.3	4.8%	5684.2	26.4%	0.0	0.0%	2284.2	10.6%	600.0	2.8%
Meadowfields	York and Selby	MHSOP	14	135	0.7%	3678.7	18.9%	2347.7	12.1%	0.0	0.0%	1175.0	6.0%	1278.8	6.6%
Oak Ward	Durham & Darlington	MHSOP	12	528.33	3.3%	218.7	1.4%	2292.0	14.4%	0.0	0.0%	1613.0	10.1%	656.3	4.1%
Roseberry Wards	Durham & Darlington	MHSOP	15	47.5	0.3%	108.0	0.7%	1816.3	11.2%	0.0	0.0%	489.0	3.0%	997.5	6.2%
Rowan Lea	North Yorkshire	MHSOP	20	893.87	3.8%	2156.4	9.1%	2493.6	10.5%	0.0	0.0%	1009.2	4.3%	738.8	3.1%
Rowan Ward	North Yorkshire	MHSOP	16	302.75	1.7%	2386.5	13.4%	2177.3	12.3%	0.0	0.0%	191.5	1.1%	1395.0	7.9%
Springwood	North Yorkshire	MHSOP	14	967.02	4.7%	2085.5	10.1%	3086.8	15.0%	0.0	0.0%	515.8	2.5%	945.0	4.6%

Ward 14	North Yorkshire	MHSOP	10	1115.35	7.5%	76.0	0.5%	346.0	2.3%	0.0	0.0%	266.8	1.8%	870.0	5.8%
Westerdale North	Teesside	MHSOP	20	269	1.2%	3289.5	15.1%	1221.2	5.6%	37.5	0.2%	5289.0	24.3%	1406.3	6.4%
Westerdale South	Teesside	MHSOP	14	178.17	0.4%	8535.0	19.8%	13981.5	32.4%	1622.0	3.8%	2923.8	6.8%	1027.5	2.4%
Harland	Durham & Darlington	Rehab	1	514.16	3.9%	192.0	1.5%	1668.5	12.7%	337.5	2.6%	803.0	6.1%	1511.3	11.5%
Kiltonview	Teesside	Day Unit	0	61.42	0.5%	0.0	0.0%	1398.7	12.3%	1507.5	13.3%	1447.4	12.7%	363.8	3.2%
The Orchard	Teesside	Day Unit	0	0	0.0%	0.0	0.0%	876.3	16.0%	562.5	10.3%	127.5	2.3%	93.8	1.7%
Thornaby Road	Teesside	Day Unit	5	1242.42	10.7%	0.0	0.0%	406.3	3.5%	17.5	0.2%	217.5	1.9%	1222.5	10.6%

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

Quality Indicators - 6 Month Total

Appendix 4

Ward Name	Locality	Speciality	Bank Usage vs Actual Hours		Quality Indicators					Incidents of Restraints				Registered Average %		Unregistered Average %	
			Hours	% against Actual Hours	Number of SIs	Number of L4 Incidents	Number of L3 Incidents	Number of Complaints	Number of PALS	Number of Incidents	Number of PRO Restraints Used	Number of Other Restraints Used	Total Number of Restraints Used	Day	Night	Day	Night
Danby Ward	North Yorkshire	Adults	1122.3	7.4%	1		1		2	13	1	20	21	88.8%	81.4%	108.0%	108.7%
Esk Ward	North Yorkshire	Adults	1829.3	11.2%			1	1	3	50	3	86	89	81.3%	99.9%	127.7%	102.0%
Bedale Ward	Teesside	Adults	4110.6	15.9%				1	7	59	6	114	120	93.4%	79.2%	140.1%	174.8%
Bilsdale	Teesside	Adults	998.3	5.6%	2				1	17	3	22	25	108.1%	112.8%	129.1%	118.1%
Birch Ward	Durham & Darlington	Adults	5686.3	27.9%						11		15	15	69.3%	101.8%	122.4%	140.6%
Bransdale	Teesside	Adults	1345.8	7.7%				2	5	37	2	58	60	118.0%	116.3%	119.9%	118.7%
Cedar	Durham & Darlington	Adults	5611.0	21.1%			6	3	5	149	11	249	260	117.5%	113.1%	85.1%	78.0%
Cedar (NY)	North Yorkshire	Adults	1432.9	7.0%			8	1	5	50	1	86	87	106.2%	105.9%	110.0%	115.8%
Ebor Ward	York and Selby	Adults	1732.5	10.7%					1	31		49	49	88.5%	100.4%	99.4%	101.9%
Elm Ward	Durham & Darlington	Adults	4445.0	24.0%	1	1	2	2	13	53	3	69	72	93.2%	101.2%	101.8%	123.0%
Farnham Ward	Durham & Darlington	Adults	1333.2	8.1%	2	1			2	12		18	18	106.2%	97.5%	114.2%	104.9%
Kirkdale	Teesside	Adults	4031.8	21.7%				1	3	6		9	9	89.2%	100.2%	102.0%	104.0%
Lustrum Vale	Teesside	Adults	3075.5	17.3%			3			3		3	3	93.9%	101.4%	124.8%	110.0%
Maple	Durham & Darlington	Adults	4618.0	27.1%			1	2	4	11		14	14	85.8%	99.1%	123.1%	115.3%
Minster Ward	York and Selby	Adults	1168.0	6.9%				2	2	37	3	52	55	88.1%	101.9%	110.8%	106.2%
Overdale	Teesside	Adults	650.3	3.8%	2	1			4	18	2	20	22	106.3%	103.3%	118.5%	111.8%
Primrose Lodge	Durham & Darlington	Adults	2458.8	15.4%										80.2%	100.1%	117.8%	100.0%
Stockdale	Teesside	Adults	1174.0	6.6%			1	1	8	17	2	20	22	119.0%	117.2%	115.0%	110.5%
The Orchards (NY)	North Yorkshire	Adults	856.0	6.7%						1		1	1	88.6%	60.6%	105.2%	133.7%
Tunstall Ward	Durham & Darlington	Adults	340.0	2.0%			2	1	6	14	1	18	19	112.0%	99.6%	102.7%	109.1%
Ward 15	North Yorkshire	Adults	3834.8	24.4%			5	1	1	14		15	15	85.9%	103.5%	122.9%	104.0%
Willow Ward	Durham & Darlington	Adults	2748.5	15.7%					3	14	2	14	16	88.6%	103.4%	149.1%	107.6%
Baysdale	Teesside	CYPS	901.2	6.1%										114.5%	102.3%	108.2%	101.9%
Holly	Durham & Darlington	CYPS	835.7	10.1%										158.3%	136.3%	161.4%	199.0%
Newberry Centre	Teesside	CYPS	2663.7	8.9%			2	1	11	937	5	1240	1245	106.7%	136.0%	141.0%	195.3%
Talbot Direct Care	Durham & Darlington	CYPS	0.0	0.0%			1			3		4	4	53.7%	94.9%	27.6%	21.8%

The Evergreen	Teesside	CYPS	2888.5	9.4%			2		1	801	31	1185	1216	80.8%	108.5%	114.8%	125.5%
Westwood Centre	Teesside	CYPS	1221.5	3.5%			1		1	192	2	290	292	93.1%	99.2%	160.9%	209.7%
Clover / Ivy	Forensics	FLD	9916.7	37.9%			1		7	171	8	347	355	94.9%	126.4%	103.7%	180.0%
Eagle / Osprey	Forensics	FLD	1735.3	16.2%										69.0%	107.5%	74.1%	88.8%
FLD Eagle ASD	Forensics	FLD	373.9	8.8%										102.9%	101.1%	116.1%	96.3%
Harrier / Hawk	Forensics	FLD	6793.5	25.7%				1	13	24	1	38	39	93.4%	107.3%	119.9%	150.3%
Kestrel / Kite.	Forensics	FLD	6261.3	24.6%				1	7	8	1	14	15	93.8%	104.9%	111.9%	143.8%
Langley	Forensics	FLD	2547.0	20.1%										80.9%	99.7%	109.4%	100.0%
Northdale Centre	Forensics	FLD	6675.0	22.1%					9	16	1	25	26	95.8%	113.7%	117.7%	106.7%
Oakwood	Forensics	FLD	2374.0	20.3%										85.5%	100.0%	163.6%	100.1%
Thistle	Forensics	FLD	1683.8	9.7%			1		1	22		36	36	83.1%	104.2%	100.9%	97.0%
Brambling	Forensics	FMH	4011.5	21.0%					1	46		90	90	102.3%	105.0%	115.4%	128.9%
Jay Ward	Forensics	FMH	2105.6	11.9%						15	1	32	33	93.3%	106.4%	104.9%	114.2%
Lark	Forensics	FMH	2090.0	12.6%					3					97.6%	103.4%	100.6%	94.4%
Linnet Ward	Forensics	FMH	1470.3	8.5%						3		3	3	90.7%	104.7%	107.0%	101.7%
Mallard	Forensics	FMH	5687.2	26.0%					28	2		2	2	103.3%	118.9%	106.6%	156.5%
Mandarin	Forensics	FMH	8172.7	34.6%					1	64		81	81	92.9%	111.7%	155.0%	185.3%
Merlin	Forensics	FMH	7502.3	27.6%				1	7	41		84	84	115.0%	100.3%	133.4%	178.4%
Newtondale	Forensics	FMH	5012.6	20.8%					10	4		5	5	108.2%	92.0%	103.7%	129.5%
Nightingale	Forensics	FMH	1787.2	10.9%					1	7		15	15	88.0%	101.1%	99.7%	98.4%
Sandpiper Ward	Forensics	FMH	3730.8	15.3%					5	415	13	897	910	99.0%	94.5%	104.8%	137.7%
Swift Ward	Forensics	FMH	1838.5	9.8%					1	34		60	60	98.1%	103.0%	96.8%	109.1%
Aysgarth	Teesside	LD	1840.0	14.0%					1	2		2	2	95.0%	99.8%	98.6%	100.1%
Bankfields Flats	Teesside	LD	635.8	5.3%										113.1%	116.3%	80.6%	97.5%
Bankfields Unit 2	Teesside	LD	2353.4	15.6%						1		1	1	114.7%	96.9%	108.5%	127.3%
Bankfields Unit 3	Teesside	LD	957.6	6.9%	1					71		112	112	87.6%	97.5%	98.5%	96.9%
Bankfields Unit 4	Teesside	LD	1108.5	8.9%										102.8%	143.3%	88.4%	85.6%
Bek-Ramsey Ward	Durham & Darlington	LD	1700.2	7.1%					1	100	13	141	154	136.9%	100.7%	110.3%	101.9%
Oak Rise	York and Selby	LD	2952.1	13.2%						31		54	54	110.7%	105.5%	93.3%	109.8%
The Lodge	Teesside	LD	91.2	1.0%						1		2	2	80.1%	88.2%	70.8%	79.2%
Acomb Garth	York and Selby	MHSOP	2723.4	7.7%						158		224	224	95.6%	116.2%	206.9%	319.8%
Ceddesfeld	Durham & Darlington	MHSOP	1640.2	8.1%					1	20		34	34	92.2%	100.6%	124.9%	118.9%
Cherry Tree House	York and Selby	MHSOP	2456.5	11.7%	1	1		2	5	8		9	9	110.1%	82.7%	102.5%	167.2%
Hamsterley	Durham & Darlington	MHSOP	5684.2	26.4%						16		17	17	95.7%	100.5%	144.3%	139.3%
Meadowfields	York and Selby	MHSOP	2347.7	12.1%						10		13	13	93.7%	98.2%	103.6%	145.7%
Oak Ward	Durham & Darlington	MHSOP	2292.0	14.4%					2	12		18	18	87.0%	101.7%	102.4%	102.2%
Roseberry Wards	Durham & Darlington	MHSOP	1816.3	11.2%			1		3	5		7	7	100.8%	101.9%	101.6%	103.5%

Rowan Lea	North Yorkshire	MHSOP	2493.6	10.5%	1	1			4	53	1	97	98	91.0%	107.6%	117.8%	117.7%
Rowan Ward	North Yorkshire	MHSOP	2177.3	12.3%	2	1			1	14		17	17	93.8%	101.9%	116.9%	125.5%
Springwood	North Yorkshire	MHSOP	3086.8	15.0%						107		145	145	86.4%	102.4%	112.6%	164.2%
Ward 14	North Yorkshire	MHSOP	346.0	2.3%						7		8	8	86.9%	101.2%	102.7%	99.5%
Westerdale North	Teesside	MHSOP	1221.2	5.6%						20		28	28	110.7%	109.5%	122.7%	153.7%
Westerdale South	Teesside	MHSOP	13981.5	32.4%					1	158		161	161	93.6%	80.1%	254.4%	373.2%
Harland Rehab Ward	Durham & Darlington	Rehab	1668.5	12.7%						3	1	6	7	109.2%	100.4%	96.5%	99.4%
Kiltonview	Teesside	Day Unit	1398.7	12.3%										108.7%		87.3%	
The Orchard	Teesside	Day Unit	876.3	16.0%										92.2%		97.6%	
Thornaby Road	Teesside	Day Unit	406.3	3.5%										103.9%		125.7%	101.4%

Quality Indicators - 6 Month Total

Appendix 5

Ward Name	Locality	Speciality	Safe Nursing Indicators											
			Falls resulting in significant harm	Pressure Ulcers	Medication Errors	Missed Breaks	Staffing Fill Rate - Day - Registered Nurses	Staffing Fill Rate - Night - Registered Nurses	Staffing Fill Rate - Day - Unregistered Nurses	Staffing Fill Rate - Night - Unregistered Nurses	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours	Mandatory Training (May 18)
Danby Ward	North Yorkshire	Adults			11	24	88.8%	81.4%	108.0%	108.7%	7.4%	10.6%	5.4%	89.27%
Esk Ward	North Yorkshire	Adults			6	26	81.3%	99.9%	127.7%	102.0%	11.2%	2.1%	1.9%	93.53%
Bedale Ward	Teesside	Adults			3	23	93.4%	79.2%	140.1%	174.8%	15.9%	5.0%	4.1%	96.74%
Bilsdale	Teesside	Adults			3	38	108.1%	112.8%	129.1%	118.1%	5.6%	1.4%	1.9%	95.05%
Birch Ward	Durham & Darlington	Adults			7	5	69.3%	101.8%	122.4%	140.6%	27.9%	4.4%	3.7%	87.65%
Bransdale	Teesside	Adults			4	8	118.0%	116.3%	119.9%	118.7%	7.7%	1.6%	1.0%	93.63%
Cedar	Durham & Darlington	Adults			5	15	117.5%	113.1%	85.1%	78.0%	21.1%	0.5%	1.8%	94.23%
Cedar (NY)	North Yorkshire	Adults			7	74	106.2%	105.9%	110.0%	115.8%	7.0%	31.0%	2.6%	92.58%
Ebor Ward	York and Selby	Adults			24	49	88.5%	100.4%	99.4%	101.9%	10.7%	4.1%	2.7%	99.05%
Elm Ward	Durham & Darlington	Adults			16	49	93.2%	101.2%	101.8%	123.0%	24.0%	6.4%	1.6%	94.67%
Farnham Ward	Durham &Darlington	Adults			2	5	106.2%	97.5%	114.2%	104.9%	8.1%	2.0%	2.5%	91.01%
Kirkdale	Teesside	Adults			13	5	89.2%	100.2%	102.0%	104.0%	21.7%	0.6%	3.1%	91.21%
Lustrum Vale	Teesside	Adults			22	5	93.9%	101.4%	124.8%	110.0%	17.3%	1.0%	3.4%	97.88%
Maple	Durham & Darlington	Adults			10	34	85.8%	99.1%	123.1%	115.3%	27.1%	4.2%	2.9%	89.36%
Minster Ward	York and Selby	Adults			41	107	88.1%	101.9%	110.8%	106.2%	6.9%	8.8%	5.8%	96.20%
Overdale	Teesside	Adults	1		3	4	106.3%	103.3%	118.5%	111.8%	3.8%	1.5%	2.4%	98.65%
Primrose Lodge	Durham & Darlington	Adults			5	1	80.2%	100.1%	117.8%	100.0%	15.4%	0.3%	5.5%	87.23%
Stockdale	Teesside	Adults			4	14	119.0%	117.2%	115.0%	110.5%	6.6%	2.6%	1.7%	94.70%
The Orchards (NY)	North Yorkshire	Adults			1	1	88.6%	60.6%	105.2%	133.7%	6.7%	0.6%	5.0%	96.45%
Tunstall Ward	Durham & Darlington	Adults			2	37	112.0%	99.6%	102.7%	109.1%	2.0%	1.7%	1.3%	94.00%
Ward 15	North Yorkshire	Adults				22	85.9%	103.5%	122.9%	104.0%	24.4%	5.5%	1.2%	88.50%
Willow Ward	Durham & Darlington	Adults			9	3	88.6%	103.4%	149.1%	107.6%	15.7%	1.3%	2.6%	95.32%
Baysdale	Teesside	CYPS			3	14	114.5%	102.3%	108.2%	101.9%	6.1%	0.0%	8.4%	89.94%

Holly	Durham & Darlington	CYPS			1	18	158.3%	136.3%	161.4%	199.0%	10.1%	0.0%	10.8%	98.32%
Newberry Centre	Teesside	CYPS			5	568	106.7%	136.0%	141.0%	195.3%	8.9%	3.1%	6.1%	94.93%
Talbot Direct Care	Durham &Darlington	CYPS			1	17	53.7%	94.9%	27.6%	21.8%	0.0%	0.0%	6.6%	
The Evergreen Centre	Teesside	CYPS			10	121	80.8%	108.5%	114.8%	125.5%	9.4%	5.6%	2.5%	85.63%
Westwood Centre	Teesside	CYPS			2	55	93.1%	99.2%	160.9%	209.7%	3.5%	0.0%	5.9%	96.35%
Clover / Ivy	Forensics	Forensics LD			10	106	94.9%	126.4%	103.7%	180.0%	37.9%	0.9%	4.3%	86.71%
Eagle / Osprey	Forensics	Forensics LD			1	14	69.0%	107.5%	74.1%	88.8%	16.2%	4.7%	3.4%	
FLD Eagle ASD	Forensics	Forensics LD				1	102.9%	101.1%	116.1%	96.3%	8.8%	7.1%	2.9%	
Harrier / Hawk	Forensics	Forensics LD			7	56	93.4%	107.3%	119.9%	150.3%	25.7%	0.0%	6.3%	99.11%
Kestrel / Kite.	Forensics	Forensics LD			5	32	93.8%	104.9%	111.9%	143.8%	24.6%	0.4%	3.4%	90.21%
Langley	Forensics	Forensics LD				6	80.9%	99.7%	109.4%	100.0%	20.1%	0.4%	1.8%	91.43%
Northdale Centre	Forensics	Forensics LD			20	56	95.8%	113.7%	117.7%	106.7%	22.1%	1.3%	5.0%	88.89%
Oakwood	Forensics	Forensics LD			3	10	85.5%	100.0%	163.6%	100.1%	20.3%	1.0%	6.1%	97.73%
Thistle	Forensics	Forensics LD			2	27	83.1%	104.2%	100.9%	97.0%	9.7%	0.3%	2.9%	97.42%
Brambling	Forensics	Forensics MH			7	44	102.3%	105.0%	115.4%	128.9%	21.0%	0.0%	0.8%	95.75%
Jay Ward	Forensics	Forensics MH			2	12	93.3%	106.4%	104.9%	114.2%	11.9%	0.0%	4.2%	96.60%
Lark	Forensics	Forensics MH			8	40	97.6%	103.4%	100.6%	94.4%	12.6%	0.0%	4.5%	91.97%
Linnet Ward	Forensics	Forensics MH			21	14	90.7%	104.7%	107.0%	101.7%	8.5%	0.0%	3.0%	95.42%
Mallard	Forensics	Forensics MH		1	5	94	103.3%	118.9%	106.6%	156.5%	26.0%	0.0%	3.3%	92.56%
Mandarin	Forensics	Forensics MH			3	64	92.9%	111.7%	155.0%	185.3%	34.6%	0.0%	2.9%	92.41%
Merlin	Forensics	Forensics MH			9	45	115.0%	100.3%	133.4%	178.4%	27.6%	0.0%	2.9%	97.47%
Newtondale	Forensics	Forensics MH			3	59	108.2%	92.0%	103.7%	129.5%	20.8%	0.0%	4.5%	97.05%
Nightingale	Forensics	Forensics MH			2	41	88.0%	101.1%	99.7%	98.4%	10.9%	0.0%	4.8%	91.71%
Sandpiper Ward	Forensics	Forensics MH			17	55	99.0%	94.5%	104.8%	137.7%	15.3%	0.0%	2.4%	91.27%
Swift Ward	Forensics	Forensics MH			5	19	98.1%	103.0%	96.8%	109.1%	9.8%	0.0%	4.2%	93.78%
Aysgarth	Teesside	LD			3	12	95.0%	99.8%	98.6%	100.1%	14.0%	0.0%	6.5%	94.10%
Bankfields Court Flats	Teesside	LD				12	113.1%	116.3%	80.6%	97.5%	5.3%	0.0%	3.6%	88.93%
Bankfields Court Unit 2	Teesside	LD			1	66	114.7%	96.9%	108.5%	127.3%	15.6%	0.0%	7.2%	88.07%
Bankfields Court Unit 3	Teesside	LD			2	11	87.6%	97.5%	98.5%	96.9%	6.9%	0.0%	2.9%	93.72%
Bankfields Court Unit 4	Teesside	LD				14	102.8%	143.3%	88.4%	85.6%	8.9%	0.0%	3.4%	90.58%
Bek-Ramsey Ward	Durham and Darlington	LD			3	0	136.9%	100.7%	110.3%	101.9%	7.1%	1.8%	5.0%	94.75%
Oak Rise	York and Selby	LD			1	14	110.7%	105.5%	93.3%	109.8%	13.2%	10.3%	2.5%	96.14%

The Lodge	Teesside	LD			1	3	80.1%	88.2%	70.8%	79.2%	1.0%	0.0%	2.9%	98.31%
Acomb Garth	York and Selby	MHSOP			4	12	95.6%	116.2%	206.9%	319.8%	7.7%	53.4%	0.5%	91.24%
Ceddesfeld	Durham & Darlington	MHSOP			2	14	92.2%	100.6%	124.9%	118.9%	8.1%	3.2%	3.3%	90.85%
Cherry Tree House	York and Selby	MHSOP	1		9	19	110.1%	82.7%	102.5%	167.2%	11.7%	22.8%	5.0%	92.83%
Hamsterley	Durham & Darlington	MHSOP			8	23	95.7%	100.5%	144.3%	139.3%	26.4%	4.8%	2.5%	87.87%
Meadowfields	York and Selby	MHSOP			15	21	93.7%	98.2%	103.6%	145.7%	12.1%	18.9%	0.7%	96.98%
Oak Ward	Durham & Darlington	MHSOP		1	11	4	87.0%	101.7%	102.4%	102.2%	14.4%	1.4%	3.3%	77.94%
Roseberry Wards	Durham & Darlington	MHSOP			1	9	100.8%	101.9%	101.6%	103.5%	11.2%	0.7%	0.3%	97.33%
Rowan Lea	North Yorkshire	MHSOP	1	1	10	42	91.0%	107.6%	117.8%	117.7%	10.5%	9.1%	3.8%	73.79%
Rowan Ward	North Yorkshire	MHSOP	1		4	38	93.8%	101.9%	116.9%	125.5%	12.3%	13.4%	1.7%	95.52%
Springwood	North Yorkshire	MHSOP			2	10	86.4%	102.4%	112.6%	164.2%	15.0%	10.1%	4.7%	86.34%
Ward 14	North Yorkshire	MHSOP			4	18	86.9%	101.2%	102.7%	99.5%	2.3%	0.5%	7.5%	94.51%
Westerdale North	Teesside	MHSOP			9	33	110.7%	109.5%	122.7%	153.7%	5.6%	15.1%	1.2%	91.85%
Westerdale South	Teesside	MHSOP			9	13	93.6%	80.1%	254.4%	373.2%	32.4%	19.8%	0.4%	78.98%
Harland Rehab Ward	Durham and Darlington	Rehab				0	109.2%	100.4%	96.5%	99.4%	12.7%	1.5%	3.9%	92.80%
Kiltonview	Teesside	Day Unit					108.7%		87.3%		12.3%	0.0%	0.5%	
The Orchard	Teesside	Day Unit					92.2%		97.6%		16.0%	0.0%	0.0%	
Thornaby Road	Teesside	Day Unit			2		103.9%	0.0%	125.7%	101.4%	3.5%	0.0%	10.7%	92.41%

Care Hours per Patient Day

APPENDIX 6

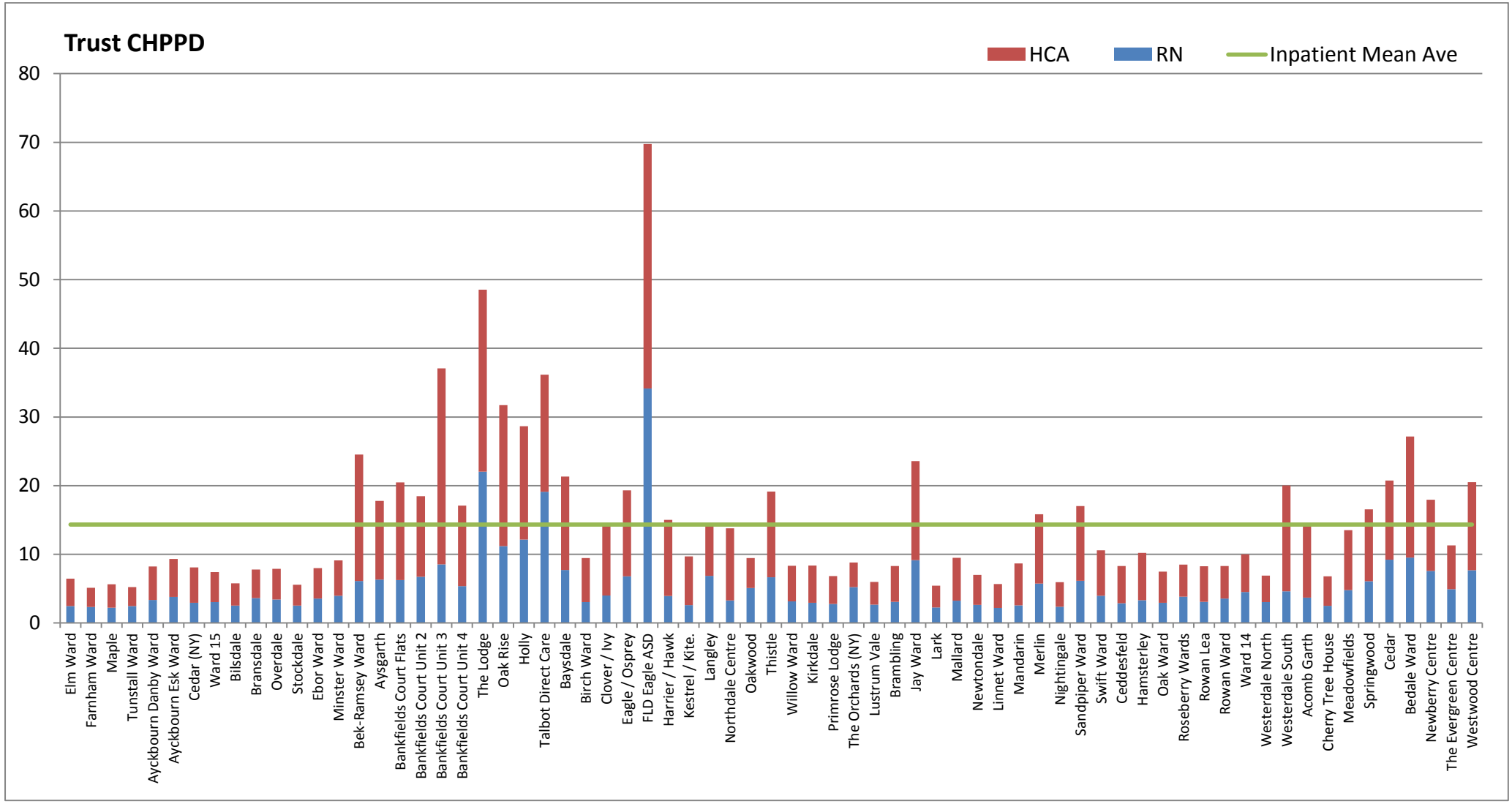
Ward Name	Locality	Speciality	Occupied Beds at Midnight							RN HOURS	HCA HOURS	CHPPD	
			Dec	Jan	Feb	Mar	Apr	May	TOTAL			RN	HCA
Elm Ward	Durham & Darlington	ACUTE	493	452	378	494	498	563	2878	7110.9	11441.8	2.5	4.0
Farnham Ward	Durham & Darlington	ACUTE	516	517	499	534	602	561	3229	7459.3	9037.3	2.3	2.8
Maple	Durham & Darlington	ACUTE	463	500	480	506	544	533	3026	6694.7	10342.2	2.2	3.4
Tunstall Ward	Durham & Darlington	ACUTE	609	580	419	553	532	587	3280	8032.3	9083.1	2.4	2.8
Danby Ward	North Yorkshire	ACUTE	338	317	279	279	297	341	1851	6214.0	9037.2	3.4	4.9
Esk Ward	North Yorkshire	ACUTE	256	258	290	321	303	319	1747	6616.5	9669.2	3.8	5.5
Cedar (NY)	North Yorkshire	ACUTE	429	439	404	421	418	423	2534	7463.3	13002.1	2.9	5.1
Ward 15	North Yorkshire	ACUTE	353	357	344	352	362	358	2126	6475.4	9264.3	3.0	4.4
Bilsdale	Teesside	ACUTE	507	520	429	514	574	549	3093	7785.1	10031.3	2.5	3.2
Bransdale	Teesside	ACUTE	282	285	387	417	385	476	2232	8069.4	9328.5	3.6	4.2
Overdale	Teesside	ACUTE	317	230	336	444	411	443	2181	7442.6	9754.0	3.4	4.5
Stockdale	Teesside	ACUTE	541	570	495	511	540	540	3197	8118.5	9654.2	2.5	3.0
Ebor Ward	York and Selby	ACUTE	295	313	318	360	353	380	2019	7165.1	8951.3	3.5	4.4
Minster Ward	York and Selby	ACUTE	270	342	275	327	321	336	1871	7387.8	9637.9	3.9	5.2
Bek-Ramsey Ward	Durham & Darlington	ALD	178	189	138	157	150	165	977	5980.8	17979.3	6.1	18.4
Aysgarth	Teesside	ALD	110	121	123	136	118	130	738	4650.2	8457.1	6.3	11.5
Bankfields Flats	Teesside	ALD	108	110	97	93	90	93	591	3681.8	8405.5	6.2	14.2
Bankfields Unit 2	Teesside	ALD	125	132	135	149	138	140	819	5502.8	9625.5	6.7	11.8
Bankfields Unit 3	Teesside	ALD	62	62	56	62	60	71	373	3183.1	10642.3	8.5	28.5
Bankfields Unit 4	Teesside	ALD	124	118	112	124	120	129	727	3891.7	8527.8	5.4	11.7
The Lodge	Teesside	ALD	31	31	28	31	30	31	182	4009.0	4821.9	22.0	26.5
Oak Rise	York and Selby	ALD	149	138	91	93	108	126	705	7891.4	14480.8	11.2	20.5
Holly	Durham & Darlington	CLD	38	36	42	55	55	64	290	3520.0	4791.9	12.1	16.5
Talbot Direct Care	Durham & Darlington	CLD	31	31	28	31	30	0	151	2884.9	2574.8	19.1	17.1
Baysdale	Teesside	CLD	109	122	102	123	119	121	696	5370.2	9467.3	7.7	13.6

Birch Ward	Durham & Darlington	EATING DISORDERS	361	336	352	343	360	402	2154	6556.5	13831.0	3.0	6.4
Clover / Ivy	Forensics	FLD	310	310	280	310	298	310	1818	7241.9	18957.2	4.0	10.4
Eagle / Osprey	Forensics	FLD	141	145	139	131			556	3773.0	6960.5	6.8	12.5
FLD Eagle ASD	Forensics	FLD					30	31	61	2083.4	2170.5	34.2	35.6
Harrier / Hawk	Forensics	FLD	310	301	252	295	300	305	1763	6946.5	19529.8	3.9	11.1
Kestrel / Kite.	Forensics	FLD	424	419	392	421	480	494	2630	6796.8	18653.6	2.6	7.1
Langley	Forensics	FLD	182	160	123	128	150	151	894	6132.9	6521.5	6.9	7.3
Northdale Centre	Forensics	FLD	372	363	326	372	360	403	2196	7169.3	23093.1	3.3	10.5
Oakwood	Forensics	FLD	183	186	168	215	240	248	1240	6313.7	5404.4	5.1	4.4
Thistle	Forensics	FLD	155	155	140	148	150	155	903	6014.4	11273.0	6.7	12.5
Willow Ward	Durham & Darlington	HD REHABILITATION	352	356	332	384	352	326	2102	6613.3	10890.1	3.1	5.2
Kirkdale	Teesside	LOCKED REHAB	348	299	275	392	439	466	2219	6527.8	12010.0	2.9	5.4
Primrose Lodge	Durham & Darlington	LT COMPLEX / CONTINUING CARE	368	416	388	385	379	402	2338	6445.7	9501.6	2.8	4.1
The Orchards (NY)	North Yorkshire	LT COMPLEX / CONTINUING CARE	220	233	261	284	235	221	1454	7615.5	5189.3	5.2	3.6
Lustrum Vale	Teesside	LT COMPLEX / CONTINUING CARE	476	451	420	511	539	572	2969	7907.1	9827.0	2.7	3.3
Brambling	Forensics	LOW SECURE	399	402	364	392	373	375	2305	7106.9	11975.9	3.1	5.2
Jay Ward	Forensics	LOW SECURE	131	139	116	77	143	145	751	6867.0	10841.0	9.1	14.4
Lark	Forensics	LOW SECURE	491	520	476	527	510	525	3049	6902.6	9646.0	2.3	3.2
Mallard	Forensics	LOW SECURE	403	391	337	387	390	403	2311	7527.0	14361.0	3.3	6.2
Newtondale	Forensics	LOW SECURE	569	552	507	603	597	619	3447	9020.7	15105.5	2.6	4.4
Linnet Ward	Forensics	MEDIUM SECURE	511	513	461	527	510	527	3049	6682.6	10563.5	2.2	3.5
Mandarin	Forensics	MEDIUM SECURE	465	465	436	465	450	441	2722	6979.4	16631.6	2.6	6.1
Merlin	Forensics	MEDIUM SECURE	300	299	252	284	283	303	1721	9897.3	17332.7	5.8	10.1
Nightingale	Forensics	MEDIUM SECURE	470	478	419	476	464	465	2772	6502.4	9927.3	2.3	3.6
Sandpiper Ward	Forensics	MEDIUM SECURE	244	232	224	248	240	248	1436	8840.0	15623.2	6.2	10.9
Swift Ward	Forensics	MEDIUM SECURE	288	293	280	310	300	310	1781	7082.3	11749.0	4.0	6.6
Ceddesfeld	Durham & Darlington	OLDER ADULTS - ACUTE	371	440	313	454	445	426	2449	6992.8	13355.0	2.9	5.5
Hamsterley	Durham & Darlington	OLDER ADULTS - ACUTE	327	364	355	354	435	270	2105	6962.2	14531.7	3.3	6.9
Oak Ward	Durham & Darlington	OLDER ADULTS - ACUTE	400	391	329	314	324	368	2126	6265.8	9631.9	2.9	4.5

Roseberry Wards	Durham & Darlington	OLDER ADULTS - ACUTE	361	363	235	259	354	330	1902	7306.1	8865.5	3.8	4.7
Rowan Lea	North Yorkshire	OLDER ADULTS - ACUTE	376	483	442	517	502	543	2863	8781.1	14881.0	3.1	5.2
Rowan Ward	North Yorkshire	OLDER ADULTS - ACUTE	419	253	156	339	477	496	2140	7626.1	10123.2	3.6	4.7
Ward 14	North Yorkshire	OLDER ADULTS - ACUTE	250	245	249	241	262	245	1492	6732.2	8186.3	4.5	5.5
Westerdale North	Teesside	OLDER ADULTS - ACUTE	556	609	497	504	440	557	3163	9616.0	12192.2	3.0	3.9
Westerdale South	Teesside	OLDER ADULTS - ACUTE	248	320	379	394	365	448	2154	9898.7	33207.6	4.6	15.4
Acomb Garth	York and Selby	OLDER ADULTS - ACUTE	428	417	391	412	407	420	2475	9155.6	26043.0	3.7	10.5
Cherry Tree House	York and Selby	OLDER ADULTS - ACUTE	540	537	464	450	536	565	3092	7687.2	13317.0	2.5	4.3
Meadowfields	York and Selby	OLDER ADULTS - ACUTE	220	223	200	181	232	385	1441	6881.4	12600.5	4.8	8.7
Springwood	North Yorkshire	OTHER SPECIALIST MENTAL HEALTH BEDS	260	231	195	167	174	217	1244	7537.3	13046.7	6.1	10.5
Cedar	Durham & Darlington	PICU	247	144	218	144	248	283	1284	11838.5	14795.3	9.2	11.5
Bedale Ward	Teesside	PICU	200	103	104	145	215	187	954	9089.8	16818.1	9.5	17.6
Newberry Centre	Teesside	TIER 4	355	342	225	194	214	330	1660	12549.2	17219.3	7.6	10.4
The Evergreen Centre	Teesside	TIER 4	489	480	426	455	439	448	2737	13465.0	17410.5	4.9	6.4
Westwood Centre	Teesside	TIER 4	233	261	244	353	343	289	1723	13216.6	22094.2	7.7	12.8
Harland Rehab Ward	Durham &Darlington		31	31	28	31	30	31	182	4577.7	8550.3	25.2	47.0
Thornaby Road	Teesside		155	155	140	155	150	155	910	3002.5	8567.4	3.3	9.4

Care Hours per Patient Day

Appendix 7



Item No 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**19th July 2018**
TITLE:	**To consider the trust's 2018 Workforce Race Equality Standard 2018 submission and associated action plan.**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Consultation and 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 trust is required to publish its latest Workforce Race Equality Standard (WRES) information set (2017/18) by 28.9.18 following ratification by its Board of Directors.

As part of the trust's 2016/17 WRES action plan research was undertaken with BAME staff to gain further insight into the differences in outcomes and experiences for this group of staff compared to white staff. A full report on the research was discussed at EMT in April 2018 and key points are summarised in this paper.
The Resources Committee supported the publication of the WRES action plan at its meeting on 12th July 2018.

Recommendations:

- The Board is asked to ratify the publication of the WRES and associated action plan as required by NHS England.
- The Board is asked to note the key points of research carried out into differences in experience and outcomes for BAME staff compared to white staff

MEETING OF:	**Board of Directors**
DATE:	**19th July 2018**
TITLE:	**To consider the trust's 2018 Workforce Race Equality Standard 2018 submission and associated action plan.**

1.0 INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Board of Directors with the trust's latest WRES information set (2017/18) and its associated action plan for ratification prior to publication and to advise the Board of the key findings of research undertaken with BAME staff as part of the trust's 2016/17 WRES action plan.

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The Trust is required to publish its latest WRES information set (2017/18) and associated action plan by 28.9.18 following ratification by the Board of Directors.

2.2 As part of the trust's 2016/17 WRES action plan research was undertaken with BAME staff to gain further insight into the differences in outcomes and experiences for this group of staff compared to white staff. A full report on the research was discussed at EMT in April 2018 the key points of which are summarised in this paper. Many of the suggestions for improvement made by participants in this research have been included in the 2017/18 action plan.

3.0 KEY ISSUES:

3.1 Appendix 1 includes the latest TEWV WRES information that has been provided by NHS England and a copy of the draft TEWV action plan produced in response to this information.

3.2 There has been a slight deterioration in indicator 2 and significant deterioration in indicator 7. Both of these indicators relate to recruitment and promotion processes and outcomes. The key issues in relation to these indicators are:

- Some detailed analysis has shown that there seems to be a disparity in the likelihood of BAME staff obtaining secondment/ acting up opportunities. As suggested in the research, work is to be undertaken to formalise the acting up/ secondment process.
- The BAME leadership course described in relation to indicator 1 ran in May and June and received extremely positive feedback from participants a number of whom are exploring further career development opportunities as a result of the course.

It is hoped the actions for indicators 1 and 2 and 7 will result in more equitable distribution of BAME staff throughout all bands and fairer access to carer progression and promotion opportunities.

3.3 The likelihood of BAME staff entering disciplinaries has increased this year. Due to the small number (under 10) detailed analysis of the context and reasons for these disciplinaries is to be undertaken.

3.4 Work is already underway to address indicator 5 (percentage of staff experiencing, bullying, harassment or abuse from patients, relatives or the public in the last 12 months). A procedure to address abuse of staff by patients, carers and relatives is currently out for consultation. This procedure will sit under the Person Centred Behaviour Support policy.

3.4.1 Significant support for this approach was shown in the research that was carried out and during the consultations that have taken place with staff. Consultation has included attendance and discussion at leadership and management network meetings, senior leadership meetings, Board of Directors, EMT, JCC, SMSC meetings and the Recovery team. The formal consultation period is due to end on 24th July. Following this the procedure will be amended as necessary and ratified.

3.4.2 To support the implementation of the procedure a series of training sessions for all modern matrons and locality managers/ deputy managers are planned during 2018/19. The provision of this training will help to raise awareness of this important issue and provide participants with more knowledge and confidence to feel better able to take actions in response to reports of abuse in line with the trust's commitment to person centred positive behavioural support.

3.5 There has been a significant deterioration in the results for indicators 6 (bullying harassment and abuse from staff in the last twelve months) and 8 (experiencing discrimination at work from any of the following: manager/ team leader or other colleagues

. BAME respondents to the research questionnaire also reported harassment, bullying and abuse from other staff, including managers, some of which had an implicit or explicit racial element. Respondents strongly supported the development of a stand-alone bullying and harassment resolution policy and its robust implementation. This policy was ratified by JCC on 3rd July 2018.

4.0 IMPLICATIONS:

4.1 **Compliance with the CQC fundamental Standards:**
It is a requirement of the CQC that the Trust publishes its WRES and associated action plan.

4.2 **Financial/Value for Money:**
Financial penalties can be incurred for non- compliance with the legislative requirements of the Equality Act. This may result in reputation loss for the Trust. The WRES supports the trust in meeting its duties under the Equality Act.

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

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

4.5 **Other implications:**
None have been identified.

5.0 RISKS:

5.1 There is a risk of reputational damage if TEWV does not work to improve the experience and outcomes of BAME staff when compared to white staff. Such information could impact upon the ability of TEWV to recruit and retain staff.

6.0 CONCLUSIONS:

6.1 The latest TEWV WRES information includes both positive and negative changes when comparing 2017/18 information with that of the previous year.

6.2 A number of actions which it is hoped will lessen the differences between BAME and white staff have already commenced.

7.0 RECOMMENDATIONS:

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

7.2 To approve and ratify the trust's 2017/18 WRES and the associated action plan prior to publication.

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

Background Papers:

WORKFORCE RACE EQUALITY STANDARD

2017/2018

making a difference together

	1. Background narrative a. Any issues of completeness of data	
	In relation to Indicator 4 the relative likelihood of BAME staff accessing non-mandatory training and CPD compared to White staff. The Trust doesn't have a process for monitoring requests or approvals for non- mandatory training at present. However the Staff Friends and Family Test does ask a question around access to non-mandatory training and this can be broken down into white and BAME staff for the purpose of this indicator.	
	b. Any matters relating to reliability of comparisons with previous years	
	The national staff survey was once again sent to all staff this year. 123 of those completing it identified as BAME. Last year 101 identified as BAME therefore the increase year on year gives the Trust greater confidence in the results.	
	2. Total numbers of staff a. Employed within this organisation at the date of the report	
	6512	
	b. Proportion of BME staff employed within this organisation at the date of the report	
	4%	
	3. Self-reporting a. The proportion of total staff who have self-reported their ethnicity	
	99.4%	

	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity	
	No	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity	
	The level of self-reporting is very high.	
	4. Workforce data a. What period does the organisation's workforce data refer to?	
	1st April 2017 to 31st March 2018	
	5. Are there any other factors or data which should be taken into consideration in assessing progress?	
	6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.	

WORKFORCE RACE EQUALITY STANDARD

	Indicator.	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Target date and person responsible
	For each of these four workforce indicators, compare the data for White and BME staff.					
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	detailed breakdown of staff 2018.docx	Detailed staff breakdown Race2.do	The percentage of BAME in the trust is affected by the large numbers of medical staff who are from BAME backgrounds. There are no BAME staff in Bands 8b, 8d and 9 for both clinical and non-clinical staff. For non- clinical staff there are no BAME staff in bands 8b and above. There has been an increase in the percentage of BAME staff in bands 5, 6 and 7.	1. To evaluate and subject to the outcome to continue to run the BAME Leadership Programme for Bands 5 – 7. 2. Please refer to the work that is to be done on improving likelihood of recruitment. 3. To publicise and raise awareness of senior BAME leaders within TEWV. 4. Invite BAME staff within each locality to meet the chairman.	Q 2 and again in Q4 Q2, Q3, Q4 Q4
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.6 times more likely to be appointed from shortlisting compared to BAME staff.	White staff are 1.32 times more likely to be appointed from shortlisting compared to BAME staff.	There has been a slight deterioration in this indicator. A review of recruitment decisions where shortlisted BAME job	1. Batch recruitment seems to result in a higher likelihood of BAME staff being appointed so it is suggested that this is used wherever possible. 2. It is suggested that	Q1-Q4 Q3

				applicants were not appointed to posts during a three month period has been undertaken. There seems to be a disparity in the likelihood of BAME staff obtaining secondment/acting up opportunities.	work be undertaken with BAME staff at bands 7 and 8a to understand why they are not progressing to higher bands. 3. Formalising the acting up/secondment may encourage more staff from the BAME community to apply. The procedure could also ensure that an appropriate closing date is applied to each post as this again may encourage more BAME staff to apply and remove the stigma that 'the appointing manager already knows who they wish to appoint' which is usually attached with posts with shorter deadlines. 4. To review the content of recruitment and selection training to ensure it addresses issues of bias. 5. To review values based recruitment questions and to publicise feedback that 'wildcard' questions are sometimes being asked inappropriately. To	Q4 Q3 Q3

					strengthen guidance on 'wildcard' questions. To consider randomly sampling interviews and to introduce questions that highlight bias during interview. 6. To publish information about recruitment of internal and externally appointed candidates and communicate the issue of perceived bias throughout the trust.	Q4
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from ta two year rolling average of the current year and the previous year.	BAME staff are 2.59 times more likely to enter the formal disciplinary process than white staff.	BAME staff are 2.08 times more likely to enter the disciplinary process than white staff.	BAME staff are more likely to enter the disciplinary process than white staff. This indicator has worsened during the past year.	1. To examine in detail the context and reasons for disciplinaries undertaken on BAME staff and in particular any processes that have gone on to address behaviour earlier. .	Q3 & Q4
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	White staff are 1.20 more likely to access non- mandatory training and CPD compared to BAME staff.	White staff are 1.15 times more likely to access non-mandatory training and CPD compared to BAME staff	This year information for this indicator has been taken from a response to a question in the staff FFT as the trust has no other way of recording this information at present. The results show that white staff	No action is to be taken on this indicator	

				are slightly more likely to access non- mandatory training and CPD compared to BAME staff		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.					
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White: 28% BAME: 34%	White: 28% BAME: 37%	The difference between the experience of white and BAME staff has improved and there has been a 3% reduction in 2017. This difference is mirrored in incidents recorded on DATIX. The trust is concerned at the high levels of all staff who experience harassment, bullying or abuse from patients, relatives or the public	1. The Trust is developing a procedure for addressing verbal abuse of staff by patients and for supporting staff. Extensive consultation has been undertaken and a draft guidance document is to go to BOD in July 2018. 2. This will be followed up by training for managers in how to implement the procedure. 3. A statement outlining the trust's position on verbal abuse of staff is being developed with the support of the chairman and CEO and once completed this will be displayed throughout the trust. .	Q2 Q4 Q3

6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White: 19% BAME: 29%	White: 17% BAME: 19%	The gap between BAME and White staff's experience of bullying, harassment and abuse has unfortunately increased by 10%. The experiences of White staff have also decreased but by a lesser figure.	1. Develop a Bullying and Harassment Resolution Policy. This is underway and will be completed July 2018. 2. BAME members of staff will be recruited as dignity at work champions. 3. Offer more 'mediation' training to staff and encourage BAME to be involved.	Q3 Q4
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion.	White: 91% BAME: 80%	White: 94% BAME: 94%	There is a significant deterioration in the reported experience of BAME staff compared to 2016 and against the experiences of white staff.	1.To raise awareness of the tie breaker provision of the Equality Act and to include this in recruitment training. 2.To explore National Staff Survey results to identify hotspots. (Please also see actions for metrics 1, 2 and 3)	Q2 Q4 Q4
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	White: 6% BAME: 18%	White: 5% BAME: 3%	BAME staff are more likely to have experienced discrimination at work from manager/ team leader or other colleagues. The results for BAME staff in relation to this indicator have worsened in the last year	Please refer to actions for metric 6.	

	Board representation indicator: For this indicator, compare the difference for White and BME staff.					
9.	Percentage difference between the organisations' Board voting, non-voting membership and NEDs and its overall BAME workforce.	Percentage difference between the Board voting membership and its overall BAME workforce is +8.5% The Percentage difference between the Board's non- voting membership and NEDs and its overall BAME workforce is -4%	Percentage difference between the organisations' BAME Board voting membership, non-voting membership and NEDs and its overall BAME workforce is -4.0%	There have been changes to the voting and executive membership of the Board.	No action is to be taken on this indicator.	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

DETAILED STAFF BREAKDOWN RACE

Band	Clinical	Non- Clinical
	BAME	BAME
1	0%	2%
2	9%	2%
3	2%	1%
4	2%	1%
5	5%	6%
6	2%	1%
7	1%	1%
8a	1%	4%
8b	0%	0%
8c	1%	0%
8d	0%	0%
9	0%	0%
VSM	0%	0%
Of which Medical and Dental		
Consultants	37%	0%
Senior Medical Manager	33%	0%
Non- consultant career grade	48%	0%
Trainee grade	40%	0%
Total (including medics)	4%	1%
Total excluding medics	2%	1%

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

DETAILED STAFF BREAKDOWN RACE

Band	Clinical	Non- Clinical
	BAME	BAME
1	0%	0%
2	7%	3%
3	2%	1%
HCA Framework	6%	0%
4	4%	2%
5	5%	3%
6	2%	0%
7	3%	0%
8a	4%	5%
8b	0%	0%
8c	2%	0%
8d	0%	0%
9	0%	0%
VSM	0%	0%
Of which Medical and Dental		
Consultants	40%	0%
Senior Medical Manager	22%	0%
Non- consultant career grade	58%	0%
Trainee grade	37%	0%
Total	5%	1.6%
Total excluding medics	2%	1.6%

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO.8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**19th July 2018**
TITLE:	**Update on Gender Pay Gap Report**
REPORT OF:	**Director of Human Resources and Organisational Development**
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:

This report provides Directors the findings of initial analysis undertaken associated with the TEWV Gender Pay Gap Report that was published in April 2018. Following the publication of the report it was agreed further analysis would be undertaken to better understand the data being presented. The report at appendix 1 provides the analysis to date undertaken to date and highlights some areas where further work could be needed.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**19th July 2018**
TITLE:	**Update on Gender Pay Gap Report.**

1. INTRODUCTION & PURPOSE:

1.1 This report provides Directors with the initial findings following analysis of information within the TEWV Gender Pay Gap report that was published in April 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Trust was required to publish information outlining details of any gender pay differences that exist within the organisation. A report was produced based on a snapshot at 31st March 2017. The report was received for consideration by the Board of Directors in March 2018. Following the publication of the report further analysis has been undertaken to better understand what the information may be highlighting.

3. KEY ISSUES:

3.1 **Appendix 1** shows the details of the analysis undertaken and provides a breakdown of issues considered and recommendations for further work.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

4.1.1 The report will provide evidence to support the Trust is striving to meet the requirements of the CQC Fundamental Standards.

4.2 Financial/Value for Money:

4.2.1 No specific implications have been identified.

4.3 Legal and Constitutional (including the NHS Constitution):

4.3.1 No implications have been identified at this time.

4.4 Equality and Diversity:

4.4.1 The publication of the Gender Pay Gap report enabled the Trust to comply with the requirements of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

4.5 Other implications:

4.5.1 No other implications have been identified at this time

5. RISKS:

No specific risks have been identified.

6. CONCLUSIONS:

6.1 The analysis undertaken to date highlights the primary reason for the difference in the gender pay is attributable to the pay systems in operation. The national systems in operation both include a recognition and reward associated with length of service and experience by awarding an annual pay increment. Changes to the new Agenda for Change pay agreement will see incremental progression more closely aligned to individual performance and appraisal.

6.2 Work is ongoing in relation to analysing and gaining an understanding of any specific areas we may wish to focus on linked to Medical Staffing which is likely to result in the development of an action plan.

6.3 One of the aims of the statutory Gender Pay reporting requirements is to highlight the important issue of differences in pay related to gender and to encourage employers to highlight any actions they may wish to focus on to eliminate any barriers which may prevent females from reaching their full potential. A number of actions have been identified within the report which Directors may wish to further explore.

7. RECOMMENDATIONS:

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

Beverley Vardon-Odonkor
Head of HR and Workforce Assurance

Appendix 1

GENDER PAY GAP REPORT ANALYSIS

1.0 Introduction

The Trust was required to publish information outlining details of any gender pay differences that exist within the organisation. A report was produced based on a snapshot at 31st March 2017. The report was received for consideration by the Trust Board. Following the publication of the report further analysis has been undertaken to better understand what the information may be highlighting.

2.0 Background

The report highlighted the mean gender pay gap and median gender pay gap for all staff, those employed on Agenda for Change and Medical and Dental terms. The table below highlights the mean and median gender pay gap:-

	All Staff	Agenda for Change	Medical & Dental
Mean Gender Pay Gap	14.9% <than males equating to £2.61 per less	7.25% <than males equating to £1.21 per hour less	11.79% <than males equating to £5.08 per hour less
Median Gender Pay Gap	9.34% <than males equating to £1.36 per hour less	5.47% <than males equating to 0.75p per hour less	6.84% <than males equating to £2.99 per hour less

3.0 Analysis

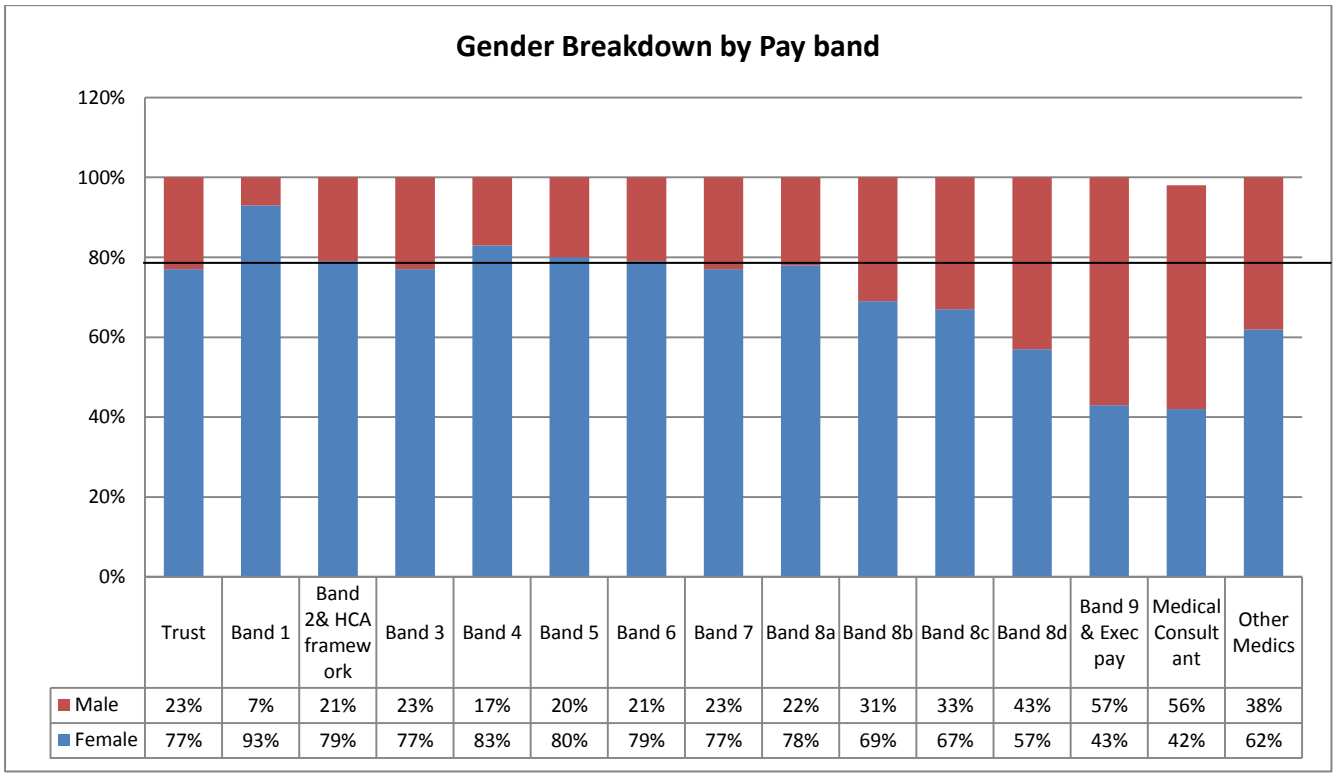
Analysis has been undertaken to understand the difference in pay reported for those staff employed on Agenda for Change terms and Medical and Dental terms. A random sample of female and male pay for each band was undertaken and the reasons for the difference in pay is attributable to the length of time in post in line with the terms and conditions.

The Gender Pay report included details of Clinical Excellence Awards made to Consultants employed on national Medical and Dental terms and conditions. The awards recognise individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role and are part of the commitment to the continuous improvement of the NHS. The table below provides a summary of the findings:-

Mean CEA Gender Pay Gap	34.66% <than males
Median CEA Gender Pay Gap	35.32% <than males

The process for considering and awarding Clinical Excellence Awards operating in the Trust is considered to be robust with particular attention being given to ensuring fairness and equity from an equality and diversity perspective. Applications for Clinical Excellence awards are historically awarded for a number of consecutive years and there are a number of possible reasons for the reported differences. A bespoke report focussing on Medical Staffing gender pay is in development which will help to understand the reasons and ultimately enable an action plan to be developed to help reduce the gender pay differences.

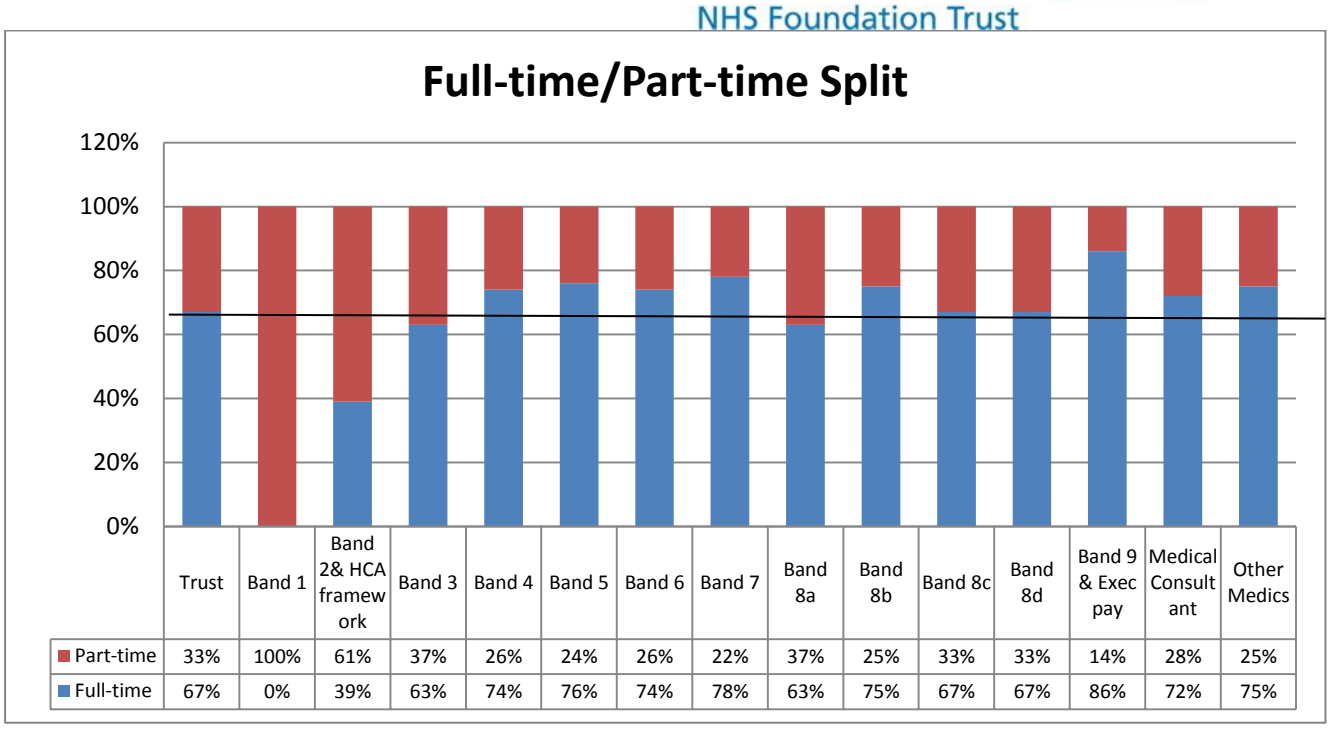
The graph below provides a breakdown by gender by pay band. The Trust gender breakdown is 77% female and 23% male. The majority of bands between 2 – 8a are representative of the Trust gender breakdown. Approximately 50 members of staff are employed in domestic positions on band 1 who are primarily female. It is clear to see the from pay band 8b and above the female gender pay representative distribution reduces.



	Trust	Band 1	Band 2& HCA framework	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultant	Other Medics
Male	23%	7%	21%	23%	17%	20%	21%	23%	22%	31%	33%	43%	57%	56%	38%
Female	77%	93%	79%	77%	83%	80%	79%	77%	78%	69%	67%	57%	43%	42%	62%

The 2017 National NHS Staff Survey reports that **93% of females (2330) believed the organisation provided equal opportunities for career progression.** Over recent years the Trust has invested in the development of a new appraisal system which includes the opportunity to participate in a talent management conversation. The focus of the talent management conversation is to allow individuals to spend protected time considering how they would like their career to develop and also highlights any personal development needs the individual may have. The information is held centrally and helps the organisation to effectively manage succession planning. **93% of female respondents** to the survey indicated they had participated in an appraisal in the preceding 12 months.

Analysis has been undertaken to consider the breakdown by band between full-time and part-time staff. The graph highlights 67% of staff work full-time and 33% work part-time. Interestingly pay bands 8a, 8c and 8d are representative of the breakdown at Trust level.



	Trust	Band 1	Band 2& HCA framework	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultant	Other Medics
Part-time	33%	100%	61%	37%	26%	24%	26%	22%	37%	25%	33%	33%	14%	28%	25%
Full-time	67%	0%	39%	63%	74%	76%	74%	78%	63%	75%	67%	67%	86%	72%	75%

The 2017 National NHS Staff Survey highlighted that 60% of females (2330) indicated they were satisfied with opportunities for flexible working patterns. Flexible working is recognised to be one of the key initiatives to positively impact on retention of staff. A review of the current procedure for considering requests for flexible working has been undertaken and a revised procedure is currently out for consultation. The revised procedure will include information being collated centrally which will enable the Trust to monitor the number of requests being received, approved and not approved.

This is an area where we may wish to undertake further analysis to better understand whether lack of flexible working opportunities are impacting on the career plans of female staff. At any one time there are approximately 150 females on maternity leave and up to 20 members of staff are taking a career break, the majority of whom are female. There is an opportunity to capture information from females returning from maternity leave and career breaks to better understand the challenges faced from balancing caring responsibilities and career aspirations.

The majority of vacancies requiring cover for a full-time post are advertised on that basis and the Trust may wish to proactively promote opportunities for job sharing. Analysis undertaken for the Annual Publication of Staff Equality Data – 1st April 2017 – 31st March 2018 highlighted females are 1.1 more likely to be appointed once shortlisted than males. A review of current recruitment practices to ensure females are not indirectly being discriminated against is another action we may wish to consider. Training on unconscious bias is provided as part of the Trust recruitment training package but we may wish to consider whether there is more we can do to proactively promote training in this topic.

FOR GENERAL RELEASE **ITEM 9**

BOARD OF DIRECTORS

DATE:	**19TH JULY 2018**
TITLE:	**REVISED LEADERSHIP AND MANAGEMENT DEVELOPMENT STRATEGY 2018 - 2022**
REPORT OF:	**DAVID LEVY DIRECTOR OF HR AND OD**
REPORT FOR:	**For Approval**

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

Executive Summary:

Expectations of leaders and managers have changed since the previous strategy was developed in 2010. A revised strategic approach to leadership and management development is required to align behaviours to Trust strategies. This approach has been developed in consultation with a wide range of stakeholders and follows the Trust strategic guidance.

Recommendations:

To approve the revised strategy

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**19 JULY 2018**
TITLE:	**REVISED LEADERSHIP AND MANAGEMENT DEVELOPMENT STRATEGY 2018 - 2022**

1. INTRODUCTION AND PURPOSE:

1.1 The current leadership and management development strategy was published in 2010. Since 2010 there has been a significant shift in the environmental challenges the Trust faces that increase expectations of leaders and managers in TEWV.

1.2 In addition the Trust has introduced a number of key strategies such as the Recovery Strategy, the Workforce Strategy and the Equality and Diversity strategy that have also informed our view about how leaders and manager need to carry out their role in the future

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Consultation about this strategy began in late 2016. It has involved a wide range of groups and perspectives including leadership and management networks, departments delivering leadership and management development training, the equality and diversity team and the BAME special interest group and the recovery programme.

2.2 Versions of the strategy have been presented at EMT with a number of Directors being actively involved in ensuring this strategy meets the needs of the Trust

2.3 The strategy follows the Trust strategic guidance

3. KEY ISSUES:

3.1 There is variation in team performance across the Trust that cannot be explained by resourcing alone. For the Trust to maintain its overall good performance in relation external audits of leadership and management a new strategic approach to leadership and management is required.

3.2 Approval of this strategy will enable decisions about recruitment, retention, performance management of all clinical and corporate leaders and managers to be aligned.It will enable gaps in development programmes to be addressed. It will enable the Trust to deliver its vision, mission and strategic goals.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** none

4.3 **Legal and Constitutional (including the NHS Constitution):** none

4.4 **Equality and Diversity:** this strategy is supportive of the Trust approach to equality and diversity

4.4 **Other implications:** Lack of alignment of the behaviours of leaders and managers to our vision, mission and strategic goals will lead workforce communication and engagement issues.

5. RISKS: none

6. CONCLUSIONS:

6.1 The current Trust strategy was published in 2010 and no longer meets the needs of the Trust. This strategy has been produced in consultation and following the Trust strategy guidance.

7. RECOMMENDATIONS: To approve the revised strategy

Author: **Michelle Brown**
Title: **Head of Organisational Development**

Background Papers:

Leadership and management strategy

2018 to 2022

Strategy Sponsor: **David Levy Director of Human Resources and Organisational Development**		
Strategy Lead: **Michelle Brown Head of Organisational Development**		
Version: **V9**	**Date approved**	**Date of Next Review:**

Executive summary

In order to meet the vision, mission and strategic goals of the Trust, a revised leadership and management development strategy 2018 to 2022 is required. In an increasingly challenging environment the behaviours of leaders and managers will impact on the delivery of all the Trust's strategic goals and strategies. This strategy places the emphasis on leaders and managers creating a culture to support the achievement of the Trusts Strategic Goal 3 'To recruit, develop and retain a skilled, compassionate and motivated workforce'.

This means that we are an excellent employer by

- Promoting a culture where our staff feel engaged and valued
- Ensuring all our staff work in line with the Trust values, behaviours and compact
- Promoting and supporting the health and wellbeing of our staff
- Ensuring we have effective leadership and management throughout the organisation
- Providing appropriate education, training, development and leadership opportunities for all staff
- Providing high quality placements for student health care professionals and trainees as the future workforce

Current results of inspections, external audits and staff surveys place TEWV in a good position. This strategy will help TEWV to maintain that good position by taking advantage of best practice, understanding what needs to addressed and setting clear goals.

Our strengths relate to; high levels of engagement, being recognised nationally for quality improvement, a strong history of providing and accessing leadership and management development programmes and a framework for appraisal and talent management that offers all staff the opportunity to reach their potential. Our challenges include; having the right number of leaders and managers with the core skills needed to successfully deliver the complex, strategic changes required, having leaders and mangers that represent the diversity of the organisation and addressing the variation in leaders and managers collective ability to deliver truly recovery focussed services.

The environmental analysis highlights; the importance of health and social care in meeting the needs of the person, an increasing transparency about performance whilst ensuring concerns are raised and responded to, the need to embed equality at all levels and the importance of high quality leadership and management in delivering sustainable services.

This strategy replaces the previous strategy published in 2010. To achieve strategic goal 3 the ambition of this strategy is to have leaders and managers who understand their shared responsibilities, make best use of the tools and resources available, they continuously develop themselves and those they work with to meet the needs of the wider organisation. Four challenging goals describe how we will meet this ambition for leaders and managers by increasing skills and experience, standardising their recruitment and

increasing service user and carer involvement in recruitment processes, increasing diversity in leadership and management posts and role modelling the values, behaviours and staff compact to improve our culture.

Include photo and electronic signature of sponsor at the end of the preface.

For further information on this strategy please contact Michelle Brown, Head of Organisational Development, michellebrown1@nhs.net

Contents

1. Introduction

When leaders and managers create positive, supportive environments for staff, staff then create caring, supportive environments for patients, delivering higher quality care. National best practice has shown where there is a culture of collective leadership, all staff members are likely to raise issues appropriately, contribute to solving problems, learn lessons and strive for responsible, safe innovation. This would increase the likelihood of achieving our vision 'To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations'. It is accepted that leaders and managers skills and behaviours will influence delivery of all our strategic goals, this strategy emphasises the importance of strategic goal 3 in particular, 'To recruit, develop and retain a skilled, compassionate and motivated workforce'. In TEWV a more facilitative, coaching approach to leadership and management will foster continuous learning, leading to increased accountability, autonomy and creativity, where roles and responsibilities may be dynamic but relationships will be honest, respectful, valued, thus ensuring our sustainability and success. Increasingly we will work together to deliver services that improve mental and physical wellbeing and lead to mental ill-health prevention, enhance skills, employability and social inclusion to realise our mission of 'improving people's lives by minimising the impact of mental-ill health or a learning disability' so that we are making a difference together.

2. Current state

TEWV has a CQC overall rating of 'Good' including an overall rating of 'Good' for 'Well Led' and achieved Investors in People (IIP) 'Gold' standard for the second time in succession in 2017. Overall TEWV staff engagement levels, as measured by the annual national staff survey and the three times per year Staff Friends and Family Test, are above average compared to other mental health and learning disability NHS trusts.

However, there are significant variations in team level performance that cannot be explained by resourcing alone. Through this strategy TEWV will ensure a supportive framework is in place to continually develop all leaders and managers to ensure high quality, safe and compassionate healthcare services are provided for all.

Our **STRENGTHS** include:

The National Staff Survey results and number of staff engaging with the staff friends and family test demonstrate that leaders and managers, clinical and corporate, are creating relatively high levels of staff engagement and a proactive approach to low or declining staff survey feedback at team level has been implemented.

There are role models across localities, specialties and professions. our systems for monitoring standards and quality improvement are well established and capabilities of some leaders and managers are well

developed. TEWV is recognised nationally for our approach to Quality Improvement.

There has been significant investment in coaching through the Think-on partnership and it is generating a more collective approach to leadership and management. A broad portfolio of leadership and management development programmes are available and access to these programmes continues to increase.

Appraisal and talent management are seen as essential to ensuring we have the right staffing in our services now and in the future. These processes help to connect teams and individuals to the strategic goals of the organisation and develop people to reach their career goals and potential.

Our CHALLENGES include:

Retention of leaders and managers**,** the age profile of leaders and managers in TEWV means as many as 30% of the current network will be eligible for retirement up to 2022 when the pension regulations change.

Recruitment of future leaders and there is a concern that staff are being promoted without the level of experience and support they need to fulfil their leadership and management responsibilities.

The level of skills and experience of leaders and managers varies potentially resulting in significant differences in the performance levels of some teams.

TEWV needs to increase the percentage of diversity in the Band 7 plus leadership and management network as it is not reflective of the organisation as a whole.

There is increasing concern that supportive processes such as supervision, reflective practice and learning and development are not being maximised which may impact on lower staff engagement and / or reduced health and wellbeing.

The size, geography and complexity of the organisation makes ensuring effective communication of the strategic changes that are required more difficult

We do not have consistency across our current leadership and management teams in having the skills required to deliver truly recovery focused services

3. Environmental Analysis and the drivers for change

The following externally driven issues are expected to have an impact upon delivery of the Trust vision during the next four years:

- Increased importance of delivery of integrated care (both health and social care and physical and mental health care)
- Increased emphasis on transparency of performance including the delivery of outcomes as evidenced by additional performance targets linked to mental health and national publication of mental health dashboards
- Significant shortages of key staff groups including medics, nurses and allied health professionals
- Increased emphasis on creating an open and transparent culture that learns from issues raised by people (patients, carers and staff) and any errors made
- Requirement to truly embed equality at all levels, including leadership, across the NHS and the wider public sector
- Increased recognition that high quality leadership and management is fundamental to delivering sustainable services

3. Gap Analysis

From analysis of the internal and external environment summarised above it has been identified that there are 4 key gaps that the organisation needs to address if we are to make progress against our Strategic Direction and in particular Strategic Goal 3. These are:

- Insufficient number of leaders and managers across the organisation
- Insufficient consistency in the abilities of our leaders and mangers in key leadership skills/competencies
- Need for our leaders and managers to have new skills to successfully lead the workforce in the changing NHS landscape
- Insufficient diversity in our current leaders and managers

4. Overall ambition

TEWV has leaders and managers, clinical and corporate, who understand their shared responsibilities and how to make best use of the tools and resources available to them and their teams. They proactively support continuous development of themselves and those they work with. They understand how their work and their collective leadership fits within the wider organisation.

5. Objectives

To reach our ambition we will:

1. **Continuously increase the % of leaders and managers with the capabilities and experience to enable their teams to deliver high quality care.**

   We will achieve this by:

   - All our programmes will be aligned to the development of core skills TEWV requires for leaders and managers, these core skill are:
     - Understanding of collective and inclusive leadership and management
     - Ability to continuously improve services
     - Ability to continuously develop themselves and others through a coaching approach
     - Live the TEWV values and staff compact
     - Ability to engage staff and patients through participation (ladder of involvement)

- The ability to lead and manage services that are driven and underpinned by the values and principles of a recovery/ wellbeing approach

- Development of a supercell level training programme that will train leaders and managers (and those that aspire to lead and manage) in the core skills required.
- Increasing the diversity of leadership and management development programmes provided to meet the needs of a diverse workforce by working with Equality and Diversity team and the Recovery programme.
- Increasing the number of opportunities for personal development by implementing the locality talent management facilitator role and increasing the number and quality of talent management conversations.
- Increasing the number of leaders and managers trained in Recovery for Leaders (Band 6 plus).
- Annually reviewing the provision of leadership and management development programmes to ensure we are developing the skills required for the delivery of Trust business plans and Strategic Direction
- Maximising the use of the apprenticeship levy for leadership and management development programmes that develop people in the core skills required.

We will know we are achieving this by reporting and improving the:

- % of frontline multi-professional leadership and management teams that have trained in the core skills identified
- % of leaders and managers with 3 or more years-experience in their role

2. Standardise the recruitment processes for all levels of leaders and managers band 7 plus by clarifying the standards for each level and increasing involvement of service users and carers in recruitment processes

We will achieve this by:

- Gaining agreement on the processes for recruiting band 7 leaders and managers involving service users and carers
- Training service users and carers in any additional knowledge and skills required to participate fully in the recruitment process
- Introducing standardised healthcare leadership model profile cards to be used in recruitment processes
- Revising the values based interviewing questions for leaders and managers to include a compulsory question on service user and carer involvement.
- Increasing the number of episodes of recruitment for band 7 plus leaders and managers that involve service users and carers.

- Improving the % of band 7 leaders and managers that attend the new managers 1 day development programme
- Offering Healthcare Leadership Model 360 feedback after 1 year in post for band 7 plus leaders and managers and monitoring uptake

We will know we are achieving this by reporting and improving the:

- % of Band 7 and above leaders and managers that are recruited using the agreed process and standards
- % of recruitment episodes for B7 and above leaders and managers where service users and carers are involved in the recruitment process.

3. Enhance the skills and abilities of leaders and managers to continuously improve services using a coaching approach resulting in reduced variation between teams

We will achieve this by:

- Maximising the partnership with Think-on and building the capability of the Master Coaches and internally accredited coaches.
- Maximising NELA York and Humber Leadership Academy partnerships.
- Developing the internal coaches accreditation programme, (to include the collating of information on the staff trained, tools developed and impact on those involved),
- Integrating the coaching approach into quality improvement activity and organisational development
- Embed coaching skills in everyday practice by creating large scale training opportunities delivered the growing internally accredited coach network
- Linking coaching to providing health and wellbeing support to all
- Develop additional tools to support staff through organisational change and improvement
- Continuing to increase alignment between TEWV business plans and strategy through implementation of team objectives, individual appraisal and talent management
- Supporting a learning culture where service users are listened to and lessons identified from issues and incidents in a positive way
- Integrating the coaching approach into policies and procedures to create a healthy work environment

We will know we are achieving this by reporting:

- %age reduction in the variation of team scores for the national staff survey responses to: “where possible my team solves problems or issues as they arise”

- %age reduction in the variation of team scores to the question "believing it is worth my while suggesting improvements" in the quarterly staff Friends and Family test

4 Increasing the diversity of leaders and managers in TEWV who then act as role models for the Trust values and Staff Compact

We will achieve this by:

- Including the principles of collective leadership and management into relevant job descriptions
- Integrating training and development into the leadership and management development programmes on unconscious bias by working with the equality and diversity team and recovery programme
- Providing training and development programmes for BAME staff that support their personal development to reach their goals and potential.
- Training leaders and managers to be "disability confident" by working with Equality and Diversity team
- Agree how information raised by freedom to speak up guardians and cultural ambassadors will be responded to and resolved
- Improving communication through introduction of a crowdsourcing platform.

We will know we are achieving this by reporting:

- %age of BAME staff and staff with a disability in the leadership and management posts.
- %age improvement in agreed culture metrics.

6. Outcomes Scorecard

Leadership and Management Strategy Scorecard							
Metric		Lead Responsible	Baseline 18/19	Targets			
				19/20	20/21	21/22	Source of data
1.							
1.1	Report and increase the % of frontline multi-professional leadership and management teams that have trained in the core skills identified	Head of Organisational Development (OD)	Establish baseline	40%	60%	80%	Training records OD and KPO
1.2	Report and increase the % of leaders and managers with 3 or more years-experience in their role	Head of Operational HR and workforce assurance	Establish baseline	40%	70%	80%	ESR
2. 2. To standardise the recruitment processes for all levels of leaders and managers band 7 plus by clarifying the standards for each level and increasing involvement of service users and carers in recruitment							
2.1	Increasing the % of Band 7 and above leaders and managers that are recruited based on the agreed process and standards	Head of OD Professional Leads	Establish baseline			80%	Training records KPO, OD and Recovery
2.2	Increasing the % of recruitment episodes for B7 and above leaders and managers where service users and carers are involved.	Head of Operational HR and workforce assurance	Establish baseline			80%	Recruitment data

3. To create a positive working environment by improving the skills and abilities of leaders and managers to continuously improve services using a coaching approach resulting in reduced variation between eligible teams (based on size) at a locality level							
3.2	Teams that say “where possible my team solves problems or issues as they occur”	Staff Survey Lead	Establish baseline				Annual staff survey
3.3	Teams that “believe that it is worth my while making suggestions”	Staff Survey Lead	Establish baseline				Quarterly staff FFT
4. An increasingly diverse group of leaders and managers in TEWV act as role models for the Trust values and Staff Compact to communicate a culture of high quality care as measured by TEWV culture metrics.							
4.1	Increased representation of BAME staff and staff with a disability in the leadership and management networks B7 plus	Head of OD and Equality and Diversity	Establish baseline				ESR
4.2	Improved culture metrics	Head of OD	To be agreed by Q2 18/19				Culture metrics

7. Glossary

Term	Description
Collective leadership	Collective leadership and management identifies the skills and behaviours that will shape our desired culture. Collective leadership implies welcoming feedback, compassionately treating complaints and errors as opportunities for learning, taking responsibility for the success of the organisation as a whole (not just for their own jobs or area), and working together to create positive, supportive environments for staff, who create caring, supportive environments for patients.
Compassionate leadership and management	Paying close attention to the people you lead and manage, understanding the impact of the situations they face, responding empathetically and taking thoughtful actions to help.
Co-production	Where professionals and citizens share power to plan and deliver support together, recognising all parties have vital contributions to make in order to succeed.
Compassion	Noticing suffering, demonstrating empathetic concern and acting to alleviate and helping to make sense of the experience.
Leaders and managers	All clinical and corporate staff that have either formal management, programme or project and /or clinical leadership of other staff and / or students responsibilities

Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

<table>
<tr><td>Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.</td><td colspan="6">Human Resources and Organisational Development Directorate</td></tr>
<tr><td>Name of responsible person and job title</td><td colspan="6">Michelle Brown Head of Organisational Development</td></tr>
<tr><td>Name of working party, to include any other individuals, agencies or groups involved in this analysis</td><td colspan="6">Leadership and management Networks
Equality and Diversity Team and BAME working group
Recovery programme
Medical Education
KPO team
EMT</td></tr>
<tr><td>Policy (document/service) name</td><td colspan="6"></td></tr>
<tr><td rowspan="3">Is the area being assessed a…</td><td>Policy/Strategy</td><td>X</td><td>Service/Business plan</td><td></td><td>Project</td><td></td></tr>
<tr><td colspan="3">Procedure/Guidance</td><td></td><td>Code of practice</td><td></td></tr>
<tr><td colspan="5">Other – Please state</td><td></td></tr>
<tr><td>Geographical area covered</td><td colspan="6">Trust wide</td></tr>
<tr><td>Aims and objectives</td><td colspan="6">TEWV has leaders and managers, clinical and corporate, who understand their shared responsibilities and how to make best use of the tools and resources available to them and their teams. They proactively support continuous development of themselves and those they work with. They understand how their work and their collective leadership fits</td></tr>
</table>

	within the wider organisation. Increased representation of BAME staff and staff with a disability in the leadership and management networks B7 plus Increasing the % of recruitment episodes for B7 and above leaders and managers where service users and carers are involved. Improved culture metrics
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	First version produced Jan 2016
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	July 2018

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
All leaders and managers, clinical and corporate band 7 plus					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Gender** (Men, women and gender neutral etc.)	No

Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

Yes – Please describe anticipated negative impact/s
No – Please describe any positive impacts/s
Strategy objectives is to increase representation of BAME staff and staff with a disability in the leadership and management networks B7 plus
Increasing the % of recruitment episodes for B7 and above leaders and managers where service users and carers are involved.

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	**X**	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports	• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership
Yes – Please describe the engagement and involvement that has taken place
Equality and Diversity Team and BAME working group Recovery programme
No – Please describe future plans that you may have to engage and involve people from different groups

5. As part of this equality analysis have any training needs/service needs been identified?	
Yes	Please describe the identified training needs/service needs below Development of a programme for staff who aspire to leadership or management with a disability Recovery for Leaders Programme Recruitment training for service users and carers to be updated based on the strategy
A training need has been identified for;	

Trust staff	Yes	Service users	Yes	Contractors or other outside agencies	No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
The completed EA has been signed off by: You the Policy owner/manager: Type name: David Levy					Date: 30 June 2018
Your reporting (line) manager: Type name: Angela Collins					Date:15 June 2018
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046					

ITEM NO 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**19 July 2018**
TITLE:	**Annual report on progress on actions arising from Directors' Visits during the period June 2017 to May 2018**
REPORT OF:	**David Brown**
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:

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

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

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**20 July 2018**
TITLE:	**Annual report on progress on actions arising from Directors' visits during the period June 2017 to May 2018**

1. INTRODUCTION & PURPOSE:

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

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

2. BACKGROUND INFORMATION, CONTEXT AND KEY ISSUES:

2.1 At the Board of Directors meeting in May 2013 it was recognised that as this programme of visits had been under way for some considerable period of time it would be worth producing an annual review of actions to provide commentary on the actions undertaken in response to these reports and to provide assurance that these matters were being dealt with accordingly.

2.2 During the past year the visits log, with reports embedded, has been submitted to the Executive Management Team (EMT) on a monthly basis for scrutiny and monitoring. This provides assurance that actions are being followed up.

2.3 The attached log of Directors' visits from June 2017 to May 2018 shows the majority of the actions as green, having been completed. Further details on all the visits can be seen on the visit reports in a reading room on Board Pad.

2.4 Further to the review of the 80+ reports that have resulted from the last 12 months' visits, it is possible for us to identify some recurring themes that are fed back by visiting teams. Recurring issues and trends are very similar to issues raised previously, but specifically:

- Issues relating to Estates and Facilities, minor actions to pick up relating to, eg, unwanted furniture or small works (not always requested formerly or outstanding, but identified during the visit).
- Insufficient or inadequate equipment, particularly IT, smartphones and laptops predominantly.
- The consistency / accuracy / meaningfulness of performance reports and the amount of time taken to validate and verify changes. This has been particularly noticeable in relation to statutory and mandatory

training information, together with the availability of courses, and the ability to book onto courses within timescales for compliance.

3. IMPLICATIONS:

3.1 **Compliance with the CQC Fundamental Standards:**
Addressed in individual actions.

3.2 **Financial/Value for Money:**
Addressed in individual actions.

3.3 **Legal and Constitutional (including the NHS Constitution):**
Addressed in individual actions.

3.4 **Equality and Diversity:**
Addressed in individual actions.

3.5 **Other implications:**
Addressed in individual actions.

4. RECOMMENDATION:

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

David Brown
Acting Chief Operating Officer

LOG OF MONTHLY DIRECTORS' VISITS JUNE 2017 – DECEMBER 2017

	2.00pm – 5.00pm Monday 12/06/17 (Governors included)	2.00pm – 5.00pm Monday 10/07/17	2.00pm – 5.00pm Monday 14/08/17 (Governors included)	2.00pm – 5.00pm Monday 11/09/17	2.00pm – 5.00pm Monday 09/10/17 (Governors included)	2.00pm – 5.00pm Monday 13/11/17	2.00pm -5.00pm Monday 11/12/17 (Governors included)
Team 1 Jennifer and David (L) Hugh Griffiths	**Nightingale Ward** **Address:** Roseberry Park Hospital Middlesbrough	**Pharmacy Team** **Address:** Lanchester Road Hospital Durham	**Acute Liaison Team** **Address:** Bootham Park Hospital York	**IAPT (Whitby)** **Address:** Whitby Hospital	**Lincoln Centre** **Address:** Sandwell Park Hartlepool	**IHTT** **Address:** The Friarage Northallerton	**All Age Wards and Diversion Team** **Address:** Durham Police
Visit Reports	Nightingale Ward	Visit rearranged to 29 September 2017 LRH Pharmacy Team	Liaison Team York	IAPT Whitby	Lincoln Ward, Sandwell Park	Friarage IHHT	D&D Liaison and Diversion Team
Action Updates							
Team 2 David (B) and Elizabeth Jim Tucker (to Aug) Lesley Bessant (from September)	**Esk Ward** **Address:** Cross Lane Hospital Scarborough	**Lustrum Vale** **Address:** Stockton on Tees	**HR Recruitment Team** **Address:** Flatts Lane Middlesbrough	**No visit**	**MHSOP CMHT (Harrogate)** **Address:** Alexander House Knaresborough	**Stockton Affective Team** **Address:** Wessex House Stockton on Tees	**Meadowfields** **Address:** York
Visit Reports	Danby & Esk Ward	Lustrum Vale	HR Recruitment Team		MHSOP CMHT Alexander House	Stockton Affective Team	**Visit rearranged to 23rd April 2018** Meadowfields, York
Action Updates							

	2.00pm – 5.00pm Monday 12/06/17 (Governors included)	2.00pm – 5.00pm Monday 10/07/17	2.00pm – 5.00pm Monday 14/08/17 (Governors included)	2.00pm – 5.00pm Monday 11/09/17	2.00pm – 5.00pm Monday 09/10/17 (Governors included)	2.00pm – 5.00pm Monday 13/11/17	2.00pm -5.00pm Monday 11/12/17 (Governors included)
Team 3 Adele, Tim and Nick Paul Murphy	**York EIP Service** **Address:** Union Terrace York	**Ryedale Adult CMHT** **Address:** Princess Road Malton	**Bedale Ward** **Address:** Roseberry Park Hospital Middlesbrough	**IAPT** **Address:** Harrogate	**Oak Rise** **Address:** 4-6 Oak Rise York	**RRICE Team** **Address:** Alexander House Knaresborough	**Stockton C&YPS** **Address:** Viscount House Stockton on Tees
Visit Reports	**Visit rearranged to 19 June** York & Selby EIP	**Visit rearranged to 27 November** Ryedale Adult CMHT	Bedale Ward	IAPT Harrogate	Oak Rise	RRICE Team, Alexander House	Stockton C&YPS
Action Updates							
Team 4 Drew and Brent Marcus Hawthorn	**MHSOP Inpatient** **Address:** Meadowfields York	**CAMHS South Durham** **Address:** Acley Centre Newton Aycliffe	**Springwood** **Address:** Malton	**Baysdale Unit** **Address:** Roseberry Park Hospital Middlesbrough	**HMP Holme House Mental Address:** Health Team	**Pharmacy Team** **Address:** Roseberry Park Hospital Middlesbrough	**EIP North Durham** **Address:** Chester-le-Street
Visit Reports	Meadowfields	CAMHS Acley Centre	**Visit rearranged to 10 November** Springwood, Malton	Baysdale Unit	Holme House Prison	Pharmacy Team, RPH	EIP North Durham CLS
Action Updates							
Team 5 Sharon and Levi Richard Simpson	**Affective Team** **Address:** Enterprise house Spennymoor	**Thistle Ward** **Address:** Roseberry Park Hospital Middlesbrough	**CMHT West Adult** **Address:** Colburn Surgery Colburn	**Langley Ward** **Address:** Lanchester Road Hospital Durham	**South of Tees CRHT** **Address:** Foxrush House Redcar	**HMP Durham Mental Health Team** **Address:**	**Stockton Adult LD Community Team** **Address:** Wessex House Stockton on Tees
Visit Reports	**Visit rearranged to 21 Sept** Sedgefield Affective Disorders	Thistle Ward, RPH	CMHT West & AMH AOT H&R	Langley Ward FLD	**Visit rearranged to 23 January 2018** Foxrush House CRHT	HMP Prison, Durham	**Visit rearranged to 20 February 2018** Stockton Adult LD Community Team
Action Updates							

	2.00pm – 5.00pm Monday 12/06/17 (Governors included)	2.00pm – 5.00pm Monday 10/07/17	2.00pm – 5.00pm Monday 14/08/17 (Governors included)	2.00pm – 5.00pm Monday 11/09/17	2.00pm – 5.00pm Monday 09/10/17 (Governors included)	2.00pm – 5.00pm Monday 13/11/17	2.00pm -5.00pm Monday 11/12/17 (Governors included)
Team 6 Ruth (H) and Rob David Jennings	**CAMHS Tier 3** **Address:** Mulberry Centre Darlington Memorial	**Care Home Liaison Team** **Address:** Bootham Park Hospital York	**Secure Outreach & Transitions Team** **Address:** Ridgeway Roseberry Park Hospital Middlesbrough	**SW CMHT (MHSOP) Acomb Garth** **Address:** 2 Oak Rise York	**SW CRHT** Cross Lane **Address:** Scarborough	**NE CMHT Adult** **Address:** Bootham Park York	**MHSOP CMHT Ryedale** **Address:** Malton
Visit Reports	CAMHS Tier 3, Mulberry Centre	Care Home Liaison Team	Secure Outreach & Transititons Team RP	MHSOP Acomb Health Centre	SW CRHT, Cross Lane, Scarborough	NE CMHT Y&S	MHSOP CMHT Ryedale
Action Updates							
Team 7 Patrick and Phil Shirley Richardson	**Affective / Access Team** **Address:** Parkside Middlesbrough	**Primrose Lodge** **Address:** Chester-le-Street	**Stockton Psychosis / EIP** **Address:** Ideal House Stockton	**LD North Long Term Integrated Team** **Address:** Seaham	**Complaints Team** **Address:** Flatts Lane Middlesbrough	**EIP South Durham** **Address:** St Aidan's House Bishop Auckland	**Hartlepool CYPS Team** **Address:** Dover House Hartlepool
Visit Reports	Affective/Access Teams, Parkside	Primrose Lodge	Stockton Psychosis & EIP	LD North Long Term Integrated Team, Sea	Complaints Team	EIP South Durham	Hartlepool CYPS
Action Updates							

LOG OF MONTHLY DIRECTORS' VISITS JANUARY 2018 – MAY 2018

	2.00 pm – 5.00 pm Monday 8/1/2018	2.00 pm – 5.00 pm Monday 12/02/18 (Governors included)	2.00 pm – 5.00 pm Monday 12/03/18	2.00 pm – 5.00 pm Monday 19/04/18 (Governors included)	2.00 pm – 5.00 pm Monday 14/05/18
Team 1 Jennifer, Dominic, David Levy and Hugh Griffiths	**Westerdale North Ward** Sandwell Park Hartlepool	**Adult CRHT** Scarborough	**CAMHS** Middlesbrough	**Mallard Ward** Roseberry Park, Middlesbrough	**Units 3 & 4** Bankfields Court, Normanby
Visit Reports	Westerdale North, Sandwell Park	Scarborough CMHT	CAMHS Forensic Outpatients West Lar	Mallard Ward	Bankfields 3&4
Action Updates					
Team 2 Adele, Ahmad, David Brown and Paul Murphy	**Ward 14** Friarage Hospital Northallerton	**Adult Crisis Team** York	**CAMHS** Scarborough	**Willow Ward** West Park Hospital	**367 Thornaby Road** Stockton
Visit Reports	Ward 14, Friarage	Adult Crisis Team, Peppermill Court, Yorl	CAMHS Scarborough	**Postponed until 21st May due to annual leave** Willow Ward, WPH	ALD Service, 367 Thornaby Road
Action Updates					
Team 3 Patrick McGahon, Sarah, Brent and Marcus Hawthorn	**Ceddesfeld Ward** Auckland Park Bishop Auckland	**Adult IHTT** Harrogate	**CAMHS** North Durham	**Kirkdale Ward** Roseberry Park Hospital, Middlesbrough	**Oakwood** Bell Vue Grove, Middlesbrough
Visit Reports	Ceddesfeld Ward	**Postponed until the 24th April due to annual leave** Harrogate IHTT	**Postponed until 5th June** CAMHS North Durham	Kirkdale Rehab, RPH	Oakwood Forensic Rehab
Action Updates					

	2.00 pm – 5.00 pm Monday 8/1/2018	2.00 pm – 5.00 pm Monday 12/02/18 (Governors included)	2.00 pm – 5.00 pm Monday 12/03/18	2.00 pm – 5.00 pm Monday 19/04/18 (Governors included)	2.00 pm – 5.00 pm Monday 14/05/18
Team 4 Tim, Sharon, Levi and Richard Simpson	**Rowan Ward** Briary Wing Harrogate	**Adult Crisis Team** Darlington & South Durham	**CAMHS** Harrogate	**Primrose Lodge** Chester Le Street	**Talbot Ward** Lanchester Road Hospital, Durham
Visit Reports	 Rowan Ward, Harrogate	 Adult Crisis Team D&SD	 CAMHS Dragon Parade Harrogate	 Primrose Lodge, CLS	 Talbot Ward
Action Updates					
Team 5 Elizabeth, Ruth Hill, Paul Foxton and David Jennings	**Cherry Tree House** York	**Adult CRHT** Lanchester Road Hospital Durham – postponed due to duplication – new date 4.6.18	**CAMHS** Limetrees, York	**Lustrum Vale** Durham Road, Stockton	**Oak Rise** York
Visit Reports	 Cherry Tree House York	 North Durham Adult CRHT	 CAMHS Limetrees York	 Lustrum Vale, Stockton	 Oak Rise, York
Action Updates		ki			
Team 6 Patrick Scott, Phil and Shirley Anne Richardson	**Roseberry Ward** Lanchester Road Hospital Durham	**H & R Adult IHTT** Northallerton	**CAMHS** Easington	**The Orchards** Ripon	**Bek & Ramsey Wards** Lanchester Road Hospital, Durham
Visit Reports	 Roseberry Ward, LRH	 H&R Adult IHTT	 Easington CAMHS	 The Orchards, Ripon	 Bek and Ramsey Wards
Action Updates					

Item 12

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**19 July 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 30 June 2018**
REPORT OF:	**Patrick McGahon, 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:

Following confirmation of the Trust receiving a control total reduction (£1,692k) it was required to submit a revised financial plan to NHS Improvement. This report reflects this update and performance to date and forecast is measured accordingly.

The comprehensive income outturn for the period ending 30 June 2018 is a surplus of £1,760k, representing 2.1% of the Trust's turnover and is £45k ahead of the revised plan.

Performance Against Plan – year to date (3.2)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £45k **ahead** of its year to date financial plan (revised control total).	-45	39	↓

Cash Releasing Efficiency Savings (CRES) (3.3)

Identified CRES schemes for the financial year are £105k **behind** financial plan.	CRES Type	Annual Achieved £000	Movement
	Recurrent	3,826	↑
	Non recurrent	4,311	↑
	Target	8,242	
	Variance	105	↑

Identified CRES schemes for the rolling 3 year period are £14,932k **behind** the £21,000k CRES target.	CRES Type	Annual Variance £000	Movement
	Recurrent	14,932	↓

A Waste Reduction Programme has been established to assist the Trust in delivering the recurrent CRES requirements in full, and a 3 year CRES plan.

Capital (3.4)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £132k ahead **of** its capital plan.	132	-187	↑

The Trust received a capital rebate relating to prior year schemes (£2,289k), with this included, capital expenditure is £2,166k behind plan.

Workforce (3.5)

	Variance £000	Movement £000	Movement
The Trust is currently £353k (24%) **in excess of** its agency cap.	353	121	↓

Agency expenditure in quarter 1 has been consistent each month in both value and service usage.

Use of Resources Risk Rating (UoRR) (3.7)

	Plan	Actual	Movement
The Trust is currently **achieving** its planned UoRR which is rated 1 to 4 with 1 being good.	3	3	0 →
The Trust is forecasting to **achieve** its planned UoRR at the financial year end.	1	1	0 →

Recommendations:

The Board of Directors is requested to:

- note the financial position at the end of quarter 1;
- approve the submission of the NHS Improvement quarter 1 return in accordance with the results detailed in this report.

MEETING OF:	**Board of Directors**
DATE:	**19 July 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 30 June 2018**

1. INTRODUCTION & PURPOSE:

1.1 This report sets out the financial position for 1 April 2018 to 30 June 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to monitor the Trust's key financial duties and performance indicators which are both statutory requirements.

2.2 NHS Improvement's Use of Resources Rating (UORR) evaluates Trusts based on ability to service debt, liquidity, I&E margin, achievement of planned I&E margin and agency expenditure.

3. KEY ISSUES:

3.1 Key Performance Indicators

The Trust is achieving targets set by NHSI at an aggregate level, though there are variances within categories. The amount of CRES identified is below required levels, and actions taken to rectify are detailed in section 3.3.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 30 June 2018 is a surplus of £1,760k (per table 1 below). NHS Improvement has confirmed in June a reduction in the Trust's annual control total (£1,692k) which is non-recurrently mitigating CRES delivery at month 3 (£302k). Adjusting for this change in control total results in the Trust being ahead of the plan to date by £45k.

Table 1	**Annual Plan**	**Year to Date Plan**	**Year to Date Actual**	**YTD Variance**
	£000	**£000**	**£000**	**£000**
Income From Activities	-326,027	-80,253	-80,259	-6
Other Operating Income	-14,437	-4,455	-4,422	33
Total Income	**-340,464**	**-84,708**	**-84,680**	**27**
Pay Expenditure	256,718	64,307	64,395	88
Non Pay Expenditure	63,873	15,556	15,769	213
Depreciation and Financing	11,317	2,827	2,756	-72
Variance from original plan	-8,556	-2,017	-1,759	258
Impact of revised control total	1,692	302	0	-302
Variance after revised control total	**-6,864**	**-1,715**	**-1,760**	**-45**

3.3 Cash Releasing Efficiency Savings (CRES)

The Trust's performance against the 2018/19 CRES target is shown in table 2 below. The Trust is marginally (£105k) behind plan and continues to identify schemes to ensure full delivery of recurrent CRES requirements.

Table 2

Identified CRES schemes for the financial year are £105k behind financial plan.	CRES Type	Annual Achieved £000	Movement
	Recurrent	3,826	↑
	Non recurrent	4,311	↑
	Target	8,242	
	Variance	105	↑

3.4 Capital

Expenditure against the capital programme to 30 June 2018 is £1,653k and is £132k ahead of plan largely due to expenditure incurred on the Roseberry Park MIST system being offset by delays on the York and Selby Inpatient facility.

The Trust received a capital rebate relating to prior year schemes (£2,289k), with this included, capital expenditure is £2,166k behind plan.

3.5 Workforce

The following table (table 3) show the Trust's performance on some of the key financial drivers identified by the Board.

Pay Expenditure as a % of Pay Budgets (table 3)							
Tolerance	Tolerance June-18	Jan	Feb	Mar	Apr	May	Jun
Establishment (a) (90%-95%)	93.4%	94.20%	93.70%	93.80%	94.60%	93.70%	93.41%
Agency (b)	1.0%	2.50%	2.50%	2.60%	2.70%	2.80%	2.80%
Overtime (c)	1.0%	1.30%	1.30%	1.30%	1.60%	1.20%	1.12%
Bank & ASH (flexed against establishment) (100%-a-b-c)	4.6%	2.90%	2.90%	2.90%	3.30%	2.90%	3.08%
Total	**100.0%**	**100.90%**	**100.40%**	**100.60%**	**102.20%**	**100.60%**	**100.41%**

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 June 2018 the tolerance for Bank and ASH is 4.6% of pay budgets.

NHS Improvement monitors agency expenditure against a control total. Agency expenditure at 30 June 2018 is £1,800k which is £353k (24%) in excess of the agreed year to date control total of £1,447k. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

3.6 Cash

Total cash at 30 June 2018 is £61,442k, and is £5,253k behind plan largely due to delays in receipts from commissioner contracts and 2017/18 bonus Provider Sustainability Fund (PSF – previously STF) that were anticipated in April and June respectively, with payments now confirmed for July.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The Use of Resources Rating for the Trust is assessed as 3 for the period ending 30 June 2018 and is in line with plan (table 4). The 3 rating arises due to a loan repayment made during April 2018, which impacts on the Capital Service Cover score. This is forecast to improve to a 1 by quarter 2.

Use of Resource Rating at 30 June 2018 (table 4)

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

TEWV Performance	Actual Achieved	Actual Rating	YTD Plan Planned	YTD Plan Rating	RAG Rating
Capital service cover	1.17x	4	1.16x	4	0
Liquidity	52.6 days	1	53.6 days	1	0
I&E margin	2.3%	1	2.0%	1	0
I&E margin distance from plan	0.3%	1	0.0%	1	0
Agency expenditure	£1,800k	2	£1,447k	1	-1
Overall Use of Resource Rating		**3**		**3**	

3.7.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.17x (can cover debt payments due 1.17 times), which is in line with plan and rated as a 4. The planned deterioration in this rating from March 2018 arises due to a loan repayment made during in April 2018.

3.7.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 52.6 days; this is ahead of plan and is rated as a 1.

3.7.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 2.3% and is rated as a 1, which is in line with plan.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan is 0.3% and is ahead of plan and is rated as a 1.

3.7.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is higher than the cap and is rated as a 2. The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 3 a surplus increase of £337k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £46,337k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £214k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £197k is required.
- Agency Cap rating – to improve to a 1 a reduction in agency expenditure of £353k is required.

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 At the end of quarter 1 the Trust is achieving targets set by NHSI at an aggregate level, though there are variances within categories.

6.2 The amount of CRES identified is below required levels; however, the Trust continues to identify schemes to ensure full delivery of recurrent CRES requirements.

6.3 The Use of Resources Rating for the Trust is assessed as 3 for the period ending 30 June 2018 and is in line with plan. This is forecast to improve to a 1 by quarter 2.

7. RECOMMENDATIONS:

7.1.1 The Board of Directors is requested to:

- note the financial position at the end of quarter 1;
- approve the submission of the NHS Improvement quarter 1 return in accordance with the results detailed in this report.

Patrick McGahon
Director of Finance and Information

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**19th July 2018**
TITLE:	**Proposed Revised Key Performance Indicators for Strategic Direction Performance Report**
REPORT OF:	**Sharon Pickering Director of Planning, Performance and Communications**
REPORT FOR:	**Approval**

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

Executive Summary:

In order to understand the progress being made against delivery of the Strategic Direction a quarterly performance report is produced. This consists of reporting progress against a number of KPIs as part the Strategic Direction Scorecard (SDS), delivery of the Business Plan (which includes the key Strategic Programmes and Priorities) and qualitative information both positive and less positive. The KPIs within the performance report have been in place since 2013/14 with some amendments in the period since then.

The KPIs within the SDS were developed some time ago and prior to the development of the core strategies which each contain a Strategy Scorecard with relevant KPIs (these are monitored by the agreed Committee). This means that currently there isn't alignment between what we are monitoring for the SDS and what we are monitoring for each Strategy.

It was therefore agreed that the KPIs would be reviewed with a view to ensuring they remain appropriate and that there is greater alignment with the underpinning strategies.

In order to achieve this the Executive Team have reviewed the KPIs and have identified a new suite of KPIs. These are presented to the Board for approval

Recommendations:

It is recommended that the Board:

- Approve the KPIs within Appendix 2 as the new set of indicators to monitor progress

against the Strategic Direction and agree for baseline data and proposed targets to be established

- Agree that the Strategy Sponsor for the Leadership and Management Development Strategy and the Equality and Diversity Strategy identify the most appropriate KPIs from the respective scorecards to be added to the KPIs in Appendix 2 under Strategic Goal 3 and Strategic Goal 5 where indicated.

MEETING OF:	**Board of Directors**
DATE:	**19th July 2018**
TITLE:	**Strategic Direction Scorecard – Proposed Revised Key Performance Indicators**

INTRODUCTION & PURPOSE:

1.1 The purpose of this report is present to the Board of Directors a revised set of Key Performance Indicators (KPIs) to be used to measure progress of the Trust in delivering its Strategic Direction for approval.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Strategic Direction of the Trust is made up of its Mission and Vision Statements and its 5 Strategic Goals and respective 'This Means That' statements. (Appendix 1 includes the Strategic Goals and the corresponding This Means That Statements). In terms of delivery this is progressed in the main via the core strategies that the Trust has agreed, the key Strategic Programmes and the Key Priorities within the Business Plan.

2.3 In order to understand the progress being made against delivery of the Strategic Direction a quarterly performance report is produced. This consists of reporting progress against a number of KPIs as part the Strategic Direction Scorecard (SDS), delivery of the Business Plan (which includes the key Strategic Programmes and Priorities) and qualitative information both positive and less positive. The KPIs within the performance report have been in place since 2013/14 with some amendments in the period since then.

3. KEY ISSUES:

3.1 The KPIs within the SDS were developed some time ago and prior to the development of the core strategies which each contain a Strategy Scorecard with relevant KPIs (these are monitored by the agreed Committee). This means that currently there isn't alignment between what we are monitoring for the SDS and what we are monitoring for each Strategy.

3.2 It was agreed therefore that it was timely to review the KPIs within the SDS. In order to ensure the alignment with the core strategies we agreed that wherever possible the revised metrics would be a "**selection**" of the most significant/important metrics from each Strategy Scorecard under the relevant Strategic Goal.

However it was recognised that there may be other KPIs that may be more appropriate, particularly for Strategic Goal 4 where there is not a relevant core strategy that underpins delivery.

3.3 EMT have held a number of discussions on which would be the best indicators to use to monitor progress against the SDS and have identified the

KPIs included in Appendix 2. In developing these the following points were taken into account.

3.4 Strategic Goals 1 and 2

It was recognised that the Recovery Strategy Scorecard KPIs at this point are mainly process KPIs as the strategy is still focusing on getting the correct system/processes/infrastructure in place to deliver a recovery focused culture/organisation. Therefore the majority of the indicators recommended for Strategic Goal 1 are not pulled from the Recovery Strategy but from other sources e.g. Quality Strategy, Trust Dashboard.

3.5 Strategic Goal 3

One of the primary strategies that underpins SG3 is to be considered at the Board of Directors meeting on the 19th July (Leadership and Management Development Strategy). Therefore a place holder has been included for two metrics from that Strategy once agreed and the Board is asked to agree that the Strategy Sponsor identifies the most appropriate KPIs from that Strategy Scorecard for inclusion.

3.6 Strategic Goal 4

There are no underpinning Strategies for this strategic goal. The suggested KPIs within Appendix 2 were agreed by EMT from a longer list of possible indicators that were identified by the Planning, Performance and Communications Directorate based on the TMTS and the Stakeholder Engagement and Communication Framework.

3.7 Strategic Goal 5

There are three strategies that underpin this goal (Finance/Digital Transformation/Equality). The Scorecard for the Equality and Diversity Strategy is currently in development. Therefore a place holder has been included for two metrics from that Strategy once agreed and the Board is asked to agree that the Strategy Sponsor identifies the most appropriate KPIs from that Strategy Scorecard for inclusion.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no direct implications re CQC but clearly the Strategic Direction and monitoring progress against it is linked to the organisation being seen as well led.

4.2 **Financial/Value for Money:**
There are no direct financial implications associated with this paper but the Finance Strategy is one of the core strategies in delivering the Strategic Direction.

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

4.4 **Equality and Diversity:**
There are no direct equality and diversity implications associated with this paper but the Equality and Diversity Strategy is one of the core strategies in delivering the Strategic Direction.

4.5 **Other implications**
None

5. RISKS:

The risk is that we do not identify the most appropriate KPIs to be included in the Strategic Direction Scorecard and therefore we cannot evidence progress towards out Strategic Goals. This is mitigated by the fact that the KPIs only form one part of the Strategic Direction Progress Report along with progress against the Business Plan and qualitative intelligence.

6. CONCLUSIONS:

6.1 This report provides the feedback from the work undertaken by EMT on identifying the KPIs that should be used in future to measure progress in terms of delivery of the Strategic Direction.

7. RECOMMENDATIONS:

7.1 It is recommended that the Board:

- Approve the KPIs within Appendix 2 as the new set of indicators to monitor progress against the Strategic Direction and agree for baseline data and proposed targets to be established
- Agree that the Strategy Sponsor for the Leadership and Management Development Strategy and the Equality and Diversity Strategy identify the most appropriate KPIs from the respective scorecards to be added to the KPIs in Appendix 2 under Strategic Goal 3 and Strategic Goal 5 where indicated.

Sharon Pickering, Director of Planning, Performance and Communications

Background Documents

Appendix 1

Trust Strategic Goals and This Means That Statements

VISION:

To improve people's lives by minimising the impact of mental ill-health or a learning disability.

MISSION

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

SRTATEGIC GOALS

SG1: To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing

This means that we make a positive difference to the lives of service users and carers by:

- Supporting individuals to achieve their personal recovery goals
- Delivering safe and effective care (at the right place and right time) that meets individual needs
- Fully engaging people in the development and delivery of their individual care plans
- Ensuring everyone has a positive experience of our services
- Providing high quality, accessible information to help service users manage their own health and care

SG2: To continuously improve the quality and value of our work

This means that we only do things that add value to our customers by:

- Constantly challenging ourselves to improve and learn from experience
- Promoting a culture and providing the tools that empower staff to improve quality and eliminate waste
- Always considering the impact on service users in the design of our processes and development of plans for change
- Having an active programme of applied research and development
- Actively responding to and learning from customer feedback
- Ensuring staff have access to accurate, timely and relevant information

SG3: To recruit, develop and retain a skilled, compassionate and motivated workforce

This means that we are an excellent employer by

- Promoting a culture where our staff feel engaged and valued
- Ensuring all our staff work in line with the Trust values, behaviours and compact
- Promoting and supporting the health and wellbeing of our staff
- Ensuring we have effective leadership and management throughout the organisation
- Providing appropriate education, training, development and leadership opportunities for all staff
- Providing high quality placements for student health care professionals and trainees as the future workforce

SG4: To have effective partnerships with local, national and international organisations for the benefit of the communities we serve

This means that we work closely with our partners to improve the health and wellbeing of the people we serve by:

- Influencing the development of local and national strategies
- Supporting our commissioners to commission excellent and efficient services that meets the needs of the communities we serve
- Work closely with all GPs and other providers to support them in providing effective healthcare for patients with mental health or learning disability needs
- Working with local authorities to provide personalised services
- Proactively engaging with a wide range of stakeholders on the wider health and social care agenda

SG5: 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.

This means that we will be a successful and sustainable organisation by:

- Having effective governance arrangements
- Actively involving Governors and Members in the work of the Trust
- Having a business and financial planning process which is flexible and responsive to the environment
- Investing in the technology, and facilities that our staff need to maximise productivity
- Ensuring we are the provider of choice of commissioners and the public
- Reducing our carbon footprint

Sharon Pickering
Director of Planning, Performance and Communications

Appendix 2

Proposed KPIs for Revised Strategic Direction Scorecard

Strategic Goal	Indicator Number	Proposed Indicator	Source	TMTS linkage/Rational
1	1a	The % teams achieving the agreed improvement benchmarks for HoNOS total score	Trust dashboard	Delivering safe and effective care (at the right place and right time) that meets individual need (Clinicians Perspective)
	1b	The % teams achieving the agreed improvement benchmarks for SWEMWBS	Trust dashboard	Delivering safe and effective care (at the right place and right time) that meets individual needs (Patients perspective)
	1c	Number of patients who said we helped them achieve the goals they set	New	Supporting individuals to achieve their personal recovery goals
	1d	%age of carer that report feeling listened to and heard	Quality Strategy	Ensuring everyone has a positive experience of our services
2	2a	%age of staff reporting that they can contribute towards improvement at work	Quality Strategy	Promoting a culture and providing the tools that empower staff to improve quality and eliminate waste
	2b	%age of patient who report feeling supported by staff to feel safe	Quality Strategy	None but safety is a key part of Quality.
	2c	%age of patient who repot their overall experience as excellent or good	Quality Strategy	None but experience key part of Quality. Also included in SG 1 above
3	3a	%age rolling 12 month TEWV labour turnover rate	Workforce Strategy	Promoting a culture where our staff feel engaged and valued as indicator of ability to retain staff
	3b	% rolling sickness absence rate	Workforce Strategy	Promoting and supporting the health and wellbeing of our staff
	3c	% staff recommending TEWV as a place to work	Workforce Strategy	Promoting a culture where our staff feel engaged and valued

	3d	Metric from Leadership and Management Strategy	Leadership and Management Strategy	Ensuring we have effective leadership and management throughout the organisation/Providing appropriate education, training, development and leadership opportunities for all staff
	3e	Metric from Leadership and Management Strategy	Leadership and Management Strategy	Ensuring we have effective leadership and management throughout the organisation/Providing appropriate education, training, development and leadership opportunities for all staff
4	4a	%age joint bids with CCGs that are successful	N/A	Supporting our commissioners to commission excellent and efficient services that meets the needs of the communities we serve
	4b	%age of mental health and learning disability budget covered by a ring-fenced budget	N/A	Supporting our commissioners to commission excellent and efficient services that meets the needs of the communities we serve
	4c	%age delayed transfers of care due to non Trust issues	N/A	Working with local authorities to provide personalised services Supporting our commissioners to commission excellent and efficient services that meets the needs of the communities we serve
	4d	%age referrals received from GPs using the standard electronic referrals template relevent for the speciality	N/A	Work closely with all GPs and other providers to support them in providing effective healthcare for patients with mental health or learning disability needs

5	5a	Delivery of control total in full as per NHSI financial plan	Finance Strategy	Having effective governance arrangements
	5b	Achieve an NHSI SOF rating of 1	N/A	Having effective governance arrangements
	5c	All clinical teams to be able to access pathology results via PARIS and order test by PARIS	Digital Transformation Strategy	Investing in the technology, and facilities that our staff need to maximise productivity
	5d	All service users being able to access care plan online or digitally	Digital Transformation Strategy	Investing in the technology, and facilities that our staff need to maximise productivity
	5e	100% clinical pathways developed and in use within PARIS	Digital Transformation Strategy	Investing in the technology, and facilities that our staff need to maximise productivity
	5f	All Trust clinicians to have access to their key service/team/patient information in near to real time	Digital Transformation Strategy	Investing in the technology, and facilities that our staff need to maximise productivity
	5g	Metrics from Equality and Diversity Strategy	E&D Strategy	Having effective governance arrangements
	5h	Metrics from Equality and Diversity Strategy	E&D Strategy	Having effective governance arrangements

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**19th July 2018**
TITLE:	**Board Committees – Operational Arrangements**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Assurance/Decision**

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

Executive Summary:

This report provides an update on work being undertaken to further develop the operational arrangements of the Board's Committees.

It includes proposals to amend the terms of reference of the Resources and Mental Health Legislation Committees.

Recommendations:

The Board is asked to:

(a) Receive and note this report.

(b) Support the changes to the operational arrangements of the Committees summarised in the report.

(c) Approve the proposed changes to the terms of reference of the Resources and Mental Health Legislation Committees as set out in Annex 1 to the report with effect from 1st October 2018.

(d) Support the proposal to undertake a further review of the Board's committee arrangements in December 2018.

MEETING OF:	**The Board of Directors**
DATE:	**19th July 2018**
TITLE:	**Board Committees – Operational Arrangements**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to advise the Board of the work being undertaken to further develop the operational arrangements of the Board's Committees.

1.2 Arising from this work the Board is asked to approve amendments to the terms of reference of the Resources and Mental Health Legislation Committees.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In accordance with minute 17/230 (26/9/17), work has been undertaken to further develop the operational arrangements of the Quality Assurance, Mental Health Legislation and Resources Committees.

2.2 The reviews of these Committees have taken into account:

(a) The findings of the External Governance Review undertaken in 2017 (minute 17/243 - 26/9/17 refers).

(b) The outcome of the Board Performance Evaluation Scheme assessment for 2017/18 (minute 18/122 – 24/4/18 refers).

(c) The introduction of the "Thinkon" approach to coaching within the Trust.

2.3 In addition, Board Members will be aware that summary reports on the Board Assurance Framework are now provided to all meetings of the principal committees enabling them to review the risks, in the context of discussions at their meetings, and to escalate any matters to the Board.

3. KEY ISSUES:

Mental Health Legislation Committee (MHLC):

3.1 The MHLC has taken forward the following developments to strengthen the assurances it is able to provide to the Board:

(a) It has reviewed the Mental Health Act Scheme of Delegation (confirmed by the Board under minute 18/148 – 22/5/18) and used the document to review its reporting arrangements.

(b) Case studies have been introduced to enable Members of the Committee to review and understand, in depth, the operation of the MHA within the Trust.

(c) Agendas for its meetings have been restructured and the use of "high quality questions" has been introduced to provide greater focus for reporting and discussions.

3.2 The above changes have been piloted and positive feedback on them has been received from the Members of the Committee.

3.3 The Board is asked to note that further work is required on the Committee's business cycle to ensure that it reflects the above changes. This matter is the subject of consultation with Members of the Committee at present, and it is intended that the revised arrangements will be introduced from October 2018.

3.4 In addition, Board Members will be aware that the membership of the MHLC includes two seats for representatives of service users and carers. For some years these seats have been held by Public Governors as there was no other means of identifying appropriate representatives. However, following discussions with the Council of Governors and the Experts by Experience it has been agreed that nominees for appointment should also be sought from the latter group. The revised terms of reference, to reflect this change, are attached as Annex 1 to this report for ratification.

Quality Assurance Committee (QuAC):

3.5 The changes being taken forward by the QuAC are focussed on improving assurance to the Board on the Trust's compliance with the CQC's fundamental standards (the Committee's principal purpose under its terms of reference). These include:

(a) Aligning agendas to the fundamental standards. This will commence for the September 2018 meeting.
(b) Using "high quality questions" to focus reporting and discussions.
(c) Improving the consistency of the LMGB reports by basing them on the CQC's key lines of enquiry (KLOE).
(d) Reviewing and refreshing the terms of reference of the thematic groups to ensure greater alignment to the CQC's KLOE.
(e) Introducing an "Assurance Tracker", akin to that used by the Audit Committee, based on the fundamental standards.
(f) Reviewing the Committee's business cycle to reflect the above changes.

3.6 Mindful of the calls on both Non-Executive and Executive Directors' time (as highlighted by the External Governance Review), discussions have also been held on whether to reduce the number of meetings of the Committee each year. This matter is due to be further considered in December 2018 to enable the impact of the above changes to be assessed.

3.7 No changes are proposed to the Committee's terms of reference at the present time.

Resources Committee:

3.8 Board Members will recall that the need to ensure appropriate coverage and balance of the Resources Committee's business was a recommendation from the External Governance Review.

3.9 The actions being taken forward in relation to the Committee, including in response to the above recommendation, are as follows:

(a) To align agendas to the Committee's key responsibilities (strategic matters, finance, workforce, IT, etc.) to provide greater visibility on the spread of the business transacted.

(b) To base the Committee's annual meeting cycle on six meetings per year and to remove the provisional meetings.

These changes should provide greater certainty for Members of the Committee about their diary commitments. For urgent matters, either special meetings will be arranged or they will be considered, directly by the Board.

As at present, meetings of the Committee will continue to be held on the same days as Board Seminars.

(c) To review reporting arrangements.

The frequency of reporting will be reviewed in consultation with the lead Directors based on the revised number of meeting dates.

(d) To prepare a revised Business Cycle (taking into account (a) to (c) above) for consideration at the Committee's meeting in September.

3.9 The following changes are also proposed to the Committee's terms of reference:

(a) In relation to the membership of the Committee:

- To reduce the number of seats for the Non-Executive Directors by one.

  This is considered appropriate as, at present, two-thirds of the Non-Executive Directors are members of the Committee.

- To revise the wording of the terms of reference to provide greater clarity on its Executive Director membership and also to make clear that all Board Members are invited to attend and participate in its meetings.

(b) To include the Equality Strategy and the WRES Action Plan within the list of strategies and plans on which the Committee provides assurance to the Board.

The proposed revisions to the terms of reference are also highlighted in Annex 1 to this report.

Implementation

3.10 It is proposed that the changes to the terms of reference of the MHLC and Resources Committee should come into effect on 1st October 2018 to reflect the annual review of Non-Executive Director membership of the Committees.

Further Review

3.11 Following discussions with the Chairman, it is suggested that the position on the operational arrangements of the Board's committees should be further reviewed in December 2018. This would include the coverage of workforce/equalities issues, potentially through the establishment of a separate committee, and the number and timing of meetings to ensure that they are aligned to the Trust's governance requirements.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The proposed changes to the operational arrangements of the QuAC and MHLC are designed to strengthen the provision of assurances to the Board on the Trust's compliance with statutory and regulatory requirements.

4.2 **Financial/Value for Money:** There are no material financial implications arising from this report.

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

4.4 **Equality and Diversity:** The proposal to specify the Equality Strategy and WRES Action Plan within the terms of reference of the Resources Committee will provide clarity on the treatment of these matters within the Trust's governance arrangements.

4.5 **Other implications:** No other implications have been identified.

5. CONCLUSIONS:

5.1 The changes to the operational arrangements of the Committees are designed to improve the provision of assurance to the Board and respond to the recommendations arising from the External Governance Review.

6. RECOMMENDATIONS:

6.1 The Board is asked to:

(a) Receive and note this report.

(b) Support the changes to the operational arrangements of the Committees summarised in the report.

(c) Approve the proposed changes to the terms of reference of the Resources and Mental Health Legislation Committees as set out in Annex 1 to the report with effect from 1st October 2018.

(d) Support the proposal to undertake a further review of the Board's committee arrangements in December 2018.

Phil Bellas, Trust Secretary

Background Papers:

Annex 1

MENTAL HEALTH LEGISLATION COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Mental Health Legislation Committee is established under Standing Order 6 of the Board of Directors

1.2 The Standing Orders of the Board of Directors, as far as they are applicable and with appropriate alterations, shall apply to meetings of the Committee.

1.3 All meetings of the Committee will be held in public.

2 FUNCTIONS

2.1 To provide assurance to the Board on the Trust's compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005, including any statutory Codes of Practice relating thereto, by:

(a) reviewing activity and performance with appropriate comparisons and trends; and

(b) identifying common themes arising from the findings of the Care Quality Commission following visits to the Trust's services

and to escalate risk and propose mitigating actions to the Board where assurance is lacking.

(NOTE: Oversight and monitoring of actions in response to recommendations received from the Care Quality Commission falls within the remit of the Quality Assurance Committee).

2.2 To consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to make recommendations, as required, for changes to the Trust's policies, procedures and practice.

2.3 To ensure appropriate arrangements are in place for the appointment and appraisal of associate managers and oversee managers' hearings.

2.4 To consider other matters at the request of the Board of Directors.

3 MEMBERSHIP

3.1 The Committee will comprise:

- A Non-Executive Director as the Chairman of the Committee
- Two other Non-Executive Directors/ Associate Non-Executive Directors
- The Chairman of the Trust

- The Director of Nursing and Governance
- The Medical Director
- The Chief Operating Officer ~~and Deputy Chief Executive~~
- ~~Two Public Governors (as representatives of service user/carers)~~
- A Public Governor or an Expert by Experience as a service user representative*
- A Public Governor or and Expert by Experiences as a carer representative*

(Note: The agreement of arrangements for filling any vacancies amongst the service user and carer representatives shall be at the discretion of the Chairman of the Trust).*

3.2 The Chairman of the Committee shall be appointed by the Board.

3.3 The Executive Director Members of the Committee may nominate deputies (with voting rights) to attend meetings on their behalf.

3.4 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman.

3.5 Any Non-Executive Director of the Trust may attend meetings should they wish and all Non-Executive Directors will receive agendas and papers.

3.6 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary to the Committee.

3.7 Other officers of the Trust may attend meetings on the invitation of the Committee.

4 QUORUM

4.1 A quorum shall be three members of whom at least one must be a Non-Executive Director and one must be an Executive Director (or nominated Deputy).

5 FREQUENCY OF MEETINGS

5.1 Meetings will be held at least every quarter.

6 RELATIONSHIP WITH THE BOARD AND OTHER COMMITTEES

6.1 In the course of fulfilling its functions and duties if the Committee becomes aware of any risk which could impact on the Trust's ability to deliver its Strategic Goals it shall seek assurances from the appropriate Director that the risk is being managed effectively. On considering the Director's report it shall:

- When necessary (in conjunction with the Quality Assurance Committee) assure itself that appropriate controls are in place to

manage the risk or specify the controls it considers should be established to mitigate the risk.

- Report to the Audit Committee if the risk raises concerns regarding the effectiveness of the Trust's governance arrangements; risk management and assurance arrangements or system of internal control.
- Make a recommendation to the Board that the risk be included in the Board Assurance Framework if it believes the risk could have a significant impact on the sustainability/viability of the Trust or on its ability to deliver the Strategic Direction.

7 DELEGATED AUTHORITY

7.1 The Committee is authorised to seek any information it requires through the Executive Directors and Chief Executive.

7.2 All executive action arising from the work of the Committee shall be taken forward either by way of a recommendation to the Board of Directors or by agreement of the relevant Executive Director under their delegated powers.

8 REPORTING ARRANGEMENTS

8.1 Following every meeting the Chairman of the Committee shall report to the Board of Directors:

- To provide assurance to the Board on the matters considered and to highlight any risks and mitigating actions identified by the Committee at its meeting (including any risks which the Committee considers should be escalated to the Board Chapter of the Integrated Assurance Framework and Risk Register).
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

9 REVIEW

9.1 The terms of reference of the Committee will be reviewed, at least, annually.

Annex 2

RESOURCES COMMITTEE (INCLUDING CHARITABLE FUNDS)

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Resources Committee is established under Standing Order 6 of the Board of Directors.

1.2 The Standing Orders of the Board of Directors, as far as they are applicable and with any appropriate alterations, shall apply to meetings of the Committee.

2 FUNCTIONS

2.1 To provide assurance to the Board that the resources available to the Trust (both financial and non-financial) to deliver its Operational/Business Plan are appropriate, sufficient and deployed effectively.

2.2 To provide assurance to the Board (in the context of paragraph 2.1 above) on the robustness and alignment of the following strategies and plans:

- The Financial Strategy
- The Capital Plan
- The Investment Strategy and Plan
- The Workforce Strategy and Plan
- The ~~Information~~ Digital Transformation ~~Strategy~~
- Equality Strategy and WRES Action Plan

2.3 To monitor, review progress and provide assurance to the Board on the delivery of the strategies and plans (set out in paragraph 2.2 above) particularly in relation to the achievement of commissioner investment in the service priorities.

(Note: The monitoring of progress on the delivery of the Operational/Business Plan shall be undertaken directly by the Board)

2.4 To review proposals (including evaluating risks) for major business cases and their respective funding sources and provide assurance to the Board.

2.5 To keep under review potential changes in the external environment in the medium to longer term and to draw any material risks to the sustainability of the Trust to the Board's attention.

2.6 To provide oversight of the management and administration of Charitable Funds held by the Trust.

3 DELEGATED AUTHORITY

3.1 The investigation of any activity within its terms of reference.

(Note: All employees are directed to cooperate with any request made by the Committee)

3.2 Approval of outline business cases for projects included in the Business Plan to progress to full business case stage subject to their financial consequences (both capital and revenue) remaining within estimate.

3.3 Approval of full business cases for:
- High risk investments valued under £250,000.
- Low risk investments valued between £250,000 and £1 million.

3.4 Approval of the submission of reference cost information to the Department of Health.

3.5 Approval of applications for financial assistance from the Trust's Charitable Trust Funds.

3.6 The commissioning of any outside legal or other independent professional advice and expertise if it considers this necessary.

4 MEMBERSHIP

4.1 The Committee shall comprise:
- A Non-Executive Director as the Chairman of the Committee
- ~~Three~~ Two other Non-Executive Directors / Associate Non-Executive Directors
- The Chairman of the Trust
- The Chief Executive
- The Director of Finance and Information*
- The Chief Operating Officer ~~and Deputy Chief Executive~~
- ~~The Director of Planning, Performance and Communications*~~
- ~~The Director of Human Resources and Organisational Development*~~

~~(Note: Executive Members marked * are only expected to attend meetings of the Committee when matters within their portfolios are due for consideration).~~

4.2 The Chairman of the Committee shall be appointed by the Board of Directors.

5 ATTENDANCE AT MEETINGS

5.1 All Board Members are invited to attend and participate in meetings of the Committee (but not to vote). To facilitate this, copies of all agendas and papers for meetings will be provided to them.

5.2 Executive Directors are expected to attend meetings of the Committee when matters within their portfolios are being considered.

5.2 3 The Committee may invite other directors and other Trust staff to attend its meetings as appropriate. It will also invite the attendance of independent external advisors as required subject to the size and complexity of the investment.

5.3 4 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary of the Committee.

6 QUORUM

6.1 A quorum shall be not less than two Non-Executive Directors, one of which will chair the meeting and one Executive Director.

7 FREQUENCY OF MEETINGS

7.1 The Committee shall meet at least once each quarter.

8 REPORTING

8.1 Following every meeting the Chairman of the Committee shall report to the Board of Directors:

- To provide assurance to the Board on the matters considered and to highlight any risks and mitigating actions identified by the Committee at its meeting (including any risks which the Committee considers should be escalated to the Board Chapter of the Integrated Assurance Framework and Risk Register).
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

9 REVIEW

9.1 The terms of reference of the Resources Committee shall be reviewed at least annually.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 July 2018**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

- 1 policy and 1 procedure that have undergone full review and require ratification:
  - CORP-0020-v7 Producing Patient and Carer Information Policy
  - CLIN-0069-v2 Inter Hospital Transfers Procedure

- 1 policy that has undergone minor amendment:
  - CLIN-0020-V6.1 Professional registration policy

- 1 policy and 1 strategy that have had their review date extended:
  - CORP-0050 Research Governance Policy
  - STRAT-0025 Research and Development Strategy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 11 July 2018

DATE:	**24 July 2018**
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.

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

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

3. KEY ISSUES:

3.1 The following policies have undergone full review and require ratification:

Ref and Title	CORP-0020-v7 Producing Patient and Carer Information Policy
Review date	11 July 2021
Reviewed by	Patrick McGahon
Approved by	Digital Safety and Information Governance Board 06 June 2018
Description of change	This policy has undergone full revision in line with current standards for producing patient and carer information.

Ref and Title	CLIN-0069-v2 Inter Hospital Transfers Procedure
Review date	19 February 2021
Approved by	Patient Safety Group 19 February 2018
Description of change	This procedure was originally written to define the process for transferring inpatients in the Durham and Darlington locality who need care in an acute hospital. A second Trust-wide procedure was also in place. Both procedures have been merged into one covering arrangements for transfers across all localities.

3.2 The following have undergone minor amendment:

Ref and Title	CLIN-0020-V6.1 Professional registration policy
Review date	01 November 2020
Reviewed by	Levi Buckley
Approved by	Policy working group 25 May 2018
Description of change	Appendix 4 was incorrect for Pharmacy staff. This has been amended to reflect the correct process and signed off by the Policy Working Group.

3.3 The following have had their review date extended:

Ref and Title	CORP-0050 Research Governance Policy
Review date	31 October 2018
Rationale	This policy has been reviewed. However the next meeting of the Research Governance Group is not until September, so the review date has been extended to allow for this.

Ref and Title	STRAT-0025 Research and Development Strategy
Review date	31 October 2019
Rationale	The current Research Strategy is from 2015-2020, so is to be extended for review in 2019 to allow publication of the next 5 year strategy in 2020

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 13 May 2018 have been presented for ratification.

7. RECOMMENDATIONS:

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

Author: Colin Martin
Title: Chief Executive