Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 22ND MARCH 2016
VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON
AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting of the Board of Directors held on **23rd February 2016**.		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To receive a briefing on key issues in Forensic Services.	**Levi Buckley to attend**	**Presentation**
Item 7	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 8	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 9	To approve the Trust's Equality Objectives 2016 – 2020.	**DL**	**Attached**

Performance (10.40 am)

Item 10	To consider the Finance Report as at 29th February 2016.	**CM**	**Attached**
Item 11	To consider the Trust Performance Dashboard as at 29th February 2016.	**SP**	**Attached**

Governance (10.55 am)

Item 12	To approve the Information Governance Toolkit submission for 2015/16.	**CM**	**Attached**

Items for Information (11.00 am)

Item 13	Policies and Procedures ratified by the Executive Management Team.	**MB**	**Attached**

Item 14 To note that the next meeting of the Board of Directors will be held on Tuesday **26th April 2016** in the Old Swan Hotel, Swan Road, Harrogate, HG1 2SR at 9.30 am.

Confidential Motion (11.05 am)

Item 15 **The Chairman to move:**

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

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

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

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

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

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

Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

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.

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
16th March 2016

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 23RD FEBRUARY 2016 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

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

In Attendance:
Miss. V. Wildon, Public Governor for Redcar and Cleveland
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Mrs. K. Ord, Deputy Trust Secretary

Ms. G. Butterfield, Ms. K. Carne, Ms. R. Carter, Ms. A. Cockrill, Ms. A. Cooke and Ms. L. Davis, student nurses.

16/29 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. D. Jennings and Mrs. B. Matthews, Non-Executive Directors.

16/30 MINUTES

Agreed *– that the public minutes of the meeting held on 26th January 2016 be approved as a correct record and signed by the Chairman.*

16/31 PUBLIC BOARD ACTION LOG

The Board noted that the Board Action Log contained no outstanding matters.

16/32 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/33 CHAIRMAN'S REPORT

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

(1) Presented a "Living the Values" Award to the Rapid Response Intermediate Care (RRICE) Team in Harrogate on 2nd February 2016.

The Board noted that:

(a) The event had provided her with opportunities to find out more about the team, including its challenges and issues, and to look around the Briary Wing.

(b) The team had been nominated for the award for its support to a service user and their family during a crisis.

(2) Attended the Ridgeway Recovery Awards on 9th February 2016.

Mrs. Bessant reported that the event had been very positive and enjoyable and had showcased recovery in action.

(3) Attended the Governor Development Day at Morton Park, Darlington on 10th February 2016 which had included an interesting presentation by Dr. Jane Leigh, the GP Strategic Advisor, on the project on engaging with GPs and their teams as partners in care.

The Chairman considered that this matter might be an appropriate topic for a future Board Seminar.

Action: Mr. Barkley

(4) Met with Cllr Carol Runciman, the Chairman of the City of York Council's Health and Wellbeing Board, on 18th February 2016.

Mrs. Bessant advised that the meeting had been very positive and Cllr Runciman was keen to further develop the partnership between the organisations.

(5) Attended the meeting of the Equality and Diversity Steering Group on 27th January 2016 which had included an interesting contribution from the Trust's Chaplains.

16/34 GOVERNOR ISSUES

No issues were raised.

16/35 QUALITY ASSURANCE COMMITTEE

The Board received and noted the report of the Quality Assurance Committee (QuAC) including:

(1) The confirmed minutes of its meeting held on 3rd December 2015 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 4th February 2016.

Dr. Griffiths, the Chairman of the Committee, drew attention to:

(1) The work being undertaken by the Patient Safety Group to ensure that the Trust would meet any applicable recommendations arising from the "Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust" undertaken by Mazars LLP, including the establishment of a mortality review group.

(2) The following matters which the Committee had escalated to the Board:

(a) A request for the project team to review the current scoring mechanisms for risk registers to ensure they were properly descriptive and did not give a false sense of assurance or non-assurance.

Mrs. Moody advised that the risk registers were being piloted and the feedback provided by the Committee, which had been very useful, had been taken on board.

(b) A recommendation that the Board might need increased visibility over the coming months and a heightened sense of reporting in relation to the York and Selby Locality due to issues with data quality, staffing, media interest and other external matters.

In response to a question from the Chairman, it was noted that a report to the Committee from the Force Reduction Group had highlighted that, although the use of prone restraint at the Westwood Centre had reduced, in common with the rest of the Trust, it remained an outlier. The Committee had, therefore, asked for a "deep dive" review of the use of prone restraint at that facility with a report to be provided to its meeting to be held on 5th May 2016.

16/36 NURSE STAFFING REPORT

The Board received and noted the report on nurse staffing for December 2015 and January 2016 as required to meet the commitments of "Hard Truths", the Government's response to the Public Inquiry into Mid Staffordshire NHS Foundation Trust (the "Francis Review").

Mrs. Moody highlighted the following matters contained in the report:

(1) The data for the York and Selby Locality, provided separately from the other Localities in Appendix 13 to the report, which showed:

(a) Eleven of the fill rate indicators rated "red" for the period. The majority of these fell into the "Registered Nurse on Day shifts category" reflecting the number of vacant posts in the Locality.

(b) High agency staff usage which was attributed to vacant posts and limited access to bank staff.

(c) Peppermill Court having the highest bank usage; however, as this unit had now closed and staff had been moved, it was expected that the Locality's position would improve in the coming months.

(2) For the other Localities:

(a) There had been an improvement on the month on month trend.

(b) The North Yorkshire and Forensic Services Localities had the lowest and highest number of "red" rated wards respectively.

(c) The lowest fill rates were on Kingfisher/Heron Ward (December) and Robin Ward (January); however, an improvement was expected following the reconfiguration of these services.

(3) The information on missed breaks and incidents raised citing staffing levels which had been included in the report in accordance with minute 16/07 (26/1/16).

It was noted that:

(a) Although the number of missed breaks remained high, it was difficult to draw any meaningful conclusions on the reasons for this as no patterns could be identified from the data e.g. missed breaks were reported for wards with "green" or "blue" fill rates. A task and finish group, led by the HR and Organisational Development Directorate had been established to provide focus on this issue and adherence to EU Working Time Directives.

(b) 26 of the 32 incidents raised during the reporting period citing staffing issues related to inpatient services.

An analysis of the data had found that no standardised escalation process was in place and there was inconsistency in documenting whether risks relating to staffing were resolved, managed or mitigated.

Through discussions with the Operational Management Team it had been agreed to establish a safe staffing task and finish group, the terms of reference of which were being prepared, to develop a standardised escalation process.

In response to a question it was noted that the task and finish group would focus on inpatient services, as data was available; however, it was recognised that consideration needed to be given to developing a separate approach for community teams.

The Board's discussions focussed on the following matters:

(1) The development of a site based approach to increasing staffing flexibility and providing support for wards.

Dr. Land drew attention to Appendix 1 to the report ("Totals of the hours of Planned Nurse Staffing Compared to Actual") which, if considered by cluster rather than alphabetically, as presented, showed low fill rates for registered nurses during daytime shifts for adult acute wards at Roseberry Park.

Based on this approach, he considered that, in assessing the risks arising from nurse staffing rates, it was necessary to take into account the extent to which mutual support between wards in a cluster was available i.e. there would be greater risks if all wards in a cluster were reporting low fill rates.

In response, Mrs. Moody and Mr. Kilmurray advised that:

(a) Through discussions with the Operational Management Team, it had been recognised that the development of site based flexibility on staffing would be beneficial particularly to mitigate risks where access to the staff bank, at short notice, was limited e.g. for qualified nurses at night.

(b) The approaches being considered included:

- The establishment of a small pool of floating staff.

It was noted that:

- This might also lend itself to providing additional staff to cover short-term tasks (e.g. the provision of escorts or enhanced observations) within the Trust's 12 hour shift system.
- Proposals were being developed for its introduction at West Park Hospital which would be discussed with the Joint Consultative Committee in due course.

- Converting unqualified to qualified posts at night.
- The introduction of more flexible bank arrangements within Forensic Services.

In response to a question from the Non-Executive Directors on how the use of flexible staffing would impact on the recording of safe staffing data, it was noted that work was already being undertaken on roster compliance and the use of flexible staff would need to be captured in narrative reporting.

(2) Concerns about staffing levels in the York and Selby Locality.

The Non-Executive Directors reported that, from their visit to the Locality on 22nd February 2016, they were aware of anxiety amongst staff arising from changes to services. This, together with active recruitment by private sector providers and the need to find sufficient staff for Peppermill Court, which was due to open in July 2016, could increase risks to staffing availability.

On this matter:

(a) Mr. Kilmurray advised that:

- The significant number of vacancies inherited by the Trust was taking time to address.
- The recruitment campaign for Peppermill Court was due to commence imminently.

(b) It was noted that plans were in place to undertake a recruitment campaign in North Yorkshire and York and funding for this had recently been agreed by the EMT.

(c) The Chairman considered that, in the circumstances, there might be benefits in over-recruiting nurses.

(d) Dr. Land suggested that it would be worthwhile to take out a paid for advertisement in the York press linked to the Peppermill Court refurbishment. This would enable the Trust to highlight the improvements made in the Locality and to promote recruitment.

The Board supported Dr. Land's suggestion.

Action: Mrs. Pickering

In addition, the Non-Executive Directors:

(1) Highlighted that a consistent message on nurse recruitment was required as, during a recent Directors' visit, a ward manager had reported that they had capped the number of applications for a vacancy due to the level of demand.

(2) Questioned whether the secondment of two qualified staff from Acomb Garth had contributed to the unit having the second lowest fill rate in the York and Selby Locality.

In response it was noted that there had been significant changes to the service and the secondments might reflect the redeployment of staff to other wards due to low bed occupancy on the unit.

Mrs. Moody undertook to look into this matter.

Action: Mrs. Moody

(3) Sought clarity on the timeframe for the completion of work by the task and finish group on safe staffing.

The Board noted that this would be confirmed at its next meeting.

Action: Mrs. Moody

16/37 MENTAL HEALTH LEGISLATION COMMITTEE

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

(1) The confirmed minutes of its meeting held on 26th October 2015.
(2) The key issues discussed by the Committee at its meeting held on 25th January 2016.

Mr. Simpson drew attention to the "significant assurance" provided by the Internal Auditors on Mental Health Act compliance.

16/38 SMOKING CESSATION AND NICOTINE MANAGEMENT PROJECT

Further to minute 15/203 (23/7/15) the Board received and noted a progress report on the Smoking Cessation and Nicotine Management Project.

Dr. Land reported that:

(1) As shown in the report all the project milestones had been achieved or were on track.
(2) By 9th March 2016, the date the Trust was due to become "smoke free", approximately 1300 staff would be trained to provide brief smoking cessation advice (Level1) and 200 staff would be trained to provide assessment and nicotine replacement options (Level 2) ensuring coverage of all inpatient wards.

Board Members highlighted the anxiety being reported by staff about the Trust becoming "smoke free" particularly as this might add to the stress they already faced in dealing with complex and challenging patients.

In response Dr. Land provided assurance on the measures being put in place to support staff including:

(1) The modern matrons being provided with plans on supporting wards becoming "smoke free".
(2) Ensuring nicotine replacement products (and e-cigarettes) were available.
(3) The provision of additional support to wards, particularly at night, including 15 smoking champions.

(4) Additional communications to consultants and ward managers which recognised the challenges but also reinforced the benefits to both physical and mental health of smoking cessation.

He acknowledged that becoming "smoke free" would be challenging and the approach taken in the early days, including ensuring sufficient staff were available and well briefed, would be crucial to the project's success.

Mrs. Moody highlighted that staff were concerned that the number of incidents might increase and sought clarity on how this would be monitored.

Dr. Land responded that monitoring should be undertaken by modern matrons and locality managers and additional support would need to be made available if required.

In addition, Board Members sought:

(1) Clarity on the future plans for present smoking shelters.

Dr. Land advised that:

(a) Decisions on the retention or removal of the shelters would be taken on a case by case basis.
(b) Plans were in place to clean the remaining shelters and courtyards and remove smoking detritus.

(2) Assurance that Lloyds Pharmacy would be ready for the Trust becoming "smoke free" due to concerns raised during a Directors' visit.

Mr. Kilmurray advised that:

(a) Mr. Williams (Chief Pharmacist) was in discussions with Lloyds Pharmacy on the ordering, etc. of nicotine replacement products to ensure these were available for wards for 9th March 2016.
(b) The stocking of nicotine replacement products for sale was a matter for the company.

It was considered that this needed to be clearly communicated.

Action: Dr. Land

16/39 NATIONAL STAFF SURVEY RESULTS

Mr. Levy provided a presentation on the results of the National Staff Survey 2015.

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

Mr. Levy drew attention to the following matters:

(1) Overall the results were very positive with 29 key findings being better than average; two findings being average; and only one key finding being worse than average.
(2) The reporting of the results by the national survey organiser, the Picker Institute, had changed from previous years in that:
    (a) The results by Locality and for local questions had not yet been received.
    (b) The segmentation of Trusts had been increased including separate categories for those mental health and learning disability Trusts providing,

and not providing, community services. The Trust had, therefore, been compared against 29 other Trusts in the 2015 results rather than 52 as in previous years.

(c) Although the survey results continued to be reported against the four staff pledges of the NHS Constitution, the number of key findings had increased to 32. Ten of these key findings were not comparable with previous years as they were either new or were subject to significant change.

(d) Comparisons with other Trusts were only provided using "above average", "average" and "below average" thresholds. Upper and lower quintiles were not provided, as in previous years, due to the relatively small number of comparable Trusts.

(3) The Trust's results did not include staff in the York and Selby Locality as the sample was based on staff in post on 1st September 2015, prior to the transfer of those services.

(4) The response rate to the survey was 53%. Whilst, over time, the rate was reducing, the trend was not as pronounced as for other Trusts.

(5) Separate results for black and minority ethnic staff were not available due to the low response rate and it was recognised that further work was required on engagement with these staff.

(6) It was suggested that, in response to the survey results, the Trust should focus on:

(a) Encouraging more staff to report harassment, bullying or abuse.

(b) Reducing the number of staff experiencing violence from patients, relatives or the public.

(c) Increasing the proportion of staff who report errors, near misses or incidents that they witness.

(7) Trustwide actions arising from the survey would be included in a refreshed composite staff action plan, which would be presented to the Board meeting to be held on 24th May 2016, with Locality action plans being produced by June 2016.

Action: Mr. Levy

Arising from the presentation, the Board discussed:

(1) The calculation of the average scores.

Mr. Levy advised that the median average had been used but it was not possible to provide information on the calculation of the tolerances, at this time, in view of the short period since the receipt of the report (22nd February 2016).

(2) The results for the key finding "Staff reporting most recent experience of harassment, bullying and abuse" which, at 17%, was one of the Trust's three least favourable scores.

Mr. Levy advised that this was a new indicator but a comparative score for 2014 had been constructed by the survey organisers.

On this matter:

(a) It was noted that the key finding was based on the "Freedom to Speak Up" report by Sir Robert Francis QC as it was considered that there was a strong link between bullying and not raising concerns.

(b) Board Members recognised that, in order to interpret the result, it was necessary to understand the number of staff reporting that they had experienced bullying, etc.

Mr. Levy responded that, taking into account the number of staff reporting that they had been bullied, etc., the result for the key finding was significant.

(3) The Trust's position on the key finding "Staff experiencing physical violence from patients, relatives or the public in the last 12 months" which was amongst the Trust's least favourable scores but, at 23%, close to the national average of 21%.

Mr. Levy responded that the inclusion of this key finding within the Trust's least favourable scores highlighted the overall positive nature of the results.

However, the Chairman considered that, in absolute terms, it was concerning that approximately 1 in 4 staff had reported that they had experienced physical violence.

Mrs. Moody advised that it might be useful to produce a breakdown of incidents of physical violence, based on levels of harm, to provide context to the result.

(4) The results for the key finding "Staff suffering work related stress in the last 12 months" which showed a significant improvement from 38% in 2014 to 28% in 2015.

Board Members considered that, in absolute terms, the number of staff experiencing stress remained high; however, the result was very positive in the context of their experiences of working in the NHS and local issues e.g. the increase in demand, over the last year.

In response to questions on the implications of the phrasing of the question included in the survey:

(a) It was noted that stress reported by staff was based on self-perception.

(b) Mr. Levy advised that stress was a complex topic and could be influenced by factors outside the working environment. He considered that it was more important to consider changes in the results over time than how staff had interpreted the question.

(5) Whether further work should be undertaken to raise awareness of the support available to staff in view of the health and wellbeing theme having the lowest proportion of "best" scores.

In response it was noted that the theme did not only focus on support for staff but also included the key findings on physical violence and bullying, etc.

(6) Staff on staff violence which had been highlighted as an issue in the 2014 staff survey.

Mr. Levy advised that the Trust's score for the key finding had not changed significantly in 2015 but was better than average.

(7) Whether any action could be taken to understand the views of staff in the York and Selby Locality on the matters covered by the survey.

The Board noted that this information would be available from the Staff Friends and Family Test which was due to be extended into the Locality for Quarter 4, 2015/16.

(8) Whether, given the changes to the reporting of the results, a review of the Trust's scores against those of mental health and learning disability trusts providing community services (i.e. as in previous years) should be undertaken.

Mr. Levy took this on board.

Action: Mr. Levy

At the conclusion of the discussions:

(1) The Chairman asked Mr. Levy to prepare a more detailed data report on the results for circulation to Board Members.

Action: Mr. Levy

(2) Mr. Barkley advised that, as in previous years, he had commissioned an independent analysis of the results which he would provide to Board Members.

Action: Mr. Barkley

16/40 FINANCE REPORT AS AT 31ST JANUARY 2016

The Board received and noted the Finance Report as at 31st January 2016.

In introducing the report and in response to questions Mr. Martin advised that:

(1) There were no significant changes to the Trust's present or forecast financial positions.

(2) There had been an increase in impairments arising from Alexander House being brought back into use as a team base. Further impairments were expected in March 2016, arising from the triennial property revaluation, and a report on this matter would be provided to the Board at its meeting to be held on 26th April 2016. The impairments were not expected to impact on the Trust's Financial Sustainability Risk Rating.

(3) The reduction in the Liquidity Days Ratio was a result of capital expenditure being in excess of internally generated funding. The rate was expected to level out due to the completion of the West Lane development and the refurbishment of Alexander House together with the purchase of land for the new inpatient facility in Harrogate falling into 2016/17 financial year.

16/41 PERFORMANCE DASHBOARD AS AT 31ST JANUARY 2016

The Board received and noted the Performance Dashboard Report as at 31st January 2016 including:

(1) The Trust Dashboard Report (Appendix 1).
(2) The Dashboard Report for the York and Selby Locality (Appendix 2).
(3) The Data Quality Assessment Report (Appendix 3).
(4) The report providing further details of unexpected deaths (Appendix 4) which included the York and Selby Locality.

Mrs. Pickering reported that the national indicator for early intervention in psychosis waiting times had been received but it was not expected to be the final version. An internal definition for this indicator had been used, to date, against which the Trust was achieving target; however, performance against the national indicator was slightly below target. Work was planned to address this matter, which was possibly due to data quality issues, led by Mr. David Brown (Director of Operations for Teesside) and Dr. Stephanie Common (Consultant Psychologist).

The Non-Executive Directors sought clarity on:

(1) The reasons for what appeared to be a general trend on KPI 17 ("Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated") with the results being below target for the months of August, September and December for the last three years.

Mrs. Pickering advised that seasonal variations on this indicator would not be expected.

(2) The reasons for the changes in the number of external referrals into Trust services in Teesside and Forensic Services.

Mrs. Pickering:

(a) Advised that the reduction in Teesside was due to the IAPT service being closed to new referrals.
(b) Considered that the position in Forensic Services might be due to increases in referrals to offender health and autism services but that she would review this matter.

Action: Mrs. Pickering

16/42 TRUST PERFORMANCE DASHBOARD TARGETS 2016/17

Further to minute 15/325 (24/11/15), consideration was given to the targets for the agreed key performance Indicators for the 2016/17 Trust Dashboard (as set out in Appendix A to the covering report) which had been proposed by the Executive Management Team.

Mrs. Pickering drew attention to the proposals to:

(1) Remove the indicator "100% Compliance with Monitor Targets" from the Dashboard.

It was noted that:

(a) Reporting against this metric, as a composite indicator, would always be a month behind.

(b) It was proposed that, in place of the metric, a monthly "Monitor Scorecard" would be monitored by the Corporate Performance Team and reported to the Board by exception.

(2) Introduce "amber" traffic lights for the majority of indicators in order to provide greater clarity on the level of risk (which would be evidenced by "red" traffic lights).

The Non-Executive Directors:

(1) Suggested that the threshold for the indicator "Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)" should be lowered.

A proposal from Mr. Barkley that the "red" rating should be less than 65% was agreed.

(2) Sought clarity on the definition of caseload turnover.

Mrs. Pickering advised that this indicator was based on those patients brought onto the caseload against those taken off. It was considered that some form of weighting needed to be introduced to recognise variations between services.

(3) Questioned whether, for the indicator "Number of patients with a length of stay over 90 days (AMH and MHSOP A&T Wards)", it would be possible to identify cases where delays were due to the absence of accommodation or where the local authority had not identified a social worker; the latter issue having been raised during the Non-Executive Directors' visit to services in York and Selby.

On this matter:

(a) Mrs. Pickering advised that those cases where absence of accommodation contributed to long lengths of stay could be captured; however, those over 90 days were investigated and were, generally, as a result of clinical need.

(b) Mr. Barkley recognised that there needed to be a greater focus on escalating cases of lengths of stay over 90 days. With regard to this he advised that:

- It had previously been agreed that, in these cases, a second clinical opinion should be sought to ensure a team was taking all appropriate steps to arrange discharge.
- Either he or Mr. Kilmurray should be informed of delays due to the lack of a social worker to enable the matter to be raised with the relevant Director of Social Services.

Agreed -

(1) that the proposed targets for the 2016/17 Performance Dashboard Indicators (as set out in Appendix A to the above report), as amended, be approved including the introduction of "amber" traffic lights for the majority of the indicators;

(2) *that the indicator "100% Compliance with Monitor Targets" be removed from the Performance Dashboard and reported, in future, by exception in the monthly Performance Dashboard reports; and*

(3) *that the targets be reviewed after three and six months to ensure they remain appropriate.*

Action: Mrs. Pickering

16/43 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report as at Quarter 3, 2015/16, including proposed changes to the Business Plan which required Board approval (as set out in Appendix 1 to the report).

In response to a question in relation to KPI 19 ("Excess cost of employing medical agency versus substantive"), Dr. Land advised that the Trust had inherited a number of medical staff vacancies in York and Selby; no more vacancies had arisen since the transfer of the services; and changes to the on-call rota had reduced requirements for agency staff in the Locality.

The Chairman highlighted the positive messages contained in the report including the Accreditation for Inpatient Mental Health Services (AIMS) achieved by Rowan Lea and the Home Treatment Accreditation Scheme (HTAS) standard achieved by the crisis team in Scarborough.

Agreed -

(1) *that the changes to the Trust Business Plan set out in Appendix 1 to the report be approved; and*

(2) *that the suggested measures for the key performance indicators under development (i.e. Research and Development Outcomes and Productivity Metric) be noted.*

Action: Mrs. Pickering

16/44 USE OF THE TRUST SEAL

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

16/45 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting of the Board of Directors would be held, in public, at 9.30 am on Tuesday 22nd March 2016 in the Board Room, West Park Hospital Darlington.

16/46 CONFIDENTIAL MOTION

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

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

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

Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

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

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

Following the transaction of the confidential business the meeting concluded at 12.15 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

BOARD OF DIRECTORS
23RD FEBRUARY 2016

STAFF SURVEY RESULTS 2015

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Background to the survey

- Distributed to staff during October to December 2015
- An above average response rate of 55% (462 staff) though lower than in previous years. York and Selby staff not included
- Key findings structured around the four pledges to staff in the NHS Constitution plus themes of equality and diversity, errors and incidents and patient experience
- 32 Key Findings compared to 29 in 2014 and 28 in 2013 with more questions about roles/rewarding jobs

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Headlines

- 29 Key Findings were better than average
- 2 Key Findings were average
- 1 Key Finding was worse than average
- There were 2 Key Findings with statistically significant changes compared to 2014
- Overall staff engagement was better than average

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Top 5 most favourable scores

- Work related stress – 28% (TEWV) 39% (national)
- Staff satisfaction with resourcing and support – 3.60 (TEWV) 3.30 (national)
- Staff satisfaction with level of responsibility and involvement – 4.05 (TEWV) 3.84 (national)
- Effective team working – 3.96 (TEWV) 3.81 (national)
- Support from immediate managers – 4.05 (TEWV) 3.85 (national)

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3 least favourable scores

- Staff reporting most recent experience of harassment, bullying or abuse – 17% (TEWV) 49% (national)
- Staff experiencing physical violence from patients, relatives or the public in the last 12 months – 23% (TEWV) 21% (national)
- Staff reporting errors, near misses or incidents witnessed in the last month – 90% (TEWV) 91% (national)

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Where staff experience improved

- Staff suffering work related stress in last 12 months – 28% (2015) 38% (2014)

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Where staff experience deteriorated

- Staff reporting most recent experience of harassment, bullying or abuse – 17% (2015) 49% (2014)

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Best scores for mental health

- TEWV scores compared to 29 mental health trusts
- 14 of the 32 scores for TEWV in 2015 were the best scores of all mental health trusts
- 2 of the 29 scores for TEWV in 2014 were the best scores of all mental health trusts
- The fewest proportion of best scores were in respect of the health and wellbeing and errors and incidents themes

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Disabled staff responses

- 91 staff disabled surveyed or 20% of all staff surveyed
- Staff suffering work related stress in the last 12 months – Disabled staff 40% Not Disabled staff 27%
- Staff experiencing physical violence from patients, relatives or the public in last 12 months – Disabled staff 33% Not disabled staff 22%
- Good communication between senior management and staff – Disabled staff 36% Not disabled staff 45%

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Some suggested areas for action

- Encouraging more staff to report harassment, bullying or abuse
- Reducing the number of staff experiencing violence from patients, relatives or the public
- Increasing the proportion of staff who report errors, near misses or incidents that they witness

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Next Steps

- Communicate the survey results throughout TEWV
- Triangulate survey results with other related information e.g. Staff FFT results, Serious Incident reports
- Develop and agree a TEWV Action Plan for consideration by Directors in May 2016
- Develop and agree locality/directorate action plans by June 2016

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ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22nd March 2016**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

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

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/07/2014	14/233	Further Board discussions to be held on the key factors influencing trends on unexpected deaths	MB	Mar-16	Completed
26/05/2015	15/133	Consideration to be given to providing greater flexibility within the Trust's 12 hour shift system as part of the Working Longer Review	DL	Mar-16	
23/06/2015	15/170	Information on the three wishes raised by teams to be included in future reports on Directors' visits	BK	Jun-16	
27/10/2015	15/293	The Board to discuss the closure of the Governance Action Plans	MB	Apr-16	
24/11/2015	15/319	The next progress report on the Francis 2 Action Plan to be prepared as a final "stock take" with those items remaining outstanding and those being taken forward through other workstreams being highlighted	MB	May-16	
24/11/2015	15/321	In future assurance on the self-assessment ratings of the Core Standards for Emergency Preparedness, Resilience and Response to be provided to the Board by the Audit Committee	BK	Sep-16	
24/11/2015	15/324	Report to be provided to the Board, following consideration by the QuAC, on the context of Performance Dashboard metrics 13 (“Percentage of patients re-admitted to Assessment & Treatment wards within 30 days”), 14 (“Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards”) and 15 (“Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward”) and the relevance of their targets	SP	Apr-16	

Date	Minute No.	Action	Owner(s)	Timescale	Status
15/12/2015	15/346	Reporting of the culture metrics, including the provision of information on trends, to be reviewed	DL	Apr-16	
26/01/2016	16/07	The project plan for the Safe Staffing Project to be provided to the Board	EM	~~Mar-16~~ Apr-16	
26/01/2016	16/07	The safe staffing review framework and tools to be piloted in the County Durham and Darlington Locality with a report to be provided to the Board on key findings	EM	Apr-16	
26/01/2016	16/12	The Equality Data Document to be used in the 2016/17 Annual Planning Cycle	SP	Oct-16	
23/02/2016	16/33	Briefing on the project on engaging with GPs and their teams as partners in care to be provided to a Board Seminar	MB	Seminar Programme to be reviewed April 16	
23/02/2016	16/36	A paid for advertisement, linked to the Peppermill Court refurbishment, to be taken out in the York Press	~~SP~~ DL	May-16	
23/02/2016	16/36	Clarity to be provided on the secondment of qualified staff at Acomb Garth	EM	Mar-16	See agenda item 8
23/02/2016	16/36	The timescale for the completion of work by the safe staffing task and finish group to be confirmed	EM	Mar-16	See agenda item 8
23/02/2016	16/38	The availability of nicotine replacement products for sale by Lloyds Pharmacy to be confirmed and communicated	NL	-	Completed
23/02/2016	16/39	The composite staff action plan, refreshed to take into account the 2015 staff survey results, to be presented to the Board	DL	May-16	
23/02/2016	16/39	The Trust's 2015 staff survey results to be compared to all mental health and learning disability trusts	DL	May-16	
23/02/2016	16/39	A data document on the 2015 staff survey results to be provided to Board Members	DL	May-16	
23/02/2016	16/39	The independent analysis of the 2015 Staff Survey results to be provided to Board Members	MB	-	Completed
23/02/2016	16/41	Clarity to be provided on the reasons for the increase in referrals to forensic services	SP	-	Completed
23/02/2016	16/42	Approval: - Of the targets for the 2016/17 Trust Performance Dashboard metrics (as amended) - Of the removal of the indicator "100% compliance with Monitor targets" with future reporting being by exception - For the targets to be reviewed after 3 and 6 months	SP	-	Approved
23/02/2016	16/43	Approval of changes to the Business Plan (as set out in Appendix 1 to the Strategic Direction Performance Report)	SP	-	Approved

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Trust Board Briefing

Forensic Service

Levi Buckley

22nd March 2016

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Our strategy going forward

- Embedding recovery
- Increasing in-patient productivity
- Staff support and development
- Improving physical health

Service issues going forward….

- **FLD** – implications of Transforming Care– massive transformational change
- **FMH** – standardising work esp. CPA and MSP
- **OH&C** – mobilisation prisons and L&D, seizing opportunities
- Procurement

Key threats to the service

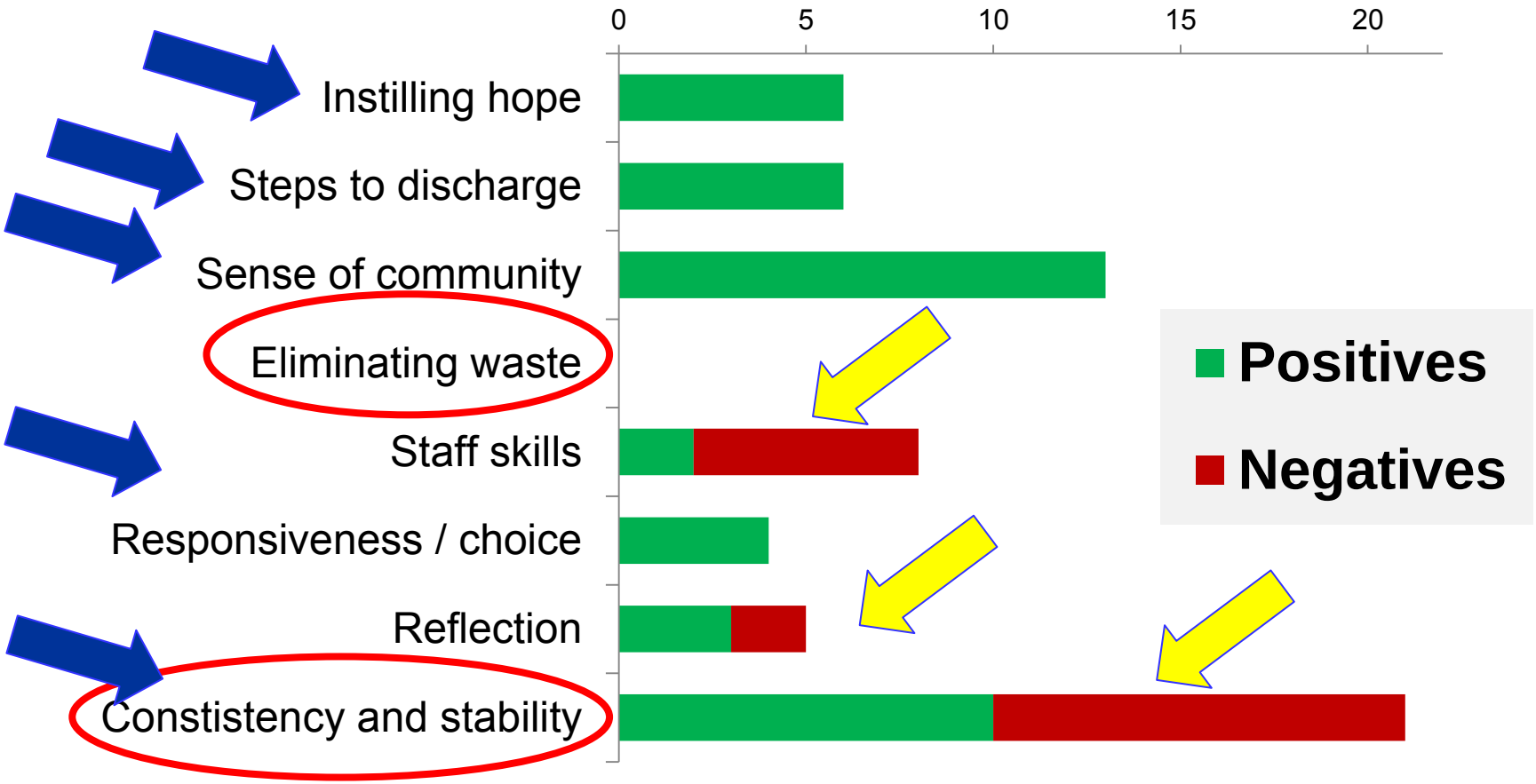
EXTERNAL

- Transforming care
- Secure procurement (2016/17)
- Meeting regulatory requirements

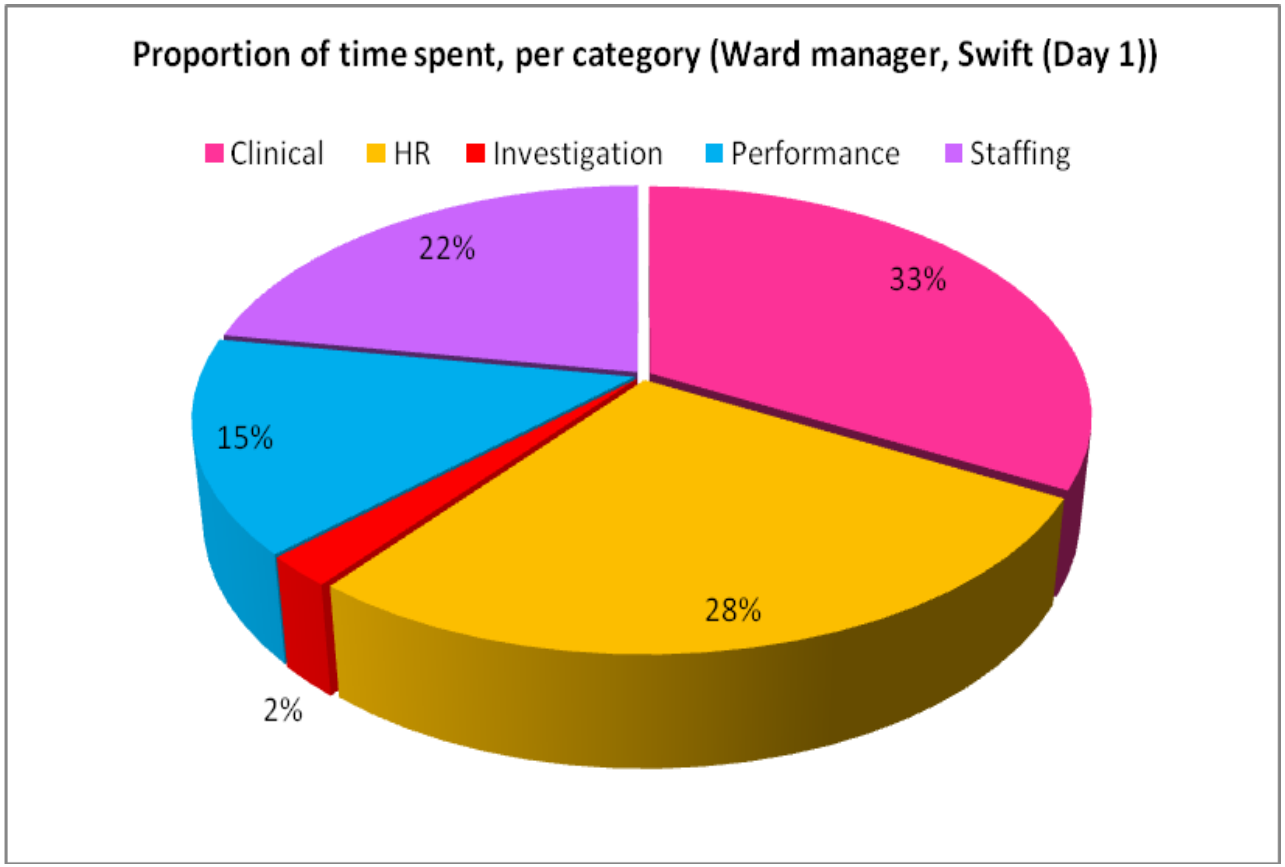
INTERNAL

- CRES
- Staff morale

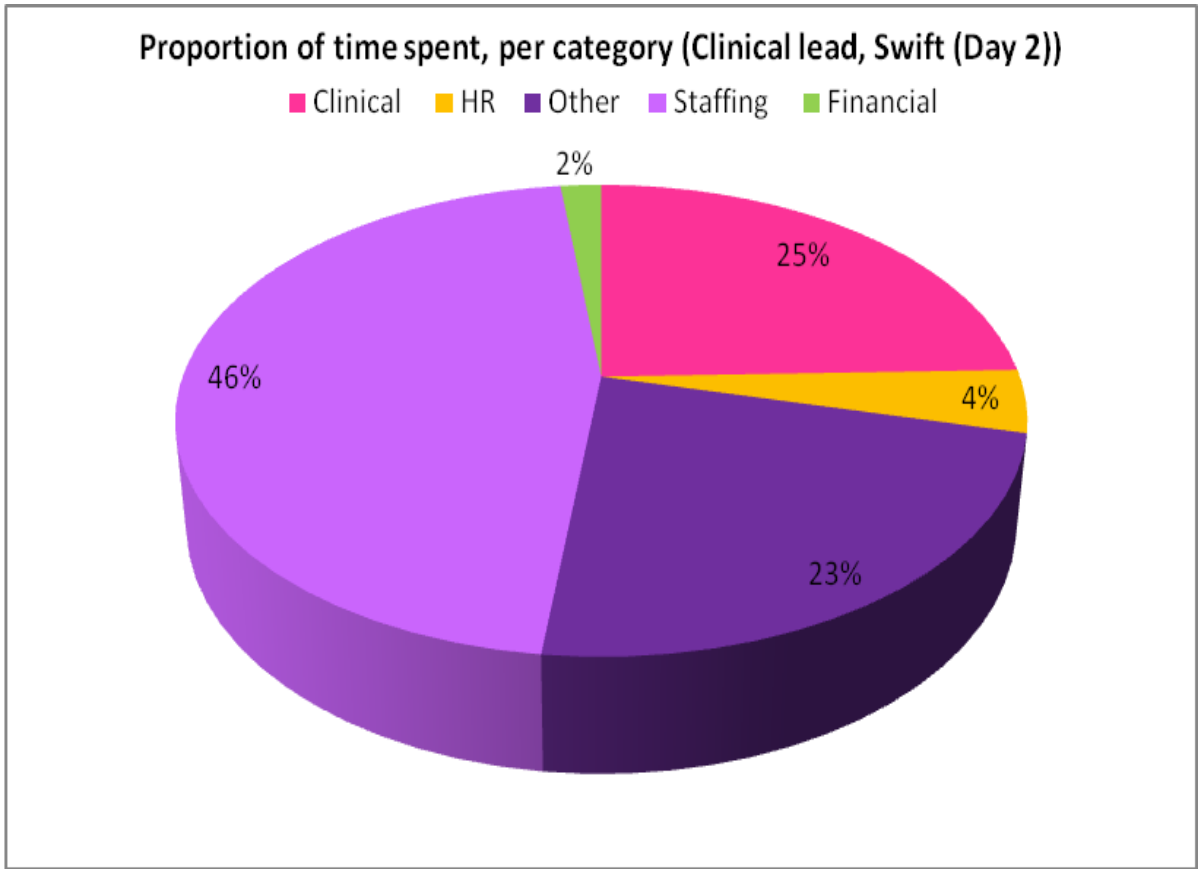
3P themes - changes



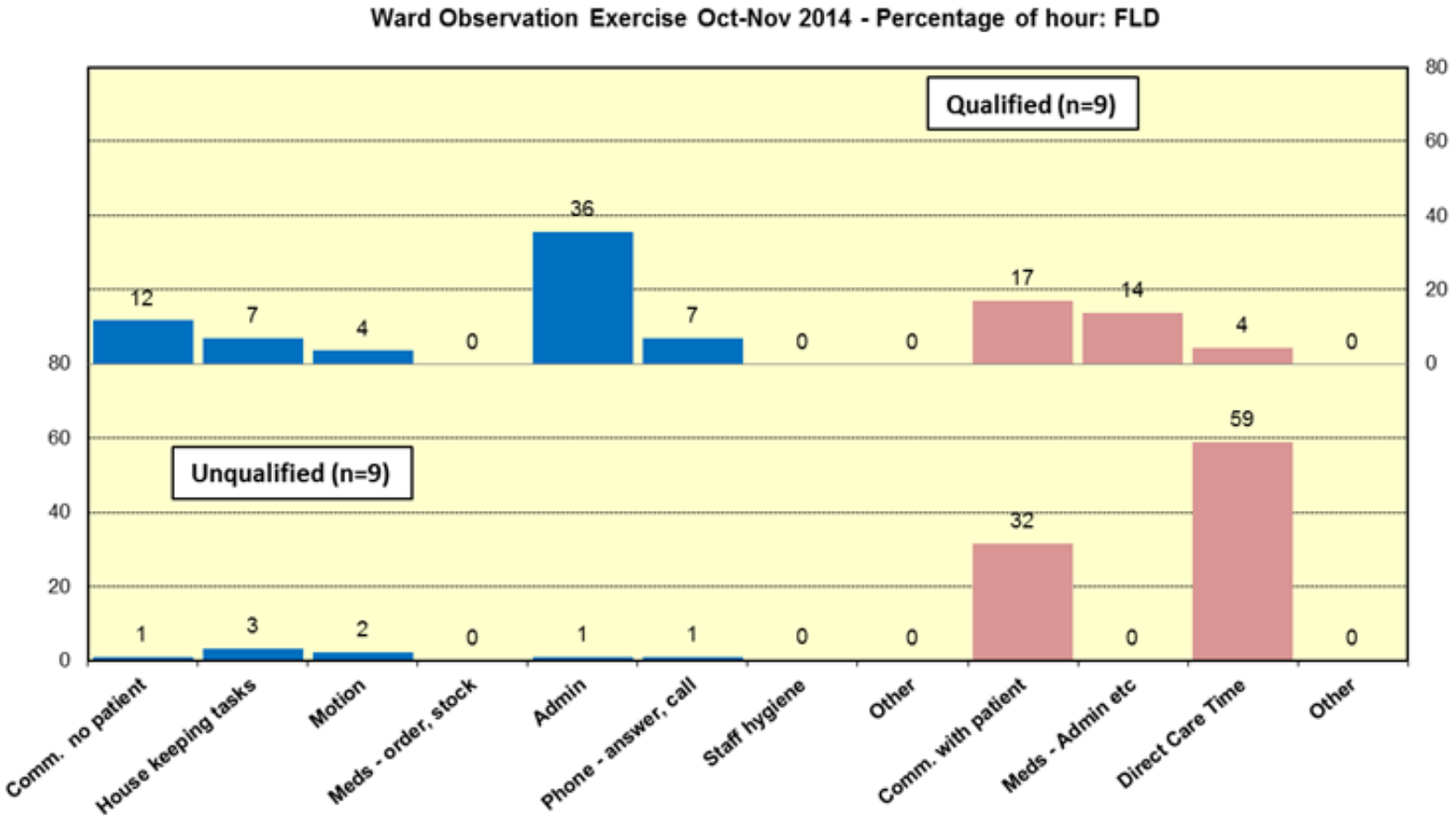
2013 B7/B6 observations



2013 B7/B6 observations



Observations 2014



Observations 2015

Ward / Teams mapped were as followed:

FLD 16 Mar Robin Heron Kingfisher	12 hour shift Band 5 Nurse
FLD17 Mar Harrier – Hawk	12 hour shift Band 6 Nurse
FLD 30 Mar Swift	12 hour shift Band 5 Nurse
FLD 31 Mar Eagle – Osprey	12 hour shift Band 6 Nurse
FLD 10 Apr Harrier – Hawk	9am – 5pm Band 7 Ward Manager
FMH 29 Apr Lark	12 hour shift Band 5 Nurse
FMH 1 May Newtondale	9am – 5pm Band 7 Ward Manager

Approximately 75 hours data

Hour by hour data available for all dates – two used in this presentation however themes emerging identified all wards

Common themes across all 12 hour shifts mapped

- Staff frequently moved from ward to ward
- Higher use of Bank Staff / overtime
- Breaks to cover and support other wards for breaks
- MDT – Missing in Action? Value added?
- Staff taking breaks in their cars – Parking issues, café expensive, access to their mobile phones
- Sickness cover
- Registered staff (Band 6's) missing their breaks

Demands on nursing teams

- Managing the shift
- Daily management (BAU)
- Escorts
- Unpredictable demand
- Nursing staff availability
- Named nurse duties
- Staff development
- Establishment
- Ward skill mix

Demands on nursing teams

Managing the shift	Health roster Bank (unfilled shifts)
Daily management (BAU)	
Escorts	
Unpredictable demand	
Nursing staff availability	
Named nurse duties	
Staff development	
Establishment	
Ward skill mix	

Demands on nursing teams

- Managing the shift
- **Daily management (BAU)**
- Escorts
- Unpredictable demand
- Nursing staff availability
- Named nurse duties
- Staff development
- Establishment
- Ward skill mix

Diary management

Clinical tasks
Managerial tasks
Administrative tasks

Handover

Demands on nursing teams

Managing the shift

Daily management (BAU)

Escorts

Unpredictable demand

Nursing staff availability

Named nurse duties

Staff development

Establishment

Ward skill mix

Community leave

Internal movements

- Therapy
- Recovery college
- Social

Maintenance works

Demands on nursing teams

- Managing the shift
- Daily management (BAU)
- Escorts
- **Unpredictable demand**
- Nursing staff availability
- Named nurse duties
- Staff development
- Establishment
- Ward skill mix

Increased Observations
Attending Acute Hospital
MOVA incidents
Court Appearances
Seclusion Reviews

Demands on nursing teams

- Managing the shift
- Daily management (BAU)
- Escorts
- Unpredictable demand
- **Nursing staff availability**
- Named nurse duties
- Staff development
- Establishment
- Ward skill mix

Ward rounds
CPAs / CTRs / MHRTs
Formulation
Training

Demands on nursing teams

Managing the shift	1:1s Care plans CPA prep Manager/Tribunal prep
Daily management (BAU)	
Escorts	
Unpredictable demand	
Nursing staff availability	
Named nurse duties	
Staff development	
Establishment	
Ward skill mix	

Demands on nursing teams

- Managing the shift
- Daily management (BAU)
- Escorts
- Unpredictable demand
- Nursing staff availability
- Named nurse duties
- **Staff development**
- Establishment
- Ward skill mix

Supervision
Appraisal

Mand and stat

Releasing time to train

- Service specific - clinical
- PARIS
- QIS

Demands on nursing teams

Managing the shift	Managing vacancies
Daily management (BAU)	
Escorts	Pregnancy Sickness
Unpredictable demand	
Nursing staff availability	Recruitment Retention
Named nurse duties	
Staff development	Understanding demographics Succession planning
Establishment	
Ward skill mix	

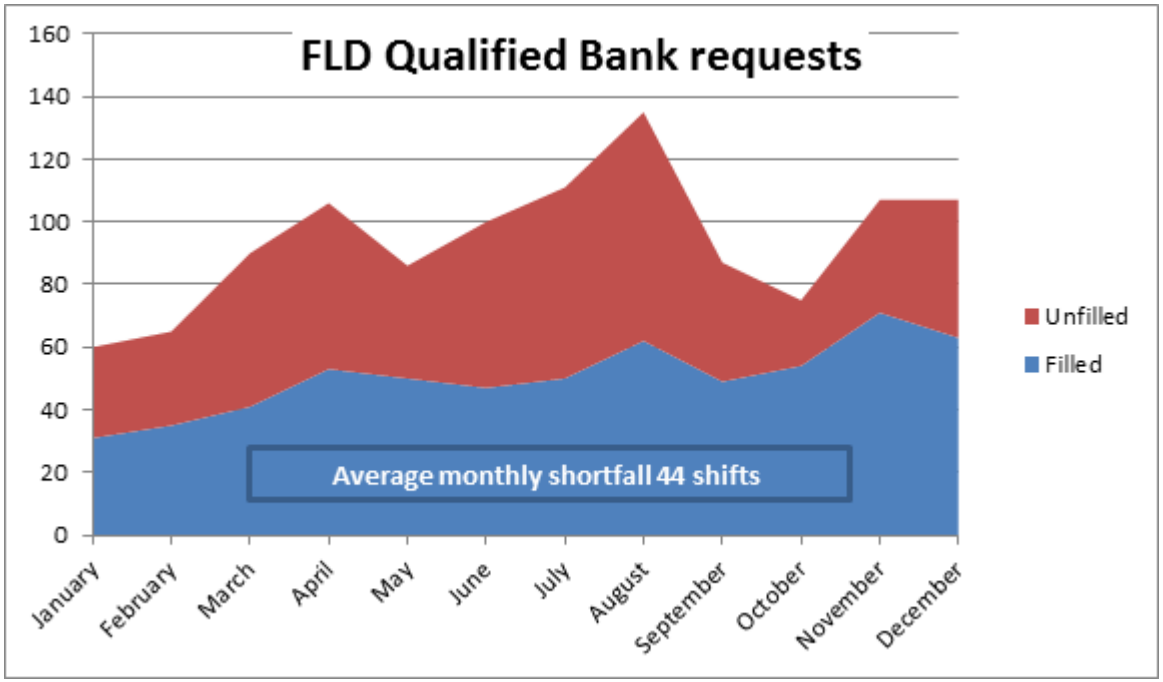
Demands on nursing teams

- Managing the shift
- Daily management (BAU)
- Escorts
- Unpredictable demand
- Nursing staff availability
- Named nurse duties
- Staff development
- Establishment
- **Ward skill mix**

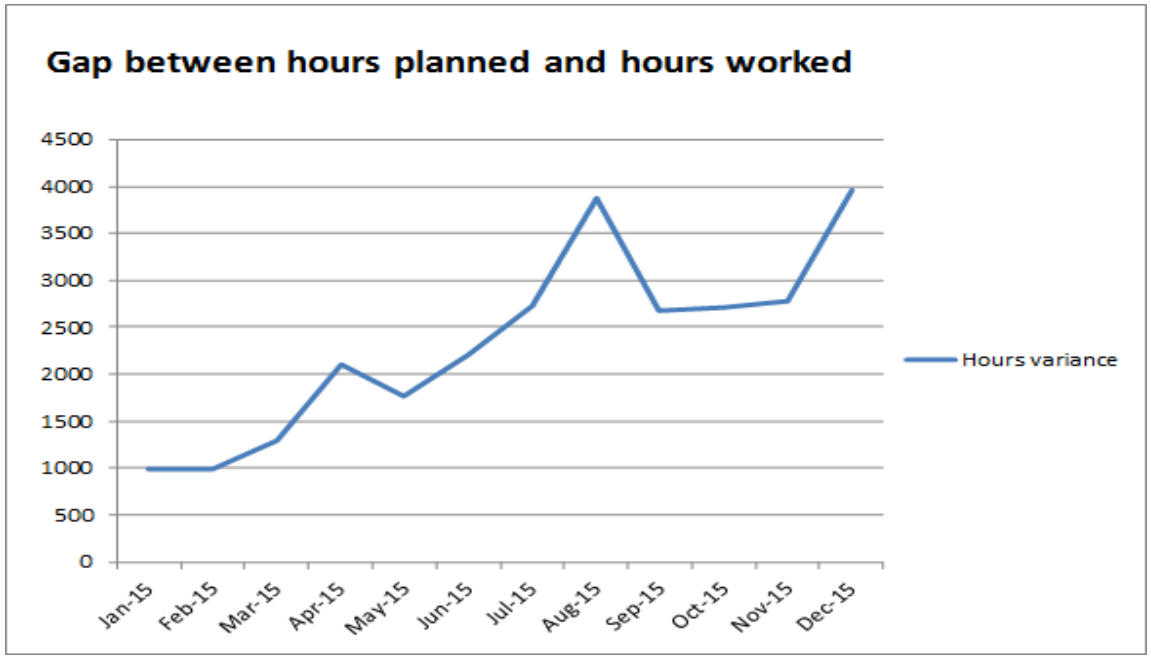
Qualified:HCA
MDT input
Patient mix

Common themes across all 12 hour shifts mapped continued……

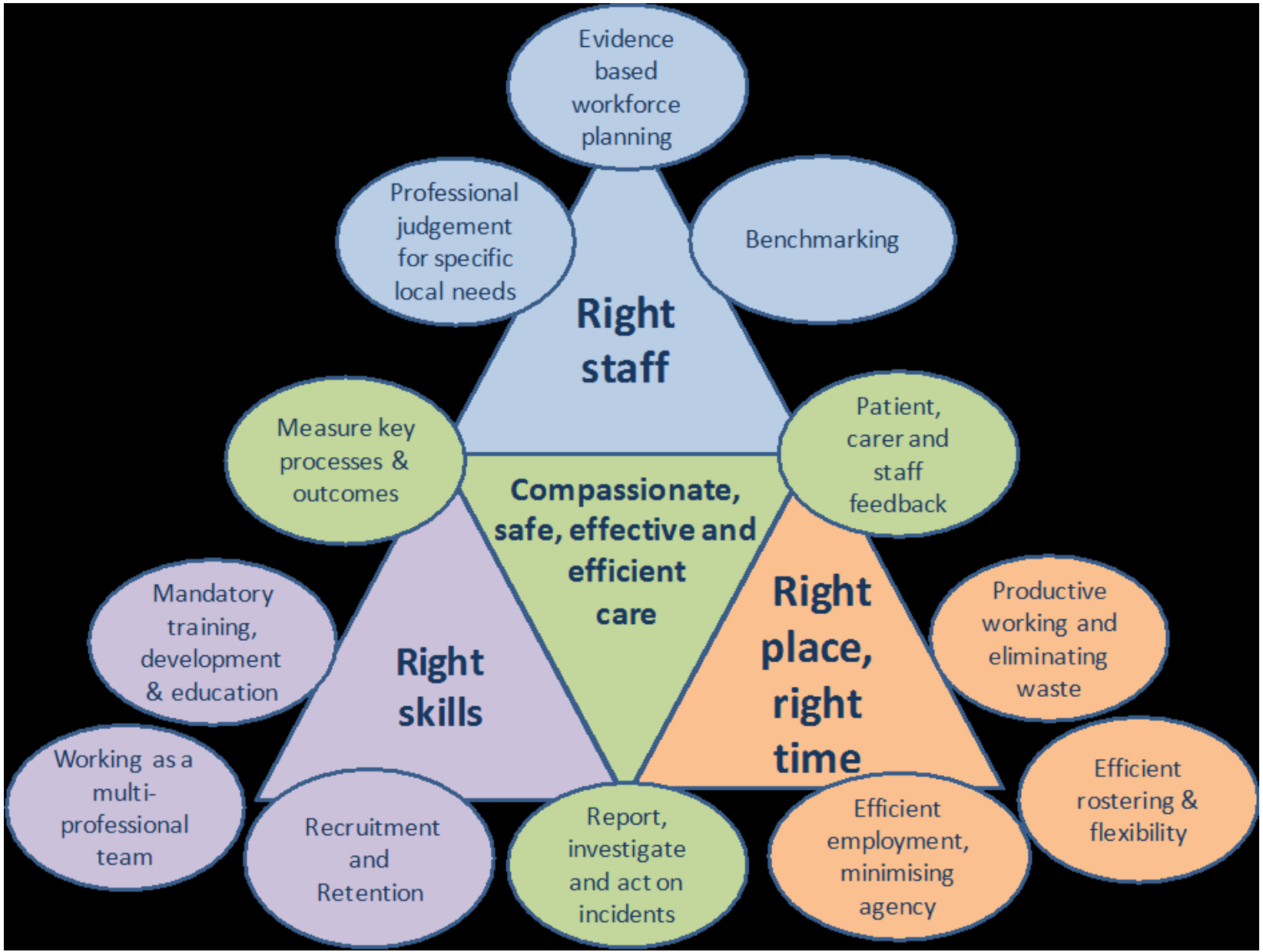
- Little evidence of matrons / managers visible on wards
- Myth busting – amount of time in office / on computer PARIS entries entered on a rota basis
- No evidence formal debriefing following incidents
- No visible evidence of admin support on wards
- Lengthy process for managing patients money on wards
- Evidence of traditional MDT approach to reviews of patient engagement (except Robin, Heron, Kingfisher – Daily Report Out and 1:1 meetings)



Issues with both demand **and** supply



Issues with both demand **and** supply


Evidence based workforce planning
Professional judgement for specific local needs
Benchmarking
Right staff
Measure key processes & outcomes
Patient, carer and staff feedback
Compassionate, safe, effective and efficient care
Mandatory training, development & education
Right skills
Right place, right time
Productive working and eliminating waste
Working as a multi-professional team
Recruitment and Retention
Report, investigate and act on incidents
Efficient employment, minimising agency
Efficient rostering & flexibility

Recovery

- My Shared Pathway integration
- Recovery College
- Community meetings
- Collaborative risk assessments
- Extend and embed Safewards
- Positive Behavioural Support

Enablers

- Model ward programme
  - Learning from model lines (prep, prep, prep)
- Certified leaders and QIS for leaders
- Senior leaders time freed up
- Releasing staff
- Head of nursing

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Transforming Care
Fast Track Update

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Item 7

FOR GENERAL RELEASE

Board of Directors

DATE:	**Tuesday, 22 March 2016**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Assurance statement pertaining to QuAC meeting held 3 March 2016:
The Quality and Assurance Committee have 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.

The key issues during the reporting period are summarised as follows:

- LMGB reports were received from 2 localities (Forensics and North Yorkshire) - staffing levels (nursing and medical), Transforming Care Agenda, out of area admissions, falls in MHSOP were noted.
- The Patient Safety Group is continuing a piece of work to ensure the Trust meets any applicable recommendations from the Southern Health report.
- There was an unannounced CQC inspection to FLD services on 22 February 2016 which had focused on restrictive practices. Initial feedback had been very positive however the formal report had not yet been received.

- The Committee were informed that EMT had approved the Harm Minimisation Project on 18 August 2015, which would develop and disseminate a new policy for harm minimisation to reflect a recovery culture, including how inpatient engagement and observation was practised.

Recommendations:

That the Board of Directors receive and note the report of the Quality Assurance Committee from its meeting held on 3 March 2016, together with the confirmed minutes of 4 February 2016.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 22 March 2016**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 3 March 2016.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

The Committee received the bi-monthly updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from the Forensic and North Yorkshire localities.

3.1 Forensic LMGB – where key issues raised were:

1. Staffing pressures on inpatient wards - there would be a 2 day model ward/staffing event on 7 and 8 March, which would report back to LMGB.

2. The Transforming Care Agenda and the implications for patients with learning disabilities and staff; a lack of clarity around investment into the community infrastructure. IP bed closures were going ahead and community models of care were being developed, however there were risks around delays in discharging patients and delays to developing the community teams.

3. There had been an unannounced CQC inspection to FLD services on 22 February 2016 which had focused on restrictive practices. Initial feedback had been very positive however the formal report had not yet been received.

4. The risk register was reviewed with comments from the Committee members that it would be useful to be able to identify if risks were increasing or decreasing.

5. Mr Phil Bellas has done some work with OMT to look at consistency in terms of risks identified and scoring across localities. The Directors of Operations would be reviewing their risk registers to reflect this.
6. There had been a high number of patient falls and the locality would be focussing some work on Mallard Ward particularly to ensure the training programme around falls management was embedded.

3.2 North Yorkshire LMGB – where key issues raised were:

1. Medical staffing in Scarborough with a lack of clinical leadership due to a long term vacancy and sick leave. Locum cover arrangements were in place; however these were above the nationally mandated capped rate on agency spend. It was noted that Monitor had been informed of this overspend which was necessary to maintain the quality of patient care in Scarborough.

2. The use of Rowan Lea MHSOP beds by out of locality patients continued to be monitored.

3. Some Tier 4 Band 5 CAMHS nurses from inpatient services had gone to work in the community and mitigating actions had been put in place to address this.

4. There had been a small spike in complaints (9) which had been discussed at EMT recently, as some of the complaints related to some difficulties with a team in Northallerton.

5. The number of level 3 and above patient related incidents was 68 against a Trust target of 4.72, however it was noted that this data was skewed by the high number of self harm incidents coming in from Tier 4.

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

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

4.1 Quarter 3 Quality Account Update Report

1. Good progress had been made against the 4 key quality priorities identified in the Quality Account, as well as performance against the quality metrics.
2. There was a slight risk around Children's assessments and care plans being recorded on PARIS but plans were in place to have these completed by the end of April 2016.
3. The number of patient falls remained above target at 50 for Quarter 3.
4. There had been 5 patients who had stayed in hospital longer than 200 days.

4.2 Clinical Audit & Effectiveness Performance Report

The clinical audit programme completion status was 52.8% (22.02.2016), with a further 46% in progress due to be completed by the end of the financial year.

The Clinical Audit Forward Programme for 2016/17 was approved.

4.4 Patient Safety Group

1. The Patient Safety Group (PSG) had met on 15 February 2016 and discussed all relevant Trust patient safety activities with issues being progressed via appropriate leads.
2. The draft terms of reference for the Trust wide Mortality Review Group had been discussed and some initial data would be brought to the March 2016 PSG meeting in order for the group to consider what information was required going forward.
3. There were no Serious Incident action plans that were over 1 month overdue.
4. Routine monthly KPI reporting for the Patient Safety Group had been agreed with the most recent data presented in the report as appendix 2.
5. The National Confidential Inquiry into Suicide and Homicide Trust Safety Scorecard had been discussed and on this matter it was noted that looking at other Trust scorecards would provide some context to the Trust data.

4.5 Patient Experience Group

1. The Patient Experience Group had met on 16 February 2016 and assurance was given to the Committee that all issues had been documented and were being progressed by appropriate leads.
2. Some work was currently underway to review the Sub-Groups that reported through to the Quality Assurance Committee and whether some of the information could be fed into the LMGB reports. QuAC would be kept informed.

4.6 Safeguarding Children and Adults

1. The Trust continued to meet the legal requirements for safeguarding adults and children within the current legislative framework.
2. The serious case review for Durham regarding a MAPPA case remained on hold, as it had been agreed that it also met the criteria for a MAPPA review, which was underway.
3. The CCG had been considering options in respect of supporting the Trust's involvement with Multi-agency safeguarding hub (MASH) for children, which had dramatically increased the workload for the Safeguarding Children Team.
4. Work continued with services in Selby where there had been a larger than expected number of safeguarding adult alerts. Multi-agency meetings had been held to address these issues.
5. There had been two significant issues raised by the Acute Trust following the transfer of patients from MHSOP services in Teesside.
   On this matter it was noted that this had been managed with multi-agency procedures and additional support and guidance had been given to the area concerned. A timeline of events was being worked up to distinguish what had happened to one of the patients that had also waited in Accident & Emergency at the Acute Trust.
6. There had been recurrent funding for the MARAC advisor post fixed term to support the MARAC process.

6. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

6.1 Compliance with CQC Registration Requirements, including Mental Health Act visit feedback summary report.

1. The Trust had been notified that the Claimant from the York & Selby locality would be going ahead with the Judicial Review for the alleged failure of TEWV to provide adequate acute mental health services in the York area.

2. An unannounced CQC visit had taken place to re-inspect restrictive practices on 22 February 2016 at Roseberry Park forensic LD.
3. The CQC had visited Bootham Park prior to the re-opening of the outpatient services.
4. The final Intelligent Monitoring report had been received with 1 risk removed (relating to employment and accommodation status) that had previously been identified in the draft report.
5. There had been 6 MHA inspections and associated monitoring reports received.
6. There would be a Trust wide CQC mock inspection for 3 weeks during April 2016.

6.2 Harm Minimisation Project Update

1. EMT had approved the Harm Minimisation Project on 18 August 2015, which would develop and disseminate a new policy for harm minimisation to reflect a recovery culture, including how inpatient engagement and observation was practised. This would replace the current CRAM policy.
2. A consultation event had taken place with Heads of Nursing with input from an expert by experience to develop the draft policy.
3. In March 2016 there would be a follow up event, with representatives from all services and localities to develop the engagement and observation guidelines to be embedded into the Policy for Harm Minimisation.
4. These guidelines would reflect the recommendations of NICE guidelines regarding violence and aggression, short term management in mental health, health and community settings.
5. The draft policy and guidelines would be presented to QuAC in April 2016.

7. GOVERNANCE

There were no additional items discussed under this section.

8 IMPLICATIONS

8.1 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.

8.2 Financial/value for money

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

8.3 Legal and Constitutional (including the NHS Constitution)

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

8.4 Equality and Diversity

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

9 CONCLUSIONS

The Quality Assurance Committee received and noted the corporate assurance and performance reports that were considered.
All risks highlighted were being addressed with proposed mitigation plans or where they were currently being managed, additional information and assurances were requested.

10. RECOMMENDATIONS

There were no matters to be escalated to the Board of Directors.

Jennifer Illingworth
Director of Quality Governance

Appendix 1

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 4 FEBRUARY 2016, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Mrs Jennifer Illingworth, Director of Quality Governance, (for minutes 16/08, 16/13 & 16/15)

Dr Nick Land, Medical Director
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr David Jennings, Non-Executive Director
Mr Jim Tucker, Non-Executive Director

In attendance:
Mrs Karen Atkinson, Head of Nursing, Teesside
Mrs Karen Agar, Associate Director of Nursing and Governance,
Dr Ruth Briel, Deputy Medical Director, York & Selby
Mr Stephen Davison, (for minute 16/14)
Mr David Brown, Director of Operations, Teesside (for minute 16/04)
Mrs Lorraine Ferrier, Head of Nursing for Durham & Darlington
Mrs Betty Gibson, Governor
Mrs Ruth Hill, Director of Operations, York & Selby (for minute 16/07)
Mrs Ann Lowery, Head of Compliance
Mr David Levy, Director of HR and Organisational Development, (for minute 16/16)
Ms C McCann, Director of Nursing
Mr Brent Kilmurray, Chief Operating Officer
Mrs Donna Oliver, Deputy Trust Secretary
Mr Chris Williams, Head of Pharmacy (for minute16/11)
Dr Ingrid Whitton, Deputy Medical Director for County Durham & Darlington (for minute 16/05)

Students from the University of Teesside: Rosie Whittle, Caroline Hartley, Tom Hind, Lesley Hindle, Bethany Horner and Gemma Hunter.

16/01 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Lenny Cornwall, Deputy Medical Director for Teesside, Mr Martin Barkley, Chief Executive, Mr Richard Simpson, Non-Executive Director, Mrs Barbara Matthews, Non-Executive Director and Ms Jo Dawson, Acting Director for Operations for Durham & Darlington.

16/02 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 3 December 2015 be signed by the Chairman of the Committee, subject to a minor amendment to page 2, 15/150, which should read that due to the low levels of SUIs, analysis was difficult.

16/03 ACTION LOG

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

The following updates were noted:

15/137 Review of Scorecard metrics.
This matter was deferred to the March 2016 QuAC meeting.

15/139 Reflect outcome of Quality Account stakeholder event back to Health and Well-being Boards. Review the current Quality Account.
This would be deferred to the March 2016 QuAC meeting.

15/148 Clinical Audit and Effectiveness – check the number of ambers on the completed clinical audits compared with the previous year.
This matter was covered under minute 15/228.
Competed

15/152 Mental Health Legislation themes to feature as part of the monthly CQC compliance report.
Completed

15/153 Information strategy and Governance report – discussion required around whether this report was required by QuAC.
This report would not report to the Quality Assurance Committee, it would be reported through Information Groups.
Completed

15/174 Discuss nursing pilot project further with representation from Nursing and Governance.
It was confirmed that Ms McCann was now a member of the Nursing Pilot group.
Completed

15/176 Force Reduction Project – undertake comparisons with pilot sites and similar types of wards to understand this work and break down the data by individuals. In Quarter 4 report there would be a breakdown of pilot sites, compared to similar size services.
This was covered under minute 15/232.
Completed

15/186 Quality Account – further clarification required around the red line on page 5 - graph reporting number of patient falls Trust wide.
This was deferred to the March 2016 QuAC meeting.

15/189 AIMs accreditation for Rowan Lee – query if this had been successful.
It was noted that this accreditation had been successful.
Completed

15/204 Escalate to Board of Directors concerns over lack of residential and nursing home placements.
Discussions had been ongoing about MHSOP beds and Mr Barkley would feed back to the March 2016 QuAC meeting on any developments.
Completed

15/204(ii) D&D locality report – breakdown the £2m forecasted deficit and how it is attributable to flexible staffing, use of agency, undelivered CRES and non-staff spend, including prescribing.
This matter was covered under minute 15/224.
Completed

15/204 iii) D&D locality report – end column of risk register to be labelled.
Completed

15/206 (3) Quality Strategy Scorecards suggested amendments to the metrics in the scorecard.
Completed

15/206 To include explanatory narrative as a footnote to appendix 2, correct radars for 3 of the indicators and correct typographical error on section 3.4.4 (p4).
Completed

16/04 TEES LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Tees LMGB assurance/exception report.

Mr Brown highlighted the top concerns at present:

1. Adult inpatient staffing levels at Roseberry Park.
   Measures had been put in place to address this matter and there would be an increased daily establishment to 1 qualified nurse on each of the 4 wards, in light of the extra patient activity from York in the first 3 months.

2. Increasing numbers of MHSOP patients being admitted out of the area.
   Admissions had fallen recently and bed occupancy was below the expected level, however peaks of demand were difficult to manage within the bed numbers available.

   It was noted that there had been 2 further closures of residential homes recently in Hartlepool.

3. Following the review of CYP patients diagnosed with ADHD some years ago there had been no issues raised around the work undertaken at that time.
   There would however be instances following reviews over the past couple of months where the diagnosis would have changed in light of the new information tools available.

4. The implication of patients going to Roseberry Park for ECT, due to the notice that had been served by the current providers at Auckland Park Hospital.
   This would impact on the capacity within the Suite, as well as the need to provide beds in the already stretched MHSOP services.

Arising from the report it was noted that:

i) The column “inadequate or uncontrolled” on the risk register should be reviewed as it currently did not provide assurance.

ii) There had been an under reporting of self-harm in CAMHS, however reporting was now more intuitive and consistent.
On this matter it was highlighted that levels of self-harm in children could not be compared to adult services, since there were different recording methods between the 2 areas.

16/05 DURHAM & DARLINGTON LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Durham & Darlington Services LMGB assurance/exception report.

Dr Whitton highlighted the top 3 concerns at present, which were:

1. AMH waiting times and out of area admissions.
Work continued to reduce the waiting times and detailed work was underway to understand the peak in out of area admissions for Darlington patients. Patients were now being reviewed at 30, 60 and 90 days on the ward with the involvement of the community teams.
2. MHSOP pressure on medical staffing.
This workload had increased significantly due to a number of factors and an action plan had been put in place to support this work. This pressure was also seen across other localities in MHSOP.
3. C&YPS capacity and waiting times.
Delivery of waiting times had been affected by staff sickness absence within the service and action plans were in place to improve the situation.

Arising from the report it was noted that:

i) The spend relating to flexible staffing of £2.2m was broken down by £1.1m on flexible staffing and £390k on agency spend. This was reported following a request for breakdown of this figure at the December 2016 QuAC meeting.

Following discussions it was noted that:

a) There was currently a lack of strategic leadership for AMPHS. This had been discussed at the January Mental Health Legislation Committee and whether there might be the potential to train our own crisis team Nurses.
b) Social workers had been informed that they could no longer transport patients in their own vehicles unless they had a medical escort. This had led to some AMPHS asking Consultants to accompany them, putting additional pressures on medical staffing.
On this matter it was noted that further clarification would be sought with the North East Ambulance Service.
c) There were ongoing issues around using Datix during the transitional period of amalgamating various information flows, however the Patient Safety Team had now been trained on Datix and had administrative support.

16/06 NORTH YORKSHIRE AND FORENSIC SERVICES LMGB ASSURANCE/EXCEPTION REPORTS

The Committee noted the locality reports for North Yorkshire and Forensic Services, which had been circulated for information, since there had been no QuAC meeting held in January 2016.

16/07 YORK & SELBY LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the first York & Selby locality Assurance/Exception Report.

Mrs Hill highlighted that the main issues and concerns at present were:

1. Adult Inpatient services were operating under Business Continuity arrangements since the loss of inpatient wards at Bootham Park Hospital.
2. Significant changes were planned throughout the service, which could potentially impact on service delivery and quality:

a) The closure of Peppermill Court (MHSOP) – all MHSOP staff were under Management of Change (MoC) in order to review and reallocate inpatient staffing.
b) White Horse View (LD) – staff under MoC as part of planned closure of unit.
c) Future changes anticipated around disaggregation of all age services to MHSOP and AMH teams.
d) An overall review of administration was also underway. Actions were in place to support the Management of Change processes to ensure continuity of services.

3. The reporting of information for the locality was limited. There was limited data on performance/ patient experience etc. There were also known challenges with data quality. Plans for transition of systems by April 2016 were in place, however would require ongoing training and support to enable new ways of working.
   On this matter it was noted that:
   a) The IT transition would go to LMGB next week.
   b) It would take time for the compendium of information to be pulled together with an anticipated date of July 2016, when any assurances could be given around the data streams. Furthermore, it would take around 6-12 months for the transitional change management to embed into services.

4. Legacy information from LYPFT had been requested, (for example action plans following serious incidents) which had now been completed, however further work was required to ensure that the action plans were completed or new ways of working embedded. There were a range of mechanisms in place to support this process, e.g. mentoring, visits, training, advice and guidance.

5. A risk register was currently being developed.

Following discussion it was noted that:

(i) A significant factor in managing York & Selby would be the handling of public opinion and the media around the closure of adult inpatient beds, together with the significant organisational change for the staff involved.
On this matter it was felt that additional HR support would be required going forward, help around PARIS, together with more input from Communications.

(ii) Discussions with Commissioners around contracts had been positive since the first meeting in January 2016.

16/08 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group report.

Arising from the report it was noted that:

1. Following the meeting of the Patient Safety Group, held on 18 January 2016 the key issues were:
    a) The establishment of a Trust wide Mortality Review group.
    On this matter it was noted that:
        i) The Trust would need to start submitting a proforma referencing mortality data and this would be raised at the Board of Directors in February 2016.
        ii) Nationally, there was an initiative to establish a set of recommendations for the definition around 'unexpected deaths'.
        iii) These recommendations could impact on the reporting process, however it was not anticipated that it would include palliative care or terminal illness.
        iv) As part of the Board Seminar in March 2016 the information from Mazaars would be heard, together with proposals going forward.

    b) A gap analysis would be undertaken of the Trust against the 23 recommendations from the Southern Healthcare report, with an action plan of any necessary improvements. One of the issues picked up in the recommendations had been around the link between intervention around physical health, as well as mental health.
    c) To review action plans from York & Selby when Leeds Partnership Trust had been managing the process to ensure all findings from action plans had been completed and documented, in accordance with Trust policy.
    On this matter it was noted that there was still an issue obtaining the reports to go with the action plans.
    d) The Patient Safety Team would attend the next Falls Executive Group and data would continue to be monitored.
2. The Patient Safety Team would continue to monitor the actions from any Serious Incidents, of which there were 2 incidents outstanding at present.
3. Key performance indicators were currently being agreed with the Head of Patient Safety and would be reported next month to the Quality Assurance Committee.

16/09 PATIENT EXPERIENCE GROUP REPORT

The Committee received and noted the Patient Experience Group report.

It was highlighted that:

1. Assurances had been received from all areas that patient experience data and complaints were being reviewed and acted upon and all issues were being discussed at the relevant QuAGs and LMGBs.
2. Several items remained red on the Scorecard and mitigating actions were in place.
3. The Patient and Carer Experience Team had carried out briefings in York and Selby Community Services and feedback would be collected by the team during February 2016. Inpatient service briefings would commence in March 2016 following procurement of rental devices to allow electronic capture of feedback on the Wards.

16/10 CLINICAL EFFECTIVENESS GROUP EXCEPTION REPORT

The Committee received and noted the Clinical Effectiveness Group exception report.

Arising from the report it was highlighted that:

1. An exception had been raised at the Clinical Effectiveness Group on 18 January 2016 around a community productivity work stream. The Group had discussed key aspects of the project, including products common to all teams and how standardisation of work could be achieved. This included things such as, daily huddles, critical process flows and caseload review.

   On this matter it was acknowledged that the Trust had many different work programmes across localities and specialties and effective cohesion of work programmes and pathway delivery would be needed to maintain high quality services.

2. A paper would go to EMT with firm proposals aligning the different pathways in due course.

16/11 DRUG AND THERAPEUTICS COMMITTEE REPORT

The Committee considered and noted the report of the Drug & Therapeutics Committee (D&T).

Arising from the report it was highlighted that:

1. There had been 2 meetings of the Drug & Therapeutics Committee, held on 3 December 2015 and 28 January 2016.
2. A piece of work was underway to harmonise the York & Selby Medicines policies with Trust policies.
3. The D&T Committee had approved the guidelines on stop smoking products, which would enable registered nursing staff to be able to administer a limited range of nicotine replacement products for up to the first 72 hours of admission.

   On this matter it was noted that there were concerns around a period of time when patients would potentially be without nicotine, ie at bed time. This would be considered in light of the new proposals and mechanisms to support patients with nicotine replacement products.

   Following discussion it was noted that:

   i) Prescribing expenditure reports would be available through the Pharmacy, via the Trust shared drive for all prescribers and teams to view community prescriptions and inpatient prescribing and associated expenditure. These reports would become more focused in the future to break down prescribing expenditure by department.
   ii) A red scoring for the audit around High Dose Antipsychotic Treatment (HDAT) would be re-audited in April 2016.
   On this matter it was pointed out that a lot of work around changing practices was already underway.

16/12 SAFEGUARDING ADULTS & CHILDREN EXCEPTION REPORT

The Committee received and noted the exception report for safeguarding adults and children.

Arising from the report it was highlighted that:

1. The serious case review for Durham regarding a MAPPA case had been put on hold as it had been agreed that it also met the criteria for a MAPPA review. This review was now underway.
2. The workload of the Safeguarding Children team had dramatically increased in light of the newly established multi-agency safeguarding hub in Durham (MASH).
   On this matter it was noted that there was currently a review underway led by the Associate Director of Nursing to look at the capacity of the safeguarding team.
3. The Service Level agreement for Richmondshire, Hambleton and Harrogate had now ended and the workload would be reviewed to avoid any future duplication.

Arising from discussion it was noted that assurances were given that any risks were short term temporary issues and mitigating actions were in place to address these with short, medium and long term action plans.

16/13 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

Arising from the report it was noted that:

1. A response to the Judicial Review following the closure of Bootham Park Hospital by a former patient had been sent to the claimant's solicitor.
2. The 136 Suite at Bootham Park had re-opened on 16th December 2015. The Trust was currently awaiting approval from CQC for outpatients to be resumed at Bootham Park.
3. The draft Intelligent Monitoring Report had been received for comments prior to the report being published on 25 February 2016.
   On this matter it was noted that there were 4 risk areas identified by the CQC:
   (i) Risk in relation to the number of deaths of patients detained under the MHA.
   (ii) Bed occupancy.
   (iii) Fully and partially upheld investigations into complaints.
   (iv) Targets for employment status and accommodation status fields.
4. The CQC had published its report following their inspection at Bootham Park Hospital in September 2015 when the hospital was managed by Leeds and York NHS Partnership Trust.
5. The Trust had received 12 MHA monitoring reports.
6. The Compliance Team had undertaken 6 mock inspections since the last reporting period.

16/14 QUARTERLY FORCE REDUCTION REPORT

The Committee received and noted the quarterly Force Reduction Report

It was highlighted from the report that:

1. The project remained on track to implement the core interventions set out in the restraint reduction plan by Quarter 1 for 2015/16.
2. The Safewards Model had now been set up in 30 inpatient wards, with significant achievements in a number of Forensic and MHSOP services.
   In order to embed the 'Safewards' approach the project team had developed a training package for 'Safewards Champions and these would be available throughout Quarter 4 of 2015/16.

3. The project team had developed a debrief tool for both patients and staff to complete for the use of restrictive interventions. This would be piloted in 10 inpatient wards across the organisation from February 2016.
4. In the longer term consideration would need to be given to the training around the management of violence and aggression, which was central to the force reduction framework.
5. The data around force reduction had revealed good results over Quarter 3, with a significant reduction in prone restraint.
6. Westwood continued to receive additional support due to the complexity of the patients.

Arising from discussion it was noted that:

a) It would be useful to understand the learning from the spike in Quarter 2, July 2015 – September 2015, when the instances of supine went up to almost 600.

Action: Mr Stephen Davison

b) Assurances were given that there had been good feedback from quality visits and patients had also made positive comments.
c) Engagement with York and Selby had commenced and more information would be available once Datix was up and running.
d) There had been a reduction of 81% in the use of prone during Quarter 3.
On this matter it was noted that some Trusts had looked at reducing prone to 0, however this collaborative approach and sometimes prone was the safest option for both the patient and staff.

Agreed: that it would be useful for a representative from Westwood Ward to attend QuAC and give a presentation on the progress made on reducing restraint and issues around managing vulnerable patients.

Action: Mrs E Moody/Mr Stephen Davison

16/15 QUALITY STRATEGY REVIEW

The Committee considered and noted the Quality Strategy Review.
Arising from the report it was noted that:

1. The paper set out the process through which the Quality Strategy would be reviewed, including stakeholder engagement and how the strategy would be disseminated across the Trust.
2. There would be 3 workshops in each of the localities held from March – April 2016 to engage staff, clinical leaders, governors and service users.

16/16 WORKFORCE STAFFING REPORT – STAFF HEALTH AND WELLBEING

The Committee received and noted an update presentation on the current issues and developments around staff health and wellbeing. (A copy of the slides discussed are attached to the minutes for reference)

16/17 QUAC ANNUAL SCHEDULE OF REPORTING 2016

The Committee received and noted the annual schedule of reporting for the Quality Assurance Committee for 2016.

It was highlighted that the following changes had been made on reporting to the Quality Assurance Committee:

1. The Information and Governance Caldicott report would not need to report through the Quality Assurance Committee and would be discussed through Information groups.
2. The Infection Prevention and Control report would now report to QuAC on a quarterly basis, rather than 6 monthly.
3. The Medical Devices and Clinical Procedures Working Group would no longer report to QuAC.
4. The Health, Safety, Security and Fire working group would report to QuAC on a 6 monthly basis, rather than 4 monthly.
5. There would potentially be additional reports to QuAC on the following:
   i) Deloitte Action Plan.
   ii) Carers Strategy 2015/16.
   iii) Harm Minimisation Project.
   iv) Recovery Project.
   v) Clinical Supervision Implementation Report.

16/18 EXCEPTION REPORTING (LMGBs, QuAC sub groups)

There was nothing to note under this item.

16/19 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD

Agreed: that the following matters should be escalated to the Board of Directors:

1. Risk Registers – due to a consistent "amber" scoring on the Tees risk register for adequacy of control, it was felt that a discussion should take place around the framework of the risk register in order to give sufficient meaning to mitigating actions that were in place around risks and to give understanding as to whether risks were going up or down.
2. Concerns were noted around the various risks associated with managing York & Selby, including the external environment, negative media and 30% of staff in the locality subject to change and uncertainty, together with issues around data and the lack of a full compendium of information.

Agreed: that there should be a heightened sense of reporting to the Board of Directors to ensure visibility around York and Selby over the coming months.

On this matter it was noted that Locality Managers would require additional support from HR, help with PARIS and more support from Communications.

16/20 ANY OTHER BUSINESS

Agreed: That following circulation of a revised Locality report template, which had been trialled for the February 2016 meeting a further meeting would be held with Locality Managers and authors of reports, as part of the consultation process, to finalise the locality report template.

Action: Mrs E Moody/Locality Managers

16/21 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 8 March 2016,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 4.45pm

……..

Dr Hugh Griffiths
CHAIRMAN
8 March 2016

Enc

ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22nd March 2016**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Update 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 the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to February 2016 data.

Key issues during the reporting period for York and Selby:

- York and Selby has been reported separately to the wider report, all information has been provided at appendix 7.

Key issues during the reporting period for TEWV:

- There was an improvement in February in relation to the month on month trend with registered nurse on days indicator showing as 'green'. All other indicators (HCA on days, HCA and RN on NIGHTS) are showing as 'red' although this is within an acceptable tolerance.
- The number of indicators within wards showing as 'red' increased in February from 47 to 50, this is outlined on page 4 of the report.
- North Yorkshire have the lowest number of red wards in both February (8) whilst Forensic services have the highest number of red wards (24), this is outlined in appendix 5 of the report.
- The lowest fill rate in February related to Kingfisher/Heron as a result of the ward not being open but are sharing staff to Robin
- The Highest fill rate was observed by Westerdale South in February with the unregistered shifts on days increasing from 293.2% (January) to 331.9% in February. This is due to an agreed uplift on the budgeted establishment.
- Westerdale South and Linnet were the highest users of bank reporting at 66% in February.
- In terms of the triangulation:

  - Bilsdale had a complaint and a low staffing fill rate
  - There were 2 PALS related issues raised in relation to Bransdale in addition to them having high bank usage
  - There were 3 PALS related issues raised in relation to Bilsdale in addition to them having a low staffing fill rate
  - There was 1 PALS related issue raised in relation to Kingfisher/Heron in addition to them having a low staffing fill rate.
- There were 930 shifts allocated in February where a break had not been taken. The majority of which were in relation to day shifts. The highest number of shifts not taken were within the Teesside locality. Heads of Nursing have been asked to investigate further.
- There were 11 incidents raised in February citing staffing levels. Most of which were reported from within the Forensic Services. Page 10 of the report summarises the issues that were cited.

Triangulation of staffing and quality data has not identified any direct risks or implications to patient safety or experience within the reporting period.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**22 March 2016**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Update Report**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (www.tewv.nhs.uk/nursestaffinginfo). The full monthly data set of day by day staffing for each of the 66 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

Work continues to rationalise the report to ensure that the monthly report focusses exclusively on providing assurance that the staffing levels were safe.

York and Selby have been removed from the main report and a separate report covering York and Selby has been attached at appendix 13.

3. KEY ISSUES:

3.1 Safe Staffing Fill Rates

3.1.1 The daily nurse staffing information aggregated for the months of February 2016 is presented in Appendices 1 and 2 with locality information in appendix 3.

The total number of inpatient rosters during the month of February 2016 was 66 which is the same as the previous month.

The month on month trend report shows an improvement in February 2016 with one of the four metrics showing as 'green'. Although the remaining metrics are showing a deterioration when compared to the month of January 2016 it is important to highlight that these figures are still within tolerance.

Month	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-15	87.70	↓	114.20	↓	96.60	↓	113.30	↓
Jan-16	88.60	↑	114.00	↓	96.40	↓	112.00	↓
Feb-16	88.80	↑	111.40	↓	95.30	↓	111.50	↓

The numbers of wards reporting a fill rate of less than 89.9% in February 2016 equates to 50 which is an increase on the previous reporting period of January 2016.

Month	February	January	December	November	October	September
No. of Red Indicators	50	47	47	44	42	43

The majority of the red wards fall into the Registered Nurse on Day shifts category where there were 31 wards shown as red in February compared to 32 in January 2015.

A deterioration can be observed in Forensic Services who also continue to have the highest number of red wards with 24 which is an deterioration when compared to January. The table below shows the split across all localities over the last 6 months with the full detail available in appendix 3 of this report:

Locality	Number of wards red across all metrics						Trend on previous month
	Feb-16	Jan-16	Dec-15	Nov-15	Oct-15	Sept-15	
Durham and Darlington	9	9	7	4	5	5	↔
Teesside	9	10	10	7	10	8	↓
North Yorkshire	8	8	6	9	13	10	↔
Forensics	24	20	24	24	14	20	↑

3.2 February 2016

The lowest staffing fill rate relates to Kingfisher/Heron who are reporting 0% for Registered Nurse on Night Shifts and 20.6% for Registered Nurses on Days. They were identified as having the lowest fill rate in December 2015 for the first time and continue to do so. The breakdown since the split of the wards is as follows:

	Feb-16	Jan-16	Dec-15
RN Day Shifts	20.6%	41.8%	32.5%
RN Night Shifts	0%	30.9%	33.6%

The low fill rates are in relation to the closure of Kingfisher and Heron following the reduction of beds as part of the transforming of care agendas. The staff still allocated to this roster is being used to support Robin ward.

The second lowest fill rate was observed by Robin who had a registered nurse fill rate on days at 35.4% and 50.2% for registered nurses on nights. Robin were identified as having one of the lowest fill rates in December 2015 for the first time and continue to do so. The breakdown since the split of the wards is as follows:

	Feb-16	Jan-16	Dec-15
RN Day Shifts	35.4%	37.4%	32.5%
RN Night Shifts	50.2%	34.4%	33.6%

The ward has articulated that the low fill rates are in relation to the patient transitions due to ward reconfigurations around Transforming Care are ongoing. Staff are being shared between Robin and Kingfisher/Heron so this is not reflective of the staffing required on the wards.

The third lowest fill rate was observed by The Orchards who had a Registered Nurse fill rate on Nights at 51.7%. The breakdown over the last 6 months is as follows:

	Feb-16	Jan-16	Dec-15	Nov-15	Oct-15	Sept-15
The Orchards	51.7%	59.7%	65.0%	100%	89.6%	120.0%

The ward has not provided any explanation for the low fill rate but has advised that there was no direct impact on patient care and that unregistered nurses were used to cover the shortfall. This is evident from within the fill rate in that the unregistered nurse fill rate for nights is reporting at 197.6%

There were 3 other wards that had low fill rates between 59.3% and 65.9%, as shown below:

	Feb-16	Jan-16	Dec-15	Nov-15	Oct-15	Sept-15
Bedale Ward	59.3%	61.1%	66.6%	71.5%	72.7%	71.8%
Bilsdale	64.0%	63.2%	77.9%	64.5%	68.0%	81.6%
Bek, Talbot & Ramsey	65.9%	80.2%	99.1%	103.9%	100.6%	98.0%

It is also important to review the fill rates that exceed their budgeted establishment (shown in blue). During the month of February there were 34 metrics that had staffing in excess of their planned requirements to address specific nursing issues. This is a reduction when compared to January where there were 39.

Westerdale South saw the highest fill rate indicators during the month of February (331.9% and 246.6%). This is now the fifth month in a row they have been in this position. February fill rates are as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westerdale South	**100.7%**	**331.9%**	**102.5%**	**246.6%**

The additional staffing are in relation to an agreed uplift on the budgeted establishment as a result of enhanced observations not generally falling below 3 and 4 on occasions.

The second highest fill rate indicator was in relation to Langley Ward who had an Unregistered fill rate for night shifts of 202.9%. The February fill rate return is as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Langley	**74.0%**	**136.7%**	**101.2%**	**202.9%**

The ward has articulated that the over establishment is due to enhanced observation levels resulting in more staff.

The third highest fill rate indicator was in relation to The Orchards with 197.6% as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
The Orchards	**90.6%**	**106.9%**	**51.7%**	**197.6%**

The ward has articulated that the high fill rate was in relation to providing backfill for the registered nurse shifts on nights.

3.3 Bank Usage

There are recognised risks in high use of bank and agency working although these are mitigated by the use of regular bank and agency staff who know the clinical areas. There is work ongoing to ensure all bank workers achieve the required competencies.

Appendix 6 highlights the usage of bank staffing, as a proportion of actual hours. These are 'RAG' rated independently of the overall fill rate.

Those wards using greater than 50% bank staffing to deliver their fill rates in February 2016 are identified below:

Locality	Ward	Bank Usage Feb-16	Comments
Teesside	Westerdale South	66%	A slight reduction in February when compared to January (67%).
Forensics	Linnet	66%	This is an increase when compared to January (45%)
Forensics	Robin	58%	This is an increase when compared to January (31%)
Teesside	Bransdale	53%	This is an increase when compared to January (38%)

43 wards were reported as Amber (between 10 and 40%) in February 2016, this is a reduction on the previous month of January where there were 46 wards.

From those wards highlighted within this report as the biggest users of bank, the month on month trend is identified as follows:

	February	January	December	November	October	September
Westerdale South	66%	67%	68%	91%	87%	74%
Linnet	66%	45%	42%	42%	25%	28%
Robin	58%	31%				
Bransdale	53%	38%	52%	52%	53%	35%

3.4 Agency Usage

When considering staffing levels it is also important to consider the amount of agency worked within the reporting period. In February 2016 there was a total of 193,518.69 hours worked across the trust of which 301.45 were agency hours, equating to 0.16% of the total hours worked.

The table below shows the breakdown of usage during the reporting period by locality and ward:

Locality	Ward	Total Agency Hours (Feb-16)	Reason for using Agency
North Yorkshire	Rowan Ward	212.50	Sickness, escort and annual leave
North Yorkshire	Cedar (NY)	88.95	Service need

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

3.5 Quality Data Triangulation

The triangulation of the staffing data against a range of quality metrics has been a feature of this monthly report for several months now and to date it has not identified any direct risks or implications to patient safety or experience. A summary is provided on a monthly basis with the detail contained within the appendices. The following is of relevance:

- There were 6 SUI's that occurred within the month of February 2016 from 4 different wards. None of the wards who had SUI's have been cited in this report so far.
- There were 4 level 4 incidents that occurred in February. None of the wards who have had level 4 incidents have been cited in this report so far.
- There were 7 level 3 incidents (self-harm) that occurred within the reporting period none of which were relating to wards that have been identified to date within this report.
- There were 2 complaints that occurred within the reporting period 1 of which were relating to Bilsdale Ward who has been identified as having a low fill rate.
- There were 36 PALS related issues raised during February of which the following is of relevance:
    - 2 X Bransdale who have been identified as having high bank usage
    - 3 X Bilsdale who have been identified as having a low fill rate
    - 1 X Kingfisher/Heron who have been identified as having a low fill rate
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was the Evergreen Centre with a total of 98 incidents requiring control and restraint. To date the Evergreen Centre has not been highlighted within this report as having either a high or low staffing fill rate, bank or agency usage.

3.6 Missed Breaks

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

A thorough analysis of the HealthRoster system has identified that there were 930 shifts in February 2016 where unpaid breaks had not been taken. This is an increase on the previous month whereby there were 901 shifts. The majority of the shifts where breaks were not taken occurred on day shifts (631 shifts in total). The number of night shifts where breaks were not taken was 299 shifts.

The breakdown by locality is as follows:

Locality	Total number of shifts whereby a break was not taken		Trend on Previous Month
	Feb-16	Jan-16	
Durham & Darlington	18	16	↑
Forensics	232	188	↑
North Yorkshire	239	221	↑
Teesside	441	476	↓

The highest number of shifts by locality where a break was not taken was Teesside with 441 shifts. This was largely to do with Aysgarth (200 shifts) and Bankfields Court Unit 2 (118 shifts) and related mostly to days shifts.

The lowest number of shifts by locality where a break was not taken was Durham & Darlington.

In terms of triangulating this information with the staffing fill rates it is difficult to draw any meaningful conclusions in that looking at the top 10 wards where breaks have not been taken on days there are 3 out of 20 metrics that are showing as ‘red’ whilst all the others are reporting as ‘green’. In terms of the top 10 wards from those night shifts where a break was not taken the staffing fill rates are either ‘green’ or ‘blue’ suggesting that missed breaks may not only occur as a result of staffing shortages.

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. It is therefore not possible to separate whether this is due to clinical need or customary practice.

A task and finish and finish group led by HR has recently been established which will provide focus on staff breaks and adherence to EU Working time directives.

3.7 Incidents raised citing Staffing Levels

It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. Within the reporting period there were 11 incidents raised citing issues with staffing of which 10 were in relation to in-patient services and 1 was in relation to community based teams which would be considered out with this report.

The incidents citing staffing problems were from the following localities:

Locality	Feb-16
	No. of Incidents
North Yorkshire	2
Durham & Darlington	4
Teesside	0
Forensics	5

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

- Planned activity had to be changed as this would have resulted in no qualified nurses being present on the ward
- Staffing was reduced as a result of a CPA meeting or for a short period of time.
- There was 1 incident raised on the 13th February highlighting that due to sickness there was no qualified nurse on duty within a Forensic unit. This was escalated to the on call manager and cover was provided.
- Low staffing levels following sickness and on 1 occasion this resulted in breaks being suspended.
- 2 incidents highlighting that there would be no junior doctor
- There were 2 incidents cited within Durham & Darlington where the alarms had been raised and only staff from the ward was in attendance.

Analysis of the above information would suggest that the escalation of incidents relating to staffing levels is not currently consistently applied across the Trust and it is not clear from the initial incident report how risks related to staffing are resolved, managed or mitigated.

Discussion has taken place at the Operational Management Team meeting regarding staffing escalation processes in order that a standard approach can be adopted across the Trust and a timely response to ensure patient safety is not compromised.

3.8 Other

Although the Board did not agree to a dedicated Safe Staffing project for this year's Annual Plan (2015/16), this piece of work will be managed under business as usual within the Nursing and Governance Directorate in 2016/17. A pilot will be undertaken within Durham & Darlington and will:

- Test out NHS England evidence based staffing framework and tools for MH wards in agreed in-patient areas.
- To ensure above indicators are compliant with emerging NICE guidance or other DH documentation
- To put in place Triangulation and hot spot systems for predicting planned requirements
- To implement regular reporting and monitoring systems within services to enable timely and informed intervention to occur

The output from the project will have a bearing on the format and quality of reports ultimately received by Board on this issue.

Work has commenced to review the process of validation and context information being sought from the wards as this is currently a manual process; any information collected is retained within the department for reference, outliers will be followed up and consideration is being given as to how best to use this information to present it in a more meaningful summary for future reports.

The Chief Nursing Officer has issued further directives regarding the Safe Staffing returns in relation to the direct clinical contact time nursing staff spend with patients. A number of tools have been suggested for use to produce data that is required to be included in the six monthly Board reports to demonstrate contact time. These will be explored as part of the Safe Staffing review.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

No direct risks or implications to patient safety from the staffing data have been identified this month, although the following is of relevance:

- There was an improvement in February in relation to the month on month trend with 1 indicator showing as ‘green’. All other indicators are showing as ‘red’ although this is within an acceptable tolerance.
- The number of wards showing as ‘red’ increased in February from 47 to 50.
- North Yorkshire have the lowest number of red wards in both February (8) whilst Forensic services have the highest number of red wards (24).
- The lowest fill rate in February related to Kingfisher/Heron as a result of the ward not being open but are sharing staff to Robin
- The Highest fill rate was observed by Westerdale South in February with the unregistered shifts on days increasing from 293.2% (January) to 331.9% in February.
- Westerdale South and Linnet were the highest users of bank reporting at 66% in February.
- In terms of the triangulation:
    - Bilsdale had a complaint and a low staffing fill rate
    - There were 2 PALS related issues raised in relation to Bransdale in addition to them having high bank usage

  - There were 3 PALS related issues raised in relation to Bilsdale in addition to them having a low staffing fill rate
  - There was 1 PALS related issue raised in relation to Kingfisher/Heron in addition to them having a low staffing fill rate.
- There were 930 shifts allocated in February where a break had not been taken. The majority of which were in relation to day shifts. The highest number of shifts not taken were within the Teesside locality.
- There were 11 incidents raised in February citing staffing levels. Most of which were reported from within the Forensic Services. Page 10 of the report summarises the issues that were cited.

4.2 **Financial/Value for Money:**

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

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

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

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

4.4 **Equality and Diversity:**

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

4.5 **Other implications:**

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

5. RISKS:

The current lack of an evidence based tool for workforce planning and monitoring in mental health and learning disability nursing increases the risk that the publication of the workforce data will be compared to other Trust's data without appreciation of context. Information published on the Trust website will assist with provision of contextual information. NICE are expected

to publish further guidance on evidence based approaches to staffing by the end of this year 2015

6. CONCLUSIONS:

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

A review of safe staffing will be undertaken during the financial year 2016/17 which will refine the usage of the data further. The comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has not shown any significant trend or impact.

6.2 It is difficult to draw any meaningful conclusions from the data presented within this report.

7. RECOMMENDATIONS:

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

Emma Haimes
Head of Quality Data
March 2016

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 29 DAYS IN February							
				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
The Orchards (NY)	North Yorkshire	Adults	10	90.6%	106.9%	51.7%	197.6%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	13	116.1%	82.0%	110.0%	93.1%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	13	103.4%	93.6%	101.3%	98.3%
Bedale Ward	Teesside	Adults	10	59.3%	170.5%	100.3%	103.8%
Bilsdale Ward	Teesside	Adults	14	64.0%	152.4%	93.4%	102.1%
Birch Ward	Durham & Darlington	Adults	15	86.6%	97.5%	100.0%	100.0%
Bransdale Ward	Teesside	Adults	14	80.6%	153.5%	104.0%	118.5%
Cedar Ward	Durham & Darlington	Adults	10	100.2%	113.4%	100.0%	110.6%
Cedar Ward (NY)	North Yorkshire	Adults	18	94.2%	90.9%	110.3%	94.7%
Earlston House	Durham & Darlington	Adults	15	97.6%	98.6%	100.0%	100.0%
Elm Ward	Durham & Darlington	Adults	20	101.4%	98.5%	100.0%	100.0%
Farnham Ward	Durham & Darlington	Adults	20	105.2%	117.2%	100.0%	106.9%
Lincoln Ward	Teesside	Adults	20	108.2%	96.4%	100.6%	103.6%
Lustrum Vale	Teesside	Adults	20	81.6%	132.8%	100.0%	100.0%
Maple Ward	Durham & Darlington	Adults	17	98.9%	96.5%	100.7%	106.9%
Overdale Ward	Teesside	Adults	18	81.5%	117.7%	90.0%	102.0%
Park House	Teesside	Adults	14	104.3%	108.4%	100.9%	96.9%
Primrose Lodge	Durham & Darlington	Adults	15	73.4%	117.2%	100.0%	100.0%
Stockdale Ward	Teesside	Adults	18	77.0%	125.2%	112.4%	97.2%
Tunstall Ward	Durham & Darlington	Adults	20	100.0%	107.5%	96.6%	100.0%

Ward 15 Friarage	North Yorkshire	Adults	14	88.6%	126.8%	103.4%	108.5%
Willow Ward	Durham & Darlington	Adults	15	82.9%	146.7%	100.0%	129.4%
Baysdale	Teesside	CYPS	6	135.7%	91.3%	99.8%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	131.1%	104.7%	101.6%	100.0%
Newberry Centre	North Yorkshire	CYPS	14	75.8%	117.9%	107.1%	101.9%
The Evergreen Centre	North Yorkshire	CYPS	16	86.3%	126.4%	101.5%	103.5%
Westwood Centre	North Yorkshire	CYPS	12	98.2%	134.2%	93.9%	191.8%
Clover/Ivy	Forensics	Forensics LD	12	99.7%	105.2%	100.0%	160.0%
Eagle/Osprey	Forensics	Forensics LD	10	91.8%	99.8%	100.0%	106.9%
Harrier/Hawk	Forensics	Forensics LD	10	74.7%	116.7%	110.3%	100.0%
Kestrel/Kite.	Forensics	Forensics LD	16	93.4%	108.2%	96.6%	113.8%
Kingfisher/Heron	Forensics	Forensics LD	4	20.6%	42.8%	0.0%	35.7%
Robin	Forensics	Forensics LD	6	35.4%	86.7%	50.2%	131.0%
Langley Ward	Forensics	Forensics LD	10	74.0%	136.7%	101.2%	202.9%
Northdale Centre	Forensics	Forensics LD	12	87.5%	92.5%	82.7%	96.9%
Oakwood	Forensics	Forensics LD	8	92.0%	153.7%	97.2%	100.0%
Thistle	Forensics	Forensics LD	5	83.4%	118.3%	86.1%	103.4%
Brambling Ward	Forensics	Forensics MH	13	94.0%	110.4%	107.5%	133.2%
Fulmar Ward.	Forensics	Forensics MH	12	103.2%	99.0%	103.8%	117.3%
Jay Ward	Forensics	Forensics MH	5	71.6%	104.8%	100.6%	100.6%
Kirkdale Ward	Forensics	Forensics MH	16	76.0%	102.8%	73.2%	93.6%
Lark	Forensics	Forensics MH	15	87.6%	100.0%	90.3%	98.9%
Linnet Ward	Forensics	Forensics MH	17	84.5%	177.2%	100.9%	177.0%
Mallard Ward	Forensics	Forensics MH	16	86.2%	117.4%	100.0%	177.4%
Mandarin	Forensics	Forensics MH	16	91.2%	92.9%	100.6%	100.6%
Merlin	Forensics	Forensics MH	10	75.0%	146.4%	87.2%	173.3%
Newtondale Ward	Forensics	Forensics MH	20	81.5%	93.9%	77.9%	102.3%
Nightingale Ward	Forensics	Forensics MH	16	95.8%	100.9%	100.6%	99.0%

Sandpiper Ward	Forensics	Forensics MH	8	111.4%	91.3%	72.6%	114.3%
Swift Ward	Forensics	Forensics MH	10	94.8%	101.6%	110.0%	120.5%
Aysgarth	Teesside	LD	6	111.6%	139.3%	99.6%	100.4%
Bankfields Court Unit 2	Teesside	LD	5	126.7%	103.9%	101.2%	100.0%
Bankfields Court	Teesside	LD	19	91.0%	117.8%	96.0%	101.5%
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	86.1%	65.9%	89.7%	79.8%
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	96.8%	135.8%	100.3%	94.8%
Hamsterley Ward	Durham & Darlington	MHSOP	10	97.8%	130.9%	100.0%	98.5%
Oak Ward	Durham & Darlington	MHSOP	12	72.0%	90.5%	100.0%	101.7%
Picktree Ward.	Durham & Darlington	MHSOP	10	73.4%	106.4%	100.0%	100.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	95.2%	97.1%	100.0%	100.0%
Rowan Lea	North Yorkshire	MHSOP	20	75.0%	111.7%	100.6%	103.2%
Rowan Ward	North Yorkshire	MHSOP	16	91.8%	133.2%	109.9%	101.7%
Springwood Community Unit	North Yorkshire	MHSOP	14	97.9%	79.4%	100.0%	136.8%
Ward 14	North Yorkshire	MHSOP	9	88.8%	109.1%	110.7%	98.6%
Westerdale North	Teesside	MHSOP	18	103.7%	142.7%	103.3%	103.7%
Westerdale South	Teesside	MHSOP	14	100.7%	331.9%	102.5%	246.6%
Wingfield Ward	Teesside	MHSOP	12	73.7%	84.0%	92.0%	100.0%

Appendix 2

February	TRUSTWIDE DAILY POSITION –all wards	
	Difference between what was planned on roster and actually worked – RNs	Difference between what was planned on roster and actually worked – HCAs
1	-5%	10%
2	-7%	9%
3	-13%	13%
4	-6%	10%
5	-11%	13%
6	-11%	12%
7	-9%	14%
8	-10%	9%
9	-7%	10%
10	-8%	11%
11	-9%	12%
12	-7%	9%
13	-13%	12%
14	-9%	11%
15	-12%	7%
16	-13%	12%
17	-14%	10%
18	-14%	10%
19	-13%	10%
20	-14%	15%
21	-13%	12%

22	-13%	10%
23	-7%	11%
24	-10%	7%
25	-10%	8%
26	-8%	6%
27	-13%	10%
28	-11%	13%
29	-10%	7%
30	0%	0%
31	0%	0%

Appendix 3

DURHAM & DARLINGTON LOCALITY REPORT - February 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Birch Ward	15	735	348	948	696	636.46	348	924	696	86.6%	100.0%	97.5%	100.0%
Elm Ward	20	846	348	696	696	857.75	348	685.83	696	101.4%	100.0%	98.5%	100.0%
Maple Ward	17	849.5	348	689.33	696	840.51	350.5	665.33	744	98.9%	100.7%	96.5%	106.9%
Farnham Ward	20	775.5	348	696	696	815.5	348	816	744	105.2%	100.0%	117.2%	106.9%
Tunstall Ward	20	771	348	696	696	771	336	748	696	100.0%	96.6%	107.5%	100.0%
Willow Ward	15	744	348	668.5	612	617	348	980.5	792	82.9%	100.0%	146.7%	129.4%
Earlston House	15	814.5	348	676.17	696	794.67	348	667	696	97.6%	100.0%	98.6%	100.0%
Primrose Lodge	15	834.33	348	696	696	612	348	816	696	73.4%	100.0%	117.2%	100.0%
Holly Unit	4	246.65	190	441.62	190	323.26	193	462.36	190	131.1%	101.6%	104.7%	100.0%
Cedar Ward PICU	10	838.5	348	679.5	1020	840	348	770.5	1128	100.2%	100.0%	113.4%	110.6%
Ceddesfeld Ward	10	853.5	348	633	696	826.25	349	859.33	660	96.8%	100.3%	135.8%	94.8%
Roseberry Wards	15	853.5	348	816	696	812.33	348	792.16	696	95.2%	100.0%	97.1%	100.0%
Oak Ward	12	853.83	348	696	696	614.7	348	629.7	708	72.0%	100.0%	90.5%	101.7%
Picktree Ward.	10	853.67	348	612.17	696	626.33	348	651.17	696	73.4%	100.0%	106.4%	100.0%
Hamsterley Ward	10	853.5	348	509.33	696	834.8	348	666.57	685.33	97.8%	100.0%	130.9%	98.5%
Bek, Ramsey, Talbot Wards	16	769.5	348	2964	1368	662.41	312	1954.08	1092	86.1%	89.7%	65.9%	79.8%

FORENSICS LOCALITY REPORT - February 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Lark	15	807.62	326.25	919.25	652.5	707.75	294.5	919.25	645.25	87.6%	90.3%	100.0%	98.9%
Brambling Ward	13	799.25	326.25	948.75	651.25	751.6	350.75	1047.5	867.5	94.0%	107.5%	110.4%	133.2%
Fulmar Ward.	12	809.45	326.25	1203.93	652.5	835.73	338.5	1191.35	765.25	103.2%	103.8%	99.0%	117.3%
Jay Ward	5	810	326.25	947	652.5	579.75	328.25	992.87	656.5	71.6%	100.6%	104.8%	100.6%
Kirkdale Ward	16	774.25	326.25	1204.5	652.5	588.42	238.75	1238.25	610.5	76.0%	73.2%	102.8%	93.6%
Linnet Ward	17	799.51	326.25	948.75	652.5	675.96	329.25	1681.23	1154.75	84.5%	100.9%	177.2%	177.0%
Mallard Ward	16	799.75	326.25	1215	652.5	689.75	326.25	1427	1157.5	86.2%	100.0%	117.4%	177.4%
Mandarin	16	794.25	326.25	941	652.5	724.25	328.25	874	656.5	91.2%	100.6%	92.9%	100.6%
Merlin	10	800.25	649.75	1203.75	652.5	600.5	566.5	1762.58	1131	75.0%	87.2%	146.4%	173.3%
Newtondale Ward	20	806.25	652.5	1518.5	652.5	656.75	508.25	1426	667.75	81.5%	77.9%	93.9%	102.3%
Nightingale Ward	16	810	326.25	947	645.5	776	328.25	955.5	638.75	95.8%	100.6%	100.9%	99.0%
Sandpiper Ward	8	806.13	652.5	1494.5	652.5	897.75	473.75	1363.75	745.5	111.4%	72.6%	91.3%	114.3%
Swift Ward	10	808.5	326.25	1211.77	652.5	766.75	359	1230.75	786.5	94.8%	110.0%	101.6%	120.5%
Clover/Ivy	12	717.18	326.25	1780.67	652.5	714.88	326.25	1872.67	1044.2	99.7%	100.0%	105.2%	160.0%
Eagle/Osprey	10	738	326.25	1454.75	652.5	677.25	326.25	1451.25	697.5	91.8%	100.0%	99.8%	106.9%
Harrier/Hawk	10	723.5	326.25	1797.75	652.5	540.5	360	2097.5	652.5	74.7%	110.3%	116.7%	100.0%
Kestrel/Kite.	16	750.75	326.25	2027.75	652.5	701.41	315	2193.78	742.5	93.4%	96.6%	108.2%	113.8%
Kingfisher/Heron	4	483.75	0	916.91	315	99.87	0	392.23	112.5	20.6%	0.0%	42.8%	35.7%
Robin	6	808	652.5	823	326.25	285.87	327.75	713.34	427.5	35.4%	50.2%	86.7%	131.0%
Northdale Centre	12	793.5	326	1948.29	1305	694.16	269.75	1802.67	1264.5	87.5%	82.7%	92.5%	96.9%

Oakwood	8	810.5	326.25	326.25	326.25	745.75	317.17	501.5	326.25	92.0%	97.2%	153.7%	100.0%
Thistle	5	715.47	324.25	1169.3	652.5	596.71	279.25	1383.08	675	83.4%	86.1%	118.3%	103.4%
Langley Ward	10	788	326.25	824.25	315	583.42	330.25	1127	639.25	74.0%	101.2%	136.7%	202.9%

NORTH YORKSHIRE LOCALITY REPORT - February 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Ayckbourn Unit Danby Ward	13	751.33	319	697	638	872.33	351	571.5	594	116.1%	110.0%	82.0%	93.1%
Ayckbourn Unit Esk Ward	13	951.5	319	699	638	983.5	323	654	627	103.4%	101.3%	93.6%	98.3%
Ward 15 Friarage	14	779.48	326.25	639.73	641.25	690.33	337.5	811	695.83	88.6%	103.4%	126.8%	108.5%
Cedar Ward (NY)	18	1011	311.75	924.3	946.5	951.92	344	840.5	896.7	94.2%	110.3%	90.9%	94.7%
The Orchards (NY)	10	853.5	696	348	348	773.5	360	372	687.48	90.6%	51.7%	106.9%	197.6%
Newberry Centre	14	1230	275.5	1247	551	932.87	295	1470.74	561.25	75.8%	107.1%	117.9%	101.9%
Westwood Centre	12	1050.75	390.75	1488	667	1031.75	366.75	1997.25	1279.25	98.2%	93.9%	134.2%	191.8%
The Evergreen Centre	16	1696.25	333.5	1318	1000.5	1463.17	338.5	1666.5	1035.5	86.3%	101.5%	126.4%	103.5%
Rowan Lea	20	994.31	338.43	1247	1010	746.19	340.43	1392.86	1042.34	75.0%	100.6%	111.7%	103.2%
Rowan Ward	16	1003	348	702	696	921	382.5	935	707.5	91.8%	109.9%	133.2%	101.7%
Springwood Community Unit	14	903.67	326.25	870	641.25	884.42	326.25	690.35	877.5	97.9%	100.0%	79.4%	136.8%
Ward 14	9	854.5	326.25	551.25	652.5	758.75	361.25	601.5	643.25	88.8%	110.7%	109.1%	98.6%

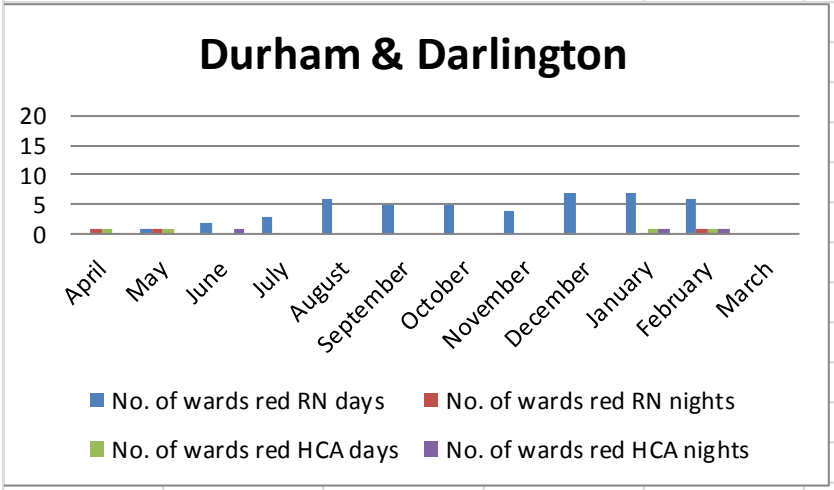
TEESSIDE LOCALITY REPORT - February 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Bedale Ward	10	772	333.5	666	1000.5	458	334.5	1135.5	1039	59.3%	100.3%	170.5%	103.8%
Bilsdale Ward	14	823.23	333.5	667	609.5	527.23	311.5	1016.47	622	64.0%	93.4%	152.4%	102.1%
Bransdale Ward	14	764.5	333.5	655.5	667	616	347	1006	790.15	80.6%	104.0%	153.5%	118.5%
Lincoln Ward	20	809.5	334.5	1150.5	667	876	336.5	1108.75	691	108.2%	100.6%	96.4%	103.6%
Lustrum Vale	20	1033	333.5	667	667	842.5	333.5	886	667	81.6%	100.0%	132.8%	100.0%
Overdale Ward	18	809.5	333.5	779.5	667	660	300	917.5	680.5	81.5%	90.0%	117.7%	102.0%
Park House	14	671	333.5	639.5	655.5	700	336.5	693.5	635.5	104.3%	100.9%	108.4%	96.9%
Stockdale Ward	18	775.5	333.5	682	667	597.25	375	853.83	648	77.0%	112.4%	125.2%	97.2%
Baysdale	6	507.93	323.93	881.88	647.57	689.19	323.18	805.52	647.57	135.7%	99.8%	91.3%	100.0%
Westerdale North	18	814.75	333.5	567.5	643.5	845	344.5	809.75	667	103.7%	103.3%	142.7%	103.7%
Westerdale South	14	824.5	333.5	687.08	632.5	830	342	2280.47	1559.52	100.7%	102.5%	331.9%	246.6%
Wingfield Ward	12	669.5	337.5	590	667	493.5	310.5	495.5	667	73.7%	92.0%	84.0%	100.0%
Aysgarth	6	489.98	291.75	775	290	546.74	290.58	1079.5	291.25	111.6%	99.6%	139.3%	100.4%
Bankfields Court Unit 2	5	441.17	290	960.46	290	558.94	293.5	997.82	290	126.7%	101.2%	103.9%	100.0%
Bankfields Court	19	1392	696	3476.66	2088	1267.35	668.33	4096.15	2119.41	91.0%	96.0%	117.8%	101.5%

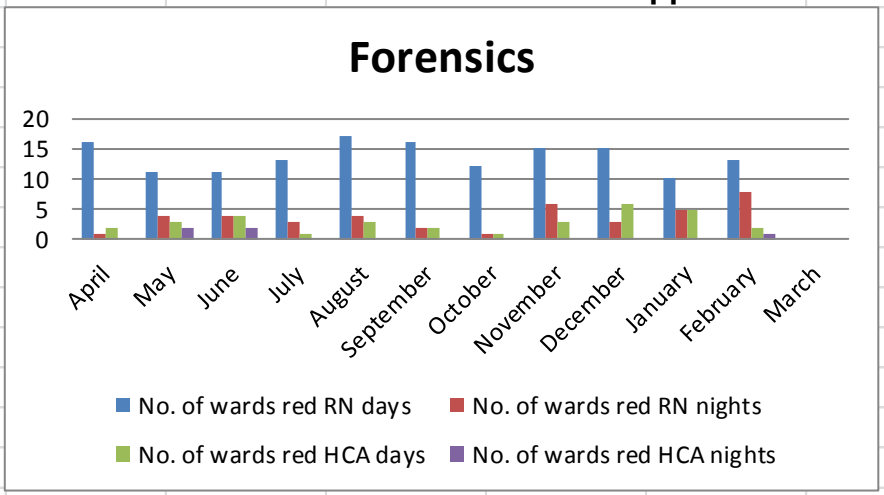
Appendix 4

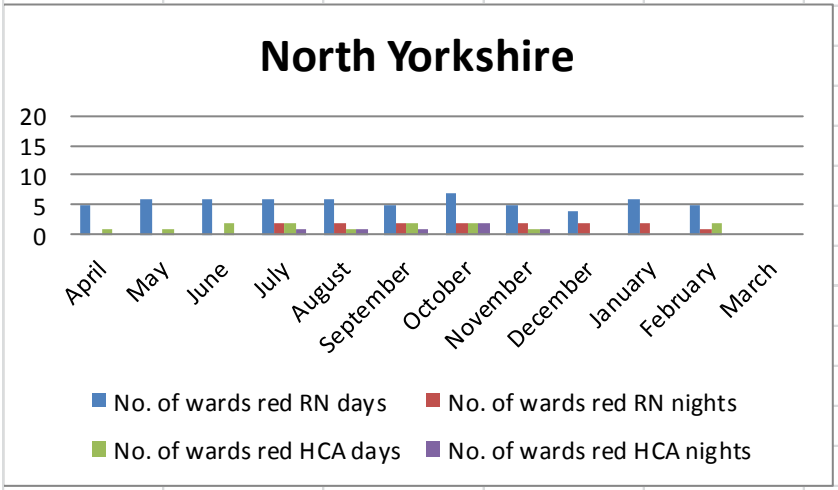
TEWV TOTAL (Excluding York and Selby) - Month on Month Trend

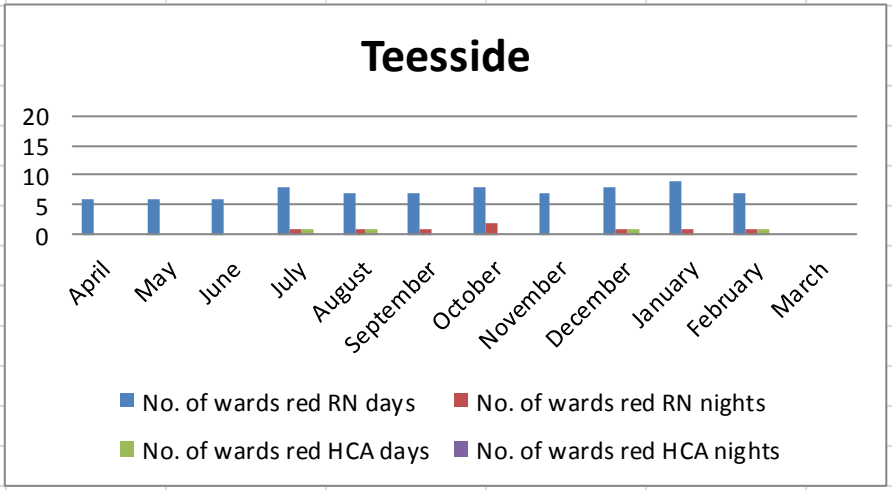
Month	Actual Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Sep-14	93.08	↑	105.27	↓	99.66	↑	109.43	↑
Oct-14	92.76	↓	108.82	↑	99.09	↓	108.67	↓
Nov-14	92.04	↓	109.45	↑	99.41	↑	108.98	↑
Dec-14	90.79	↓	102.47	↓	98.22	↓	107.13	↓
Jan-15	93.61	↑	107.32	↑	100.95	↑	110.20	↑
Feb-15	92.65	↓	107.14	↓	102.52	↑	109.17	↓
Mar-15	91.99	↓	106.64	↓	100.62	↓	110.48	↑
Apr-15	93.12	↑	111.42	↑	101.19	↑	111.20	↑
May-15	93.00	↓	110.34	↓	102.27	↑	110.09	↓
Jun-15	93.12	↑	109.50	↓	100.62	↓	112.27	↑
Jul-15	90.80	↓	114.10	↑	99.40	↓	115.30	↑
Aug-15	87.90	↓	112.60	↓	98.10	↓	110.10	↓
Sep-15	90.3	↑	113.6	↑	98.20	↑	112.6	↑
Oct-15	89.8	↓	119.0	↑	99.01	↑	113.8	↑
Nov-15	90.72	↑	118.47	↓	96.82	↓	114.52	↑
Dec-15	87.70	↓	114.20	↓	96.60	↓	113.30	↓
Jan-16	88.60	↑	114.00	↓	96.40	↓	112.00	↓
Feb-16	88.80	↑	111.40	↓	95.30	↓	111.50	↓

Number of Red Wards by Locality **Appendix 5**









Appendix 6

Scored Fill Rate compared to Quality Indicators - FEBRUARY 2016					Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total score	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4	Level 3	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Aysgarth	Teesside	LD	6	9	2208.07	395.98	18%									
Tunstall Ward	Durham & Darlington	AMH	20	8	2551	36	1%			1		1				
Westerdale South	Teesside	MHSOP	14	10	5011.99	3297.69	66%						5		7	7
Earlston House	Durham & Darlington	AMH	15	8	2505.67	240	10%									
Bankfields Court Unit 2	Teesside	LD	5	9	2140.26	536.2	25%									
Holly Unit	Durham & Darlington	CAMHS	4	9	1168.62	45.34	4%									
Lincoln Ward	Teesside	AMH	20	8	3012.25	183.5	6%						3		5	5
Westerdale North	Teesside	MHSOP	18	9	2666.25	406.25	15%					2				
Westwood Centre	North Yorkshire	CAMHS Tier 4	12	10	4675	1716.5	37%						53	3	91	94
Farnham Ward	Durham & Darlington	AMH	20	8	2723.5	240	9%	2	2	1		2	3		4	4
Hamsterley Ward	Durham & Darlington	MHSOP	10	9	2534.7	527.99	21%						2		2	2
Mallard Ward	Forensics	FMH	16	8	3600.5	1711.75	48%						1		1	1
Rowan Ward	North Yorkshire	MHSOP	16	9	2946	699	24%						2		2	2
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	9	2694.58	340	13%						9		9	9
Elm Ward	Durham & Darlington	AMH	20	8	2587.58	310.33	12%									
Stockdale Ward	Teesside	AMH	18	8	2474.08	913.5	37%						6		6	6
Northdale Centre	Forensics	FMH	12	6	4031.08	790.08	20%						2		3	3
Bedale Ward	Teesside	AMH	10	8	2967	392	13%						2		2	2

Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	4	4020.49	434.72	11%						10	2	9	11
Brambling Ward	Forensics	FMH	13	9	3017.35	1297	43%						18		29	29
Bransdale Ward	Teesside	AMH	14	8	2759.15	1455	53%					2	5		6	6
Lustrum Vale	Teesside	AMH	20	8	2729	1042.5	38%									
Bilsdale Ward	Teesside	AMH	14	8	2477.2	885.5	36%				1	3	1		4	4
Birch Ward	Durham & Darlington	AMH	15	7	2604.46	216	8%									
Cedar Ward (NY)	North Yorkshire	AMH	18	8	3033.12	477	16%					1	1		1	1
Eagle/Osprey	Forensics	FLD	10	8	3152.25	697.25	22%						1		2	2
Maple Ward	Durham & Darlington	AMH	17	8	2600.34	670.66	26%	2	1			1	3		6	6
Picktree Ward.	Durham & Darlington	MHSOP	10	7	2321.5	732.49	32%						7		20	20
Primrose Lodge	Durham & Darlington	AMH	15	7	2472	453	18%									
Newberry Centre	North Yorkshire	CAMHS Tier 4	14	7	3259.86	190.43	6%						2		2	2
The Evergreen Centre	North Yorkshire	CAMHS Tier 4	16	8	4503.67	747.75	17%	1	1				58		98	98
Ward 14	North Yorkshire	MHSOP	9	7	2364.75	22.5	1%									
Willow Ward	Durham & Darlington	AMH	15	9	2737.5	743	27%			1			4		5	5
Baysdale	Teesside	CAMHS	6	9	2465.46	170.27	7%									
Langley Ward	Forensics	FLD	10	9	2679.92	1216	45%									
Merlin	Forensics	FMH	10	8	4060.58	1897	47%						4		5	5
Oak Ward	Durham & Darlington	MHSOP	12	7	2300.4	159.26	7%									
Oakwood	Forensics	FLD	8	9	1890.67	208.25	11%									
Bankfields Court	Teesside	LD	19	8	8151.24	1028.2	13%					1	32		41	41
Park House	Teesside	AMH	14	8	2365.5	561	24%									
Cedar Ward	Durham & Darlington	AMH	10	8	3086.5	1161.67	38%					2	5		9	9
Fulmar Ward.	Forensics	FMH	12	8	3130.83	796.07	25%						17	1	30	31
Jay Ward	Forensics	FMH	5	7	2557.37	498.75	20%									
Kingfisher/Heron	Forensics	FLD	4	4	604.6	22.5	4%					1				

Robin	Forensics	FLD	6	6	1754.46	1009.02	58%									
Nightingale Ward	Forensics	FMH	16	8	2698.5	823.75	31%						1		2	2
Sandpiper Ward	Forensics	FMH	8	7	3480.75	930	27%					1	17	1	45	46
Springwood Community Unit	North Yorkshire	MHSOP	14	8	2778.52	468.92	17%						49		51	51
Thistle	Forensics	FLD	5	6	2934.04	721.41	25%									
Ward 15 Friarage	North Yorkshire	AMH	14	8	2534.66	712.37	28%						2		2	2
Overdale Ward	Teesside	AMH	18	6	2558	519.5	20%	1		1			7	1	8	9
Linnet Ward	Forensics	FMH	17	9	3841.19	2538.21	66%						15		17	17
Swift Ward	Forensics	FMH	10	9	3143	1306	42%			3		1	33		56	56
Ayckbourn Unit Esk Ward	North Yorkshire	AMH	13	8	2587.5	325	13%					3	5		9	9
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	13	7	2388.83	526.5	22%									
Clover/Ivy	Forensics	FLD	12	9	3958	865.01	22%					2	5		6	6
Kirkdale Ward	Forensics	FMH	16	6	2675.92	663.75	25%									
Roseberry Wards	Durham & Darlington	MHSOP	15	8	2648.49	694.16	26%									
Lark	Forensics	FMH	15	7	2566.75	763.75	30%					1				
Wingfield Ward	Teesside	MHSOP	12	6	1966.5	416.5	21%									
Kestrel/Kite.	Forensics	FLD	16	8	3952.69	1554.28	39%				1	5				
The Orchards (NY)	North Yorkshire	AMH	10	8	2192.98	109.5	5%									
Mandarin	Forensics	FMH	16	8	2583	582.75	23%					2				
Rowan Lea	North Yorkshire	MHSOP	20	7	3521.82	340.54	10%						6		8	8
Newtondale Ward	Forensics	FMH	20	6	3258.75	887	27%					4				
Harrier/Hawk	Forensics	FLD	10	7	3650.5	708.75	19%					1	1		3	3

Appendix 7

YORK AND SELBY SAFE STAFFING REPORT

Introduction:

The total number of rosters during the period of February 2016 for York and Selby equates to 6 as a result of Peppermill Court closing.

Month on Month Trend:

The month on month trend report shows a deterioration when across 2 of the fill rate indicators when compared to January, as shown below:

Month	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
Oct-15	89.29	-	101.0	-	112.99	-	104.68	-
Nov-15	76.39	↓	91.27	↓	56.40	↓	101.89	↓
Dec-15	84.50	↑	91.40	↑	91.60	↑	107.40	↑
Jan-16	78.60	↓	96.40	↑	91.80	↑	112.70	↑
Feb-16	77.90	↓	95.30	↓	85.00	↓	114.00	↑

Although there are red fill rates these are still within an acceptable tolerance.

Red Fill Rate Indicators:

The position in February was that there were 11 of the 24 metrics that had fill rates of less than 89.9% (shown as red) across both staff groups for all shifts as shown below:

Month	October	November	December	January	February
No. of Red Indicators	7	10	11	11	11

The majority of the red indicators fall into the Registered Nurse on Day shifts category where there were 5 wards shown as red in February 2016 as follows:

	October	November	December	January	February
No. of wards red RN days	3	5	5	5	5
No. of wards red RN nights	1	2	2	2	2
No. of wards red HCA days	2	3	4	4	3
No. of wards red HCA nights	1	0	0	0	1

February 2016 Staffing Fill Rates:

The lowest fill rate was observed by Recovery Unit Acomb who had a Registered Nurse on nights fill rate of 48.9%. The breakdown over the last 4 months is as follows:

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Recovery Unit Acomb	154.8%	89.8%	75.8%	50%	48.3%

The ward has articulated that this is due to the temporary closure of the unit, the number of patients has reduced and so staff has been freed up to work in other areas of the locality as and when required.

The second lowest fill rate was observed by White Horse View who had a Registered Nurse on Days fill rate of 60.8%. The breakdown over the last 4 months is as follows:

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
White Horse View	90.5%	83.0%	58.2%	79.7%	60.8%

The ward has articulated that the low fill rate is in relation to the low occupancy on the ward, as it moves towards closure at the end of March. The reason for the variance is that the staffing numbers have been reduced in line with lower occupancy and risk (established numbers are 5-5-3; currently operating on 4-4-3). The service is also carrying vacancies for HCA posts.

The third lowest fill rate was observed by Meadowfields with a fill rate of 64.9% on registered nurse days as follows:

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Meadowfields	71.3%	62.3%	68.9%	48.9%	64.9%

The ward has articulated that the low fill rate is in relation to having vacancies. Cover was provided by agency. In addition flexing of the workforce has also taken place.

There were 3 wards that had staffing in excess of their budgeted establishments (shown as 'blue') as articulated below:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Worsley Court	**87.8%**	**106.9%**	**111.6%**	**160.1%**
Cherry Tree House	**78.0%**	**133.1%**	**86.1%**	**124.0%**

At the time of writing the report we had not received any feedback in relation to the excess of budgeted establishment.

Bank Usage:

The Bank Staffing, as a proportion of actual hours worked for the reporting period is identified below:

	February 2016		
	Total Hours Worked	Bank Usage (Hours)	Bank %
Meadowfields	3324	604.6	18%
Oak Rise	2810.85	486.5	17%
Recovery Unit Acomb	2549.25	149.5	6%
White Horse View	2486	44	2%
Worsley Court	3518.5	184	5%
Cherry Tree House	3786	498	13%

The highest user of bank is Meadowfields in February.

Agency Usage:

The Agency usage, as a proportion of actual hours worked covering the reporting period is identified below:

	February-15		
	Agency Usage (Hours)	Total Hours Worked	Agency %
Meadowfields	3324.00	86.50	2.6%
Oak Rise	2810.85	0.00	0.0%
Recovery Unit Acomb	2549.25	0.00	0.0%
White Horse View	2486.00	0.00	0.0%
Worsley Court	3518.50	895.50	25.5%
Cherry Tree House	3786.00	235.50	6.2%

The highest user of agency was Worsley Court in February.

Quality Data Triangulation:

In turning to the triangulation of the staffing data against a range of quality metrics the following is of relevance:

- In February 2016, Worsley Court had a PALS related issue in addition to a high fill rate and high agency usage.

In Conclusion

The following is of relevance:

- The month on month trend showed that 1 of the 4 indicators were ‘green’ the same as January.
- The number of red wards remains at 11 in February
- In February, the Recovery Unit Accomb had the lowest fill rate.
- Worsley Court and Cherry Tree both had staffing above their establishments
- Bank usage is reporting as ‘green’ and ‘amber’ with Meadowfields have the largest bank usage.
- Worsley Court had the highest agency usage in February
- In turning to the triangulation there was 1 PALS related issue identified in February relating to the Worsley Court. They also had a high fill rate and high agency usage.

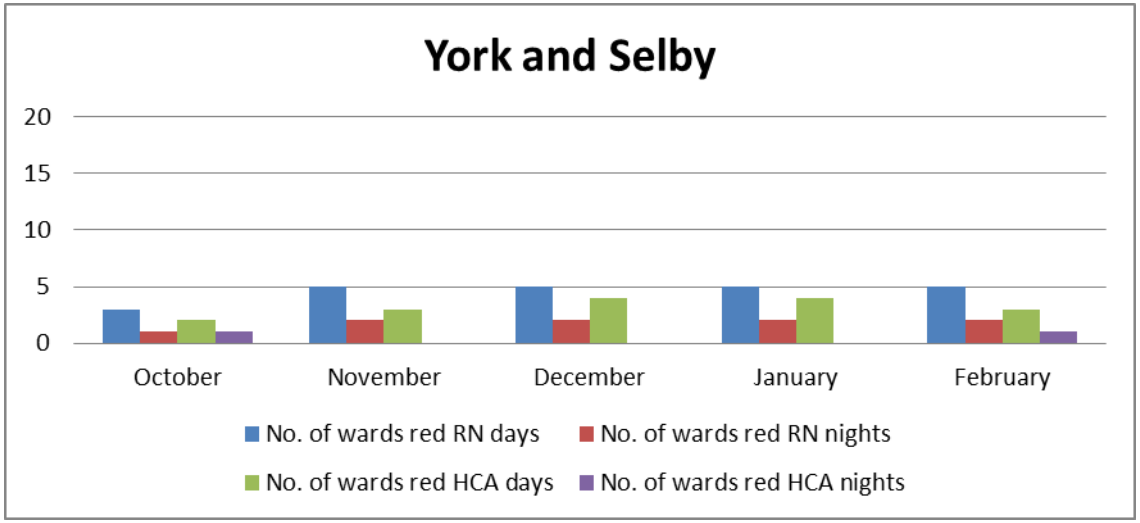
TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 29 DAYS IN February							
				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Meadowfields	York and Selby	MHSOP	18	64.9%	79.1%	99.1%	107.1%
Oak Rise	York and Selby	LD	8	109.5%	106.3%	100.0%	100.0%
Recovery Unit Acomb	York and Selby	Adults	16	77.9%	77.2%	48.3%	88.1%
White Horse View	York and Selby	LD	8	60.8%	78.5%	100.6%	100.0%
Worsley Court	York and Selby	MHSOP	14	87.8%	106.9%	111.6%	160.1%
Cherry Tree House	York and Selby	MHSOP	16	78.0%	133.1%	86.1%	124.0%

YORK AND SELBY LOCALITY REPORT - February 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Meadowfields	18	1647.5	348	1552	638	1068.7	345	1227.3	683	64.9%	99.1%	79.1%	107.1%
Oak Rise	8	870	311.75	867.5	623.5	953.07	311.75	922.53	623.5	109.5%	100.0%	106.3%	100.0%
Recovery Unit Acomb	16	862.5	638	1305	638	672.25	308	1007	562	77.9%	48.3%	77.2%	88.1%
White Horse View	8	870	311.75	1298.75	623.5	528.75	313.75	1020	623.5	60.8%	100.6%	78.5%	100.0%
Worsley Court	14	870	319	1305	627	763.5	356	1395	1004	87.8%	111.6%	106.9%	160.1%
Cherry Tree House	16	840	374	1218.5	957	655.5	322	1621.5	1187	78.0%	86.1%	133.1%	124.0%

YORK & SELBY TOTAL - Month on Month Trend

Month	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
Oct-15	89.29	-	101.0	-	112.99	-	104.68	-
Nov-15	76.39	↓	91.27	↓	56.40	↓	101.89	↓
Dec-15	84.50	↑	91.40	↑	91.60	↑	107.40	↑
Jan-16	78.60	↓	96.40	↑	91.80	↑	112.70	↑
Feb-16	77.90	↓	95.30	↓	85.00	↓	114.00	↑

Number of Red Wards – York and Selby



Quality Indicators

Scored Fill Rate compared to Quality Indicators - February 2016				Total score	Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers		Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Meadowfields	York & Selby	MHSOP	18	6	3324	604.6	18%									
Oak Rise	York & Selby	LD	8	8	2810.85	486.5	17%					1				
Recovery Unit Acomb	York & Selby	Adults	16	4	2549.25	149.5	6%									
White Horse View	York & Selby	LD	8	6	2486	44	2%									
Worsley Court	York & Selby	MHSOP	14	8	3518.5	184	5%					1				
Cherry Tree House	York & Selby	MHSOP	16	8	3786	498	13%									

BOARD OF DIRECTORS
FOR GENERAL RELEASE

Item 9

DATE:	**22nd March 2016**
TITLE:	**Equality objectives 2016 - 2020**
REPORT OF:	**David Levy, Director of Human Resources and Organisational Development**
REPORT FOR:	**Decision**

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

Executive Summary:

Every four years as part of its public sector equality duties under the Equality Act the Trust must set and publish equality objectives. The purpose of this report is to review progress on the equality objectives set in 2012 and to seek approval of the equality objectives for 2016 – 2020.
Work has been undertaken on all seven equality objectives set for 2012 – 2016. Despite this further work is needed on objectives 1, 4 and 5.

Recommendations:

- The Board of Directors is asked to ratify the review of the equality objectives for 2012 -2016 and to note the work still required on objectives 1, 4 and 5.
- The Board of Directors is asked to approve the equality objectives for 2016 – 2020
- The Board of Directors is asked to ratify the governance arrangements proposed for the 2016 – 2020 equality objectives.

MEETING OF:	**Board of Directors**
DATE:	**22nd March 2016**
TITLE:	**Equality objectives 2016 - 2020**

1.0 INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to review progress on the equality objectives set in 2012 and to seek ratification of the equality objectives for 2016 – 2020.

2.0 BACKGROUND INFORMATION AND CONTEXT:

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

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

2.2 The Trust has complied with its specific public sector duty to publish information demonstrating its compliance with the general equality duty. Based on the analysis of the information contained in this report the Trust must set and publish equality objectives, every four years.

2.3 The Trust set equality objectives for the period April 2012 – April 2016. New equality objectives must be set for the period April 2016 – April 2020.

3.0 KEY ISSUES:

The following seven objectives were identified for 2012 – 2016. A summary of progress is provided below and further details can be found in Appendix 1

3.1.1 The Trust has identified from consultation with people from protected groups that its clinical staff need to develop cultural competency particularly around ethnicity, LGB and gender reassignment.

3.1.2 ***Objective 1***

By March 2016, the Trust will develop and deliver cultural competency training to all clinical staff, to provide assurance that the needs of the Trust's diverse service users are met and to increase the proportion of BAME and LGB and T patients reporting satisfaction with services to the same level as those of white British and heterosexual patients.

This will be monitored through the Trust's patient experience questionnaire.

3.1.3 **Progress on Objective 1**

A business plan was developed to enable the delivery of cultural competency training to all. Due to the amount of time required to adequately train clinical

staff this was not felt to be practical and a revised plan went to the Equality and Diversity steering group for consideration in January 2013. As a result of this services identified 55 clinical staff to act as 'equality experts' in their areas and for whom an in depth, clinically focused, equality and diversity training programme has been developed.
Despite the work that has gone on in the last four years initial analysis of the patient experience questionnaires has shown that there are significant differences in experience between patients of different ethnicities (see appendix 3). Further work is required to understand the reasons for this and to develop appropriate actions.

3.2.1 The Trust has identified through engagement with its communities that the role of religious and spiritual needs in relation to mental health must be recognised and supported.

3.2.2 ***Objective 2***
*By March 2016, the Trust will have put systems in place to meet service religious and spiritual needs by ensuring that 100% of patients have their religious and spiritual needs addressed through their care plan by the development of the TEWV Spiritual Care Resources and their incorporation into CPA and care pathway*s.
This will be monitored through the feedback from the Spirituality Pathway Implementation Group.

3.2.3 **Progress on Objective 2**
Work has continued to promote awareness and use of the TEWV Spiritual Care Resources and their inclusion in pathways and care plans including:

- All new members of staff in the trust are made aware of the resources at the trust corporate induction.
- Members of the chaplaincy team have worked closely with MHSOP in the development of the Model Line Affective Disorders Pathway, of which the Spirituality Resources are now an integral and prominent part.
- Autumn 2015 also saw the launch of a Spirituality Liaison Service with an honorary consultant psychiatrist, Professor Chris Cook, offering advice and support to services for cases where spirituality plays a prominent part.

3.3.1 The Trust has identified through engagement with its staff, communities, third sector and statutory partners that there is a considerable under representation of the Gypsy Roma Traveller population amongst the Trust's service users. This has been confirmed by a survey of community teams in North Yorkshire.

3.3.2 ***Objective 3***
The Trust will implement a focused workplan to improve the access to Trust for the Gypsy, Roma and Traveller communities. The workplan will be initially piloted on a site in North Yorkshire and a site in County Durham in 2012/13 and aims to improve access for this community by 50% by March 2016 from the access baseline in March 2012.

3.3.3 **Progress on Objective 3**

The Trust has worked in partnership with Horton Housing and has run a pilot drop in service on one of its sites in North Yorkshire. This has identified a considerable need amongst the community and has begun to meet this need and to engage the community into services.

In County Durham the Trust continues to work with Public Health on its gypsy, roma and traveller health project.
The Trust has added Gypsy, Roma Travellers to the options for recording on Paris to enable it to record services provided to this community. The numbers recorded on PARIS have increased from 10 in 2013 to 82 in January 2016.

3.4.1 **Objective 4**

By March 2016, to decrease by 50% the number of indicators in the staff survey where staff who have long term health conditions have statistically significantly less favourable scores.

3.4.2 **Progress on Objective 4**

The staff survey results have consistently shown a number of indicators are scored lower for staff who have a disability however it is not always the same indicators.
The Trust commissioned Picker, our staff survey provider to report on if there was any scores that scored significantly lower for disabled staff consistently over the last two years. Picker reported that there were two areas.

- KF1 - Satisfied with quality of work?
- KF28 - Suffered discrimination in last 12 months

The trust has taken the following actions:

- developed a reasonable adjustments information pack to support managers.
- set up the diversity engagement group which has a disabled staff subgroup who are supporting this strand of work.
- the introduction of disability leave.

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3.5.1 **Objective 5**

By March 2016, to identify indicators in the staff survey where staff who share protected characteristics score worse than staff in general and to develop appropriate actions.

3.5.2 **Progress on Objective 5**

The 2014 staff survey results relating to Black and Minority ethnic staff provide a mixed picture. The survey results showed the following indicators were significantly lower:

- KF19 – Experiencing harassment, bullying or abuse from staff
- KF28 - Suffered discrimination in last 12 months

The following actions have been taken:

- The Trust has been working with the Clinical Director and groups of BAME ethnic medics through focus groups to try and better understand the reasons for these differences. A number of actions have been developed in response to the findings.
- the Trust has set up the diversity engagement group which has a BAME staff subgroup which is being developed and that it is hoped will be able to further develop this work.

3.6.1 **Objective 6**
By March 2013, to undertake a Trust wide equal pay audit.

3.6.2 **Progress on Objective 6**
The Trust has undertaken an Equal Pay Audit. As per the Trust's pay and reward statement a further equal pay audit is to be undertaken.

3.7.1 Through consultation with the staff, service users and carers accessing the Learning Disability services it has been recognised there is further improvement required to enhance the experience of and ease of access to services

3.7.2 ***Objective 7***
By March 2016 the Trust will have monitored and further developed the access through the Green Light Access to Healthcare plan.
This will be monitored by the performance measures for the Green Light action plan, the patient experience feedback from LD service users and complaints/incident reports.

3.7.3 **Progress on Objective 7**
The Trust started to record issues relating to access for LD service users to NHS services and takes action to address any inequalities it identifies in this. There are increasingly less incidents reported which would indicate that progress has been made.

Progress has been made across the Trust in relation to Learning Disabled people accessing mainstream adult mental health services and there have been local successes where links with community teams/crisis teams have established however this differs from locality to locality.

Equality Objectives 2016 – 2020.

3.8 Each locality has been asked to develop an equality objective for 2016 – 2020, together with an outline of the actions for the first year (for action plans please see appendix 2). There was evidence of good consultation and activities in some localities which have led to the development of the equality objectives. The proposed equality objectives are:

3.8.1 **Durham and Darlington overall objective**: To raise staff awareness of autism and to improve service provision and encourage effective multi agency holistic provision for people with autism of all ages and abilities in Co. Durham and Darlington 2016 – 2020

3.8.2 **York and Selby overall objective**: Working with partners to improve access and experience of mental health services for students and young people (16 – 25) in York and Selby.

3.8.3 **Forensic services objective 1:** Continue the work with LGB and T patients that was commenced after the CQC July 2014.
Objective 2: Review the support for women who are on maternity leave.

3.8.4 **Teesside objective 1**To continue implementation of the Greenlight audit in adult services, building on the work carried out last year and completing the self-assessment. The actions will be to undertake the Greenlight self-assessment audit tool and move from red to amber categories in all areas that relate to TEWV.
Objective 2 To ensure access to mental health services for refugees and asylum seekers on Teesside particularly in adult services and in children's teams

3.8.5 **North Yorkshire objective** To better understand the mental health needs of the farming communities in North Yorkshire and where appropriate take action to improve and increase access to services

3.8.6 **Trust Wide – Workforce**

Overall objective: To undertake research to better understand the causes of any differences where staff who share similar characteristics report lower levels of satisfaction in either the staff friends and family test or the staff survey and to take steps to reduce or eliminate any lower levels of satisfaction

3.9 It is proposed that progress on the 2016 – 2020 equality objectives be reported to locality LMGBs, then to the EDHR steering group and to QAC in the bi annual equality and diversity reports. It is critical to the achievement of the equality objectives that there is good partnership working between services and the EDHR team.

4 IMPLICATIONS:

4.1 **Compliance with the CQC fundamental Standards:**
It is a requirement of the CQC fundamental standards that the Trust meets its obligations under the Equality Act 2010.

4.2 **Financial/Value for Money:**
Financial penalties can be incurred for non- compliance with the legislative requirements of the Equality Act. This may result in reputational loss for the Trust.

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

4.4 **Equality and Diversity:**

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

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

5 RISKS:

5.1 In order for these equality objectives to be achieved, localities will have to allocate some resources. In the current financial climate this may prove challenging.

6.0 CONCLUSIONS:

6.1 The Trust must review and publish progress on its equality objectives for 2012-2016.The information in paragraphs 3.1 – 3.7 will meet this requirement.

6.2 There is work still needed on objectives 1, 4 and 5. Whilst work will continue on these they will not be included in the 2016 – 2020 equality objectives.

6.3 The Trust must set and publish equality objectives for 2016–2020 by 6th April 2016. The objectives at point 3.8 will meet this requirement.

7.0 RECOMMENDATIONS:

7.1 The Board of Directors is asked to ratify the review of the equality objectives for 2012-2016.

7.2 The Board of directors is asked to ratify the equality objectives for 2016 – 2020..

7.3 The Board of Directors is asked to approve the governance arrangements proposed in 3.9.

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

Background Papers:

Appendix 1

The Trust has identified from consultation with people from protected groups that its clinical staff need to develop cultural competency particularly around ethnicity, LGB and gender reassignment.

Objective 1
By March 2016, the Trust will develop and deliver cultural competency training to all clinical staff, to provide assurance that the needs of the Trust's diverse service users are met and to increase the proportion of BAME and LGB and T patients reporting satisfaction with services to the same level as those of white British and heterosexual patients.

This will be monitored through the Trust's patient experience questionnaire.

Progress on Objective 1
A business plan was developed to enable the delivery of cultural competency training to all. Due to the amount of time required to adequately train clinical staff this was not felt to be practical and a revised plan went to the Equality and Diversity steering group for consideration in January 2013. As a result of this the Trust has identified 55 clinical staff to act as 'equality experts' in their areas and for whom an in depth, clinically focused, equality and diversity training programme is being developed. Training sessions have been held on ethnicity and religion, LGB and T patients and disability (including sessions on deafness, learning disabilities and dementia)
Older people's services in Stockton and Middlesbrough have undertaken awareness raising and consultation sessions with members of the South Asian communities around dementia with the aim of increasing early referrals from the community and ensuring that services are able to meet the needs of those from the community accessing memory services.
The patient and carer friends and family test gathers information on service users' gender, age, sexual orientation and race. This is analysed and fed back to services. Despite the work that has gone on in the last four years initial analysis of this has shown that there are significant differences in experience between patients of different ethnicities, however it should be noted that significant numbers of patients have not provided details of their ethnicity so the information published must therefore be viewed as descriptive and any interpretations of it must be conservative. Actions are being developed to understand the reasons for the differences and to address them.
Please see appendix 3 for the patient experience outcomes.

The Trust has identified through engagement with its communities that the role of religious and spiritual needs in relation to mental health must be recognised and supported.

Objective 2
By March 2016, the Trust will have put systems in place to meet service religious and spiritual needs by ensuring that 100% of patients have their

*religious and spiritual needs addressed through their care plan by the development of the TEWV Spiritual Care Resources and their incorporation into CPA and care pathway*s.
This will be monitored through the feedback from the Spirituality Pathway Implementation Group.

Progress on Objective 2
Work has continued to promote awareness and use of the TEWV Spiritual Care Resources and their inclusion in pathways and care plans. All new members of staff in the trust are made aware of the resources at the trust corporate induction. The Spirituality Flower provided a focus for TEWV Arts in 2015 and had a prominent part in the exhibition at Ripon Cathedral. Members of the chaplaincy team have worked closely with MHSOP in the development of the Model Line Affective Disorders Pathway, of which the Spirituality Resources are now an integral and prominent part. This might be seen as a model for how they can be incorporated into other pathways. Training provided for the pilot teams was very well evaluated. The chaplaincy team also continue to work closely with the Recovery project to ensure that the essential relationship between spirituality and a recovery approach is maintained. Spirituality and Recovery courses run regularly within the Durham Recovery College and are shortly to begin in the Forensic Recovery College. These are a valuable way of promoting the spirituality resources and giving trust service users confidence to articulate the importance of their own spirituality. Funding has also been obtained to produce a service user led film on spirituality and its significance. Autumn 2015 also saw the launch of a Spirituality Liaison Service with an honorary consultant psychiatrist, Professor Chris Cook, offering advice and support to services for cases where spirituality plays a prominent part.

The Trust has identified through engagement with its staff, communities, third sector and statutory partners that there is a considerable under representation of the Gypsy Roma Traveller population amongst the Trust's service users. This has been confirmed by a survey of community teams in North Yorkshire.

Objective 3
The Trust will implement a focused work plan to improve the access to Trust for the Gypsy, Roma and Traveller communities. The work plan will be initially piloted on a site in North Yorkshire and a site in County Durham in 2012/13 and aims to improve access for this community by 50% by March 2016 from the access baseline in March 2012.

Progress on Objective 3
The Trust has worked in partnership with Horton Housing and has run a pilot drop in service on one of its sites in North Yorkshire. This has identified a considerable need amongst the community and has begun to meet this need and to engage the community into services.

In County Durham the Trust continues to work with Public Health on its gypsy, roma and traveller health project.

The Trust has added Gypsy, Roma Travellers to the options for recording on Paris to enable it to record services provided to this community. The numbers recorded on PARIS have increased from 10 in 2013 to 82 in January 2016.

Objective 4
By March 2016, to decrease by 50% the number of indicators in the staff survey where staff who have long term health conditions have statistically significantly less favourable scores.

Progress on Objective 4
The staff survey results have consistently shown a number of indicators are scored lower for staff who have a disability however it is not always the same indicators. The last staff survey results showed the following indicators with significantly lower results:

- KF11 – work related stress
- KF20 – Feeling pressure to attend work when unwell
- KF21 – good communication between staff and senior management
- KF23 – Job satisfaction
- KF24 – Recommend the Trust as a place to work or receive treatment
- KF25 – Staff motivation
- KF27 – equal opportunity for career progression
- Overall Engagement Score

The Trust commissioned Picker, our staff survey provider to report on if there was any scores that scored significantly lower for disabled staff consistently over the last two years. Picker reported that there were just two areas interestingly there is no overlap between these two sets of results:

- KF1 - Satisfied with quality of work?
- KF28 - Suffered discrimination in last 12 months

The trust has developed a reasonable adjustments information pack as it was felt that managers were uncertain about what was required of them and the support available to them. This information pack provides the relevant forms for completion and provides the expected timescales by which action should be taken. The forms are designed to be completed on line to be user friendly; however they can also be printed out and handwritten.

Additionally the Trust has set up the diversity engagement group which has a disabled staff subgroup who are supporting this strand of work.
The 2015 staff survey is currently being completed by staff with the results available to the Trust around February 2016 when a final analysis will be presented.

Objective 5
By March 2016, to identify indicators in the staff survey where staff who share protected characteristics score worse than staff in general and to develop appropriate actions.

Progress on Objective 5
The staff survey results relating to Black and Minority ethnic staff provide a mixed picture, for many indicators the position is positive and for others the position is more concerning. The 2014 staff survey showed just four areas where Black and Minority ethnic staff responses were less favourable than white staff in Key findings 7 and 25 (appraisal and motivation respectively) were both marginally lower however the following indicators where significantly lower:

- KF19 – Experiencing harassment, bullying or abuse from staff
- KF28 - Suffered discrimination in last 12 months

Given the significance of these indicators this is the area of greatest focus. The Trust has been working with the Clinical Director with groups of Black and Minority ethnic medics through focus groups to try and better understand the reasons for these differences. A number of actions have been developed in response to the findings from these focus groups.
Additionally the Trust has set up the diversity engagement group which has a Black, Asian and minority ethnic staff subgroup which is being developed and that it is hoped will be able to further develop this work.

Objective 6
By March 2013, to undertake a Trust wide equal pay audit.

Progress on Objective 6
The Trust has undertaken and Equal Pay Audit.

Through consultation with the staff, service users and carers accessing the Learning Disability services it has been recognised there is further improvement required to enhance the experience of and ease of access to services
Objective 7
By March 2016 the Trust will have monitored and further developed the access through the Green Light Access to Healthcare plan.
This will be monitored by the performance measures for the Green Light action plan, the patient experience feedback from LD service users and complaints/incident reports.

Progress on Objective 7
The Trust started to record issues relating to access for LD service users to NHS services and takes action to address any inequalities it identifies in this. There are increasingly less incidents reported which would indicate that progress has been made.

Progress has been made across the Trust in relation to Learning Disabled people accessing mainstream adult mental health services and there have been local successes where links with community teams/crisis teams have established however this differs from locality to locality.

'Transforming Care for learning disability' agenda aims to reduce the number of admissions into inpatient beds, shorten the length of stay and provide effective support to people in their communities. It seeks to do this through strengthened community services and developing positive models of provision through partnerships with a wide range of public and private organisations.

The principles of Green Light can support the development of enhanced community services enabling access to the right support at the right time in the right location, ensuring that people are well supported at home.

When people do require inpatient admission it should be to the most appropriate service and location to meet their needs; for some patients their presentation may be so complex that admission to a learning disability bed is the most appropriate. Alternatively for some their acute mental health needs will be best met within mainstream mental health services with reasonable adjustments. The reduction in learning disability beds highlights the need for the principles of Green Light to be embedded in mainstream mental health services to ensure that the needs of those with learning disabilities can be appropriately met.

The Trust also need to take the opportunity to further develop joint working on clinical pathways/work force development/risk stratification and crisis planning

Appendix 2

DURHAM AND DARLINGTON

Overall objective: To raise staff awareness of autism and to improve service provision and encourage effective multi agency holistic provision for people with autism of all ages and abilities in Co. Durham and Darlington 2016 – 2020

Action 1 To scope what services have in place with regard to assessment of people with autism.
Measurement

- time taken from referral to assessment
- Time taken from assessment to diagnosis
- Is there a pathway in place

All by Q3 16/17

Action 2: LMGB to identify a link person in each speciality (ASD link) who will lead on the work needed to achieve this objective and work to develop a network of ASD champions in each speciality.
Measurement: number of specialties with an ASD coordinator by Q3 16/17

Action 3: To map out the sensory provision and speech and language provision received by people with autism during assessment and following diagnosis
Measurement:

- % of people undergoing autism assessment who receive a sensory profile and a speech and language assessment
- % of people with a diagnosis of autism who receive a sensory profile and a speech and language assessment

All by Q3 16/17

Action 4: To scope out what staff training is undertaken and to make recommendations for improving staff awareness and training.
Measurement: Scoping document and proposals to LMGB by Q3 2016/17

Action 5 to profile what post diagnostic provision is available in each speciality, to identify a tool with which to undertake a gap analysis, complete the gap analysis and to make recommendations for improvements. This will include what patient and family support groups etc are available.
Measurement: Scoping document and proposals to LMGB by Q3 16/17
To identify and use a mechanism to measure feedback on patient and family support.–

Action 6 To identify what multi agency provision is available and to clarify where responsibilities lie
Measurement: Scoping document to LMGB by Q3 16/17. The ultimate aim to produce a multi- agency concordat on autism provision.

YORK AND SELBY

Overall Objective: Working with partners to improve access and experience of mental health services for students and young people (16 – 25) in York and Selby.

Action 1 To establish a base line of access to mental health services and satisfaction rates for students and young people aged 16 – 25 and to scope out any work needed to improve the data completeness and quality.

Measurement:

- Numbers of young people on PARIS accessing services
- Satisfaction rates for 16 – 25 year olds shown through the patient FFT.
- Scoping document on data completeness and quality to LMGB by Q3 2016/17

Action 2: To improve transition from CAMHS to adult services

Measurement:

- Setting up pilot transition panel
- Identifying methods of measuring the success of transitions from CAMHS to AMH services.
- Satisfaction rates for young people transitioning to adult mental health services

Action 3: To engage with partners to form a collaborative approach to improving access and experience of mental health services for students and young people in York (and Selby)

Measurement:

- Identification of partners Q1 2016/17
- Meeting held with partners to scope out actions needed Q2 2016/17
- Development of action plan Q3 2016/17

Action 4 To develop an action plan to progress the objective in 2017/18
Measurement Development of action plan to which all partners sign up Q3 2016/17

FORENSIC SERVICES

Objective Continue the work with LGB and T patients that was commenced after the CQC July 2014

Action 1
Q1 re-run the equality survey with some patient focus groups (what has been their experience, what issues have been raised with them and what issues have been raised with them and what does it indicate in respect of further support for staff and patients)
Measurement completion and analysis of survey and focus groups by Q1 16/17

Action 2
Q2 review the role of the matron E&D champions pending results of survey and focus groups.

Measurement completion of report on role of matron E and D champions

Action 3
Q3 access an external LGBT support group to work into Ridgeway with service users
Measurement: contact with external LGBT support group and development of model for them to work into Ridgeway with service users.

Action 4
Q4 Report back to LMGB Identify whether further work required for 2017/18
Measurement
Development review report and action plan for 2017/18

Objective
Review the support for women who are on maternity leave

Action 1
Q1 Small survey with recent staff returning from maternity leave - Do we follow the policy in terms of keeping in touch with women on maternity.
Measurement Completion and analysis of survey with interim report to LMGB, identifying any immediate actions

Action 2
Q2 Undertake interviews with people who have returned from maternity leave regarding their experience.
Measurement: Completion and analysis of interview and report to LMGB identifying actions needed to improve compliance with policy on keeping in touch with women on maternity leave

Action 3
Q3 Identify standard work in respect of findings
Measurement Development and approval of standard work.

Action 4
Q4 Report back to LMGB

Measurement Report identifying whether further work required for 2017/18

TRUST WIDE – WORKFORCE

Overall objective: To undertake research to better understand the causes of any differences where staff who share similar characteristics report lower levels of satisfaction in either the staff friends and family test or the staff survey and to take steps to reduce or eliminate any lower levels of satisfaction.

Action 1 To Develop actions to be included in the staff survey action plan to address any areas where known differences exist and are understood. Q1

Action 2 To establish baseline data based on the 2015 staff survey and corresponding staff friends and family tests Q1

Action 3 To commission and undertake reliable research based on the base line data Q4

Action 4 To report the findings of this research to the Diversity Engagement Group, Workforce and Development Group and the Equality and Diversity Steering Group Q4

TEESSIDE

Objective 1 To continue implementation of the Greenlight audit in adult services, building on the work carried out last year and completing the self-assessment. The actions will be to undertake the Greenlight self-assessment audit tool and move from red to amber categories in all areas that relate to TEWV To continue implementation of the new Greenlight in adult services, building on the

Action 1

Q1 To review the Greenlight self- assessment and to identify any gaps

Measurement completion and analysis of self- assessment audit tool by Q1 16/17

Action 2

Q2 To develop and implement action plan to enable movement from red to amber in all areas that relate to TEWV

Measurement Development of action plan and monitoring of progress by LMGB and EDHR steering group

Action 3

Q3 Implementation of action plan

Measurement Monitoring of action plan by LMGB and EDHR steering group

Action 4

Q4 Report back to LMGB Identify whether further work required for 2017/18

Objective To ensure access to mental health services for refugees and asylum seekers on Teesside particularly in adult services and in children's teams.

Action 1

Q1 To understand current arrangements for accessing mental health services and to identify any gaps

Measurement

Completion of gap analysis

Action 2

To develop and implement action plan ensuring services are ready to accept asylum seekers and refugees and to raise awareness of our services with groups working with refugees and asylum seekers

Measurement
Development of action plan and monitoring of progress by LMGB and EDHR steering group

Action 3
Implementation of action plan

Measurement
Monitoring of action plan by LMGB and EDHR steering group

Action 4
Report back to LMGB Identify whether further work required for 2017/18

NORTH YORKSHIRE

Objective To better understand the mental health needs of the farming communities in North Yorkshire and where appropriate take action to improve and increase access to services.

Action 1
Q1 To scope out current access to services and to identify any gaps. To identify leads within North Yorkshire to take this work forward

Measurement Completion of gap analysis based on information already in services and analysis of any statistical information available.

Action 2
Q2 To develop and commence implementation of engagement plan with farming communities to better understand their mental health needs and any barriers to accessing mental health services that they experience.
Measurement Engagement plan

Action 3
Q3 Continued Implementation of engagement plan

Measurement Monitoring of engagement plan by LMGB and EDHR steering group

Action 4
Q4 Report back to LMGB Identify further work required for 2017/18

APPENDIX 3. ETHNICITY.

		Number of surveys						Percentage						
		2011	**2012**	**2013**	**2014**	**2015**	**Total**	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**	
White British	Excellent	310	785	1656	3643	6892	13286	94.3%	92.5%	92.9%	91.1%	92.0%	91.9%	% of Excellent and good response
	Good	152	367	754	1591	3108	5972	490	1246	2594	5743	10873	20946	Number of surveys used for %
	Fair	23	72	133	363	616	1207							
	Poor	4	16	34	95	151	300							
	Very Poor	1	6	17	51	106	181							
	Don't know	10	10	19	22	0	61							
	not answered	0	267	0	111	233	611							
White Other	Excellent	4	5	28	26	2	65	100.0%	81.3%	85.7%	97.3%	100.0%	90.3%	% of Excellent and good response
	Good	2	8	8	10	0	28	6	16	42	37	2	103	Number of surveys used for %
	Fair	0	1	4	1	0	6							
	Poor	0	0	1	0	0	1							
	Very Poor	0	2	1	0	0	3							
	Don't know	0	0	1	0	0	1							
	not answered	0	2	0	2	2	6							
Black	Excellent	1	4	8	18	46	77	66.7%	71.4%	76.5%	81.3%	68.3%	71.8%	% of Excellent and good response
	Good	1	1	5	8	25	40	3	7	17	32	104	163	Number of surveys used for %

	Fair	0	1	2	4	4	11							
	Poor	0	0	1	1	9	11							
	Very Poor	1	1	1	1	20	24							
	Don't know	0	0	0	0	0	0							
	not answered	0	2	0	0	5	7							
Asian	Excellent	5	17	25	48	118	213	72.7%	87.0%	87.5%	84.1%	81.1%	82.7%	% of Excellent and good response
	Good	3	3	17	21	49	93	11	23	48	82	206	370	Number of surveys used for %
	Fair	2	3	5	12	22	44							
	Poor	0	0	0	1	9	10							
	Very Poor	1	0	1	0	8	10							
	Don't know	1	0	1	0	0	2							
	not answered	0	4	0	0	6	10							
Mixed race	Excellent	9	15	22	34	73	153	91.7%	95.7%	86.8%	93.3%	84.0%	88.1%	% of Excellent and good response
	Good	2	7	11	22	27	69	12	23	38	60	119	252	Number of surveys used for %
	Fair	0	1	5	3	6	15							
	Poor	0	0	0	0	9	9							
	Very Poor	1	0	0	1	4	6							
	Don't know	0	0	0	3	0	3							
	not answered	0	3	0	0	3	6							

Other	Excellent	2	6	4	25	42	79	100.0%	100.0%	84.6%	83.7%	76.3%	81.2%	% of Excellent and good response
	Good	2	3	7	11	19	42	4	9	13	43	80	149	Number of surveys used for %
	Fair	0	0	2	3	8	13							
	Poor	0	0	0	2	5	7							
	Very Poor	0	0	0	2	6	8							
	Don't know	1	1	0	0	0	2							
	not answered	0	0	0	0	1	1							
Unknown	Excellent	10	33	83	525	836	1487	85.7%	82.1%	87.1%	87.4%	89.0%	87.9%	% of Excellent and good response
	Good	8	22	39	1244	414	1727	21	67	140	2023	1405	3656	Number of surveys used for %
	Fair	3	9	13	181	79	285							
	Poor	0	1	3	58	25	87							
	Very Poor	0	2	2	15	51	70							
	Don't know	2	1	6	31	2	42							
	not answered	26	207	45	4958	3973	9209							
Total	Excellent	341	865	1826	4319	8009	15360	93.4%	91.7%	92.2%	90.1%	91.1%	91.0%	% of Excellent and good response
	Good	170	411	841	2907	3642	7971	547	1391	2892	8020	12789	25639	Number of surveys used for %
	Fair	28	87	164	567	735	1581							
	Poor	4	17	39	157	208	425							

	Very Poor	4	11	22	70	195	302							
	Don't know	14	12	27	56	2	111							
	not answered	26	485	45	5071	4223	9850							
Total	All responses	587	1888	2964	13147	17014	35600							
Total non-White British (excludes unknown)	Excellent	21	47	87	151	281	587	86.1%	88.5%	85.4%	87.8%	78.5%	82.8%	% of Excellent and good response
	Good	10	22	48	72	120	272	36	78	158	254	511	1037	Number of surveys used for %
	Fair	2	6	18	23	40	89							
	Poor	0	0	2	4	32	38							
	Very Poor	3	3	3	4	38	51							
	Don't know	2	1	2	3	0	8							
	not answered	0	11	0	2	17	30							

SEXUALITY

		Number of surveys						Percentage						
		2011	**2012**	**2013**	**2014**	**2015**	**Total**	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**	
Heterosexual	Excellent	0	620	1491	3336	1601	7048	-	92.5%	92.9%	91.8%	88.9%	91.4%	% of Excellent and good response
	Good	0	278	660	1418	760	3116	0	971	2316	5177	2656	11120	Number of surveys used for %
	Fair	0	56	117	305	205	683							
	Poor	0	12	32	68	67	179							
	Very Poor	0	5	16	50	23	94							
	Don't know	0	8	13	15	0	36							
	not answered	0	230	0	110	3	343							
Prefer not to say	Excellent	0	106	209	346	227	888	-	89.0%	90.4%	84.1%	84.1%	86.1%	% of Excellent and good response
	Good	0	55	129	204	106	494	0	181	374	654	396	1605	Number of surveys used for %
	Fair	0	14	30	72	38	154							
	Poor	0	3	5	20	10	38							
	Very Poor	0	3	1	12	15	31							
	Don't know	0	2	12	6	0	20							
	not answered	0	38	0	0	0	38							
Bisexual	Excellent	0	9	39	66	66	180	-	76.2%	89.2%	81.9%	80.0%	82.2%	% of Excellent and good response
	Good	0	7	19	47	34	107	0	21	65	138	125	349	Number of surveys used for %
	Fair	0	2	5	19	15	41							
	Poor	0	2	1	6	5	14							
	Very Poor	0	1	1	0	5	7							
	Don't know	0	0	0	2	0	2							
	not answered	0	1	0	6	1	8							
Gay	Excellent	0	12	29	45	28	114	-	88.5%	86.3%	83.3%	74.6%	82.1%	% of Excellent and good response
	Good	0	11	15	25	19	70	0	26	51	84	63	224	Number of surveys used for %

	Fair	0	3	6	11	8	28							
	Poor	0	0	0	2	4	6							
	Very Poor	0	0	1	1	4	6							
	Don't know	0	1	1	1	0	3							
	not answered	0	3	0	3	0	6							
Lesbian	Excellent	0	7	15	44	20	86	-	84.6%	80.8%	83.1%	76.1%	80.7%	% of Excellent and good response
	Good	0	4	6	10	15	35	0	13	26	65	46	150	Number of surveys used for %
	Fair	0	2	3	3	5	13							
	Poor	0	0	1	7	3	11							
	Very Poor	0	0	1	1	3	5							
	Don't know	0	0	0	2	0	2							
	not answered	0	4	0	2	0	6							
Unknown	Excellent	341	111	43	482	6067	7044	93.4%	93.3%	91.7%	88.6%	92.3%	91.8%	% of Excellent and good response
	Good	170	56	12	1203	2708	4149	547	179	60	1902	9503	12191	Number of surveys used for %
	Fair	28	10	3	157	464	662							
	Poor	4	0	0	54	119	177							
	Very Poor	4	2	2	6	145	159							
	Don't know	14	1	1	30	2	48							
	not answered	26	209	45	4950	4219	9449							
Total	Excellent	341	865	1826	4319	8009	15360	93.4%	91.7%	92.2%	90.1%	91.1%	91.0%	% of Excellent and good response
	Good	170	411	841	2907	3642	7971	547	1391	2892	8020	12789	25639	Number of surveys used for %
	Fair	28	87	164	567	735	1581							
	Poor	4	17	39	157	208	425							
	Very Poor	4	11	22	70	195	302							
	Don't know	14	12	27	56	2	111							
	not answered	26	485	45	5071	4223	9850							

Total	All responses	587	1888	2964	13147	17014	35600							
Total non-Heterosexual (excludes unknown & prefer not to say)	Excellent	0	28	83	155	114	380	-	83.3%	86.6%	82.6%	77.8%	81.9%	% of Excellent and good response
	Good	0	22	40	82	68	212	0	60	142	287	234	723	Number of surveys used for %
	Fair	0	7	14	33	28	82							
	Poor	0	2	2	15	12	31							
	Very Poor	0	1	3	2	12	18							
	Don’t know	0	1	1	5	0	7							
	not answered	0	8	0	11	1	20							

ITEM NO. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22 March 2016**
TITLE:	**Finance Report for Period 1 April 2015 to 29 February 2016**
REPORT OF:	**Colin Martin, Director of Finance**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 29 February 2016 is a surplus of £5,243k, which is equivalent to 1.9% of turnover. The financial position is £99k behind plan largely due to the impairment of Trust properties being £1,287k above plan. Excluding impairments the Trust is ahead of plan by £1,188k largely due to a non-recurrent surplus within projects and higher than planned contract income.

Identified Cash Releasing Efficiency Savings at 29 February 2016 are in line with plan.

The Trust has identified schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for future years.

The Financial Sustainability Risk Rating for the Trust is 4 for the period ending 29 February 2016.

Recommendations:

The Board of Directors are requested to receive the report, to note the conclusions in section 5 and to raise any issues of concern, clarification or interest.

MEETING OF:	**Board of Directors**
DATE:	**22 March 2016**
TITLE:	**Finance Report for Period 1 April 2015 to 29 February 2016**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2015 to 29 February 2016.

2. BACKGROUND INFORMATION

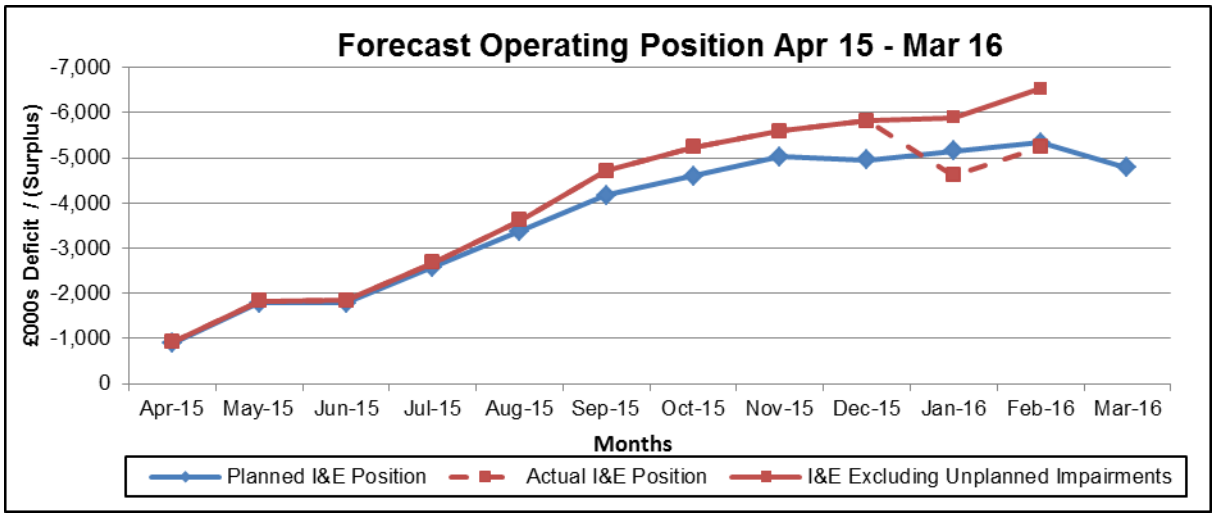
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

The financial position shows a surplus of £5,243k for the period 1 April 2015 to 29 February 2016, representing 1.9% of the Trust's turnover and is £99k behind plan. This is largely due to a planned impairment of Trust property being £1,287k higher than anticipated. Excluding impairments the Trust is ahead of plan by £1,188k, largely due to a non-recurrent surplus within projects and higher than planned contract income.

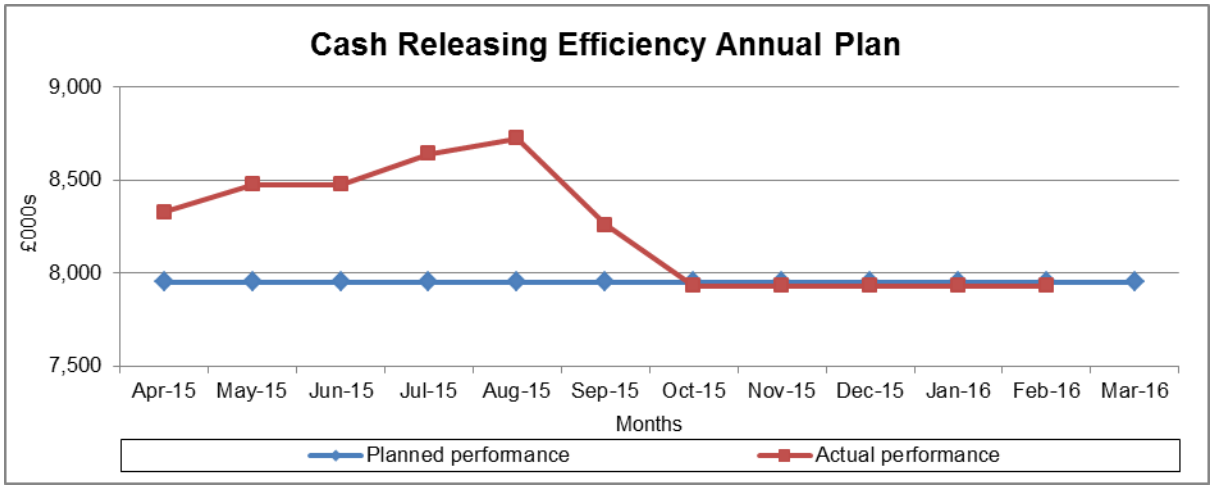
The graph below shows the Trust's planned operating surplus against actual performance and the Trusts position excluding impairments.



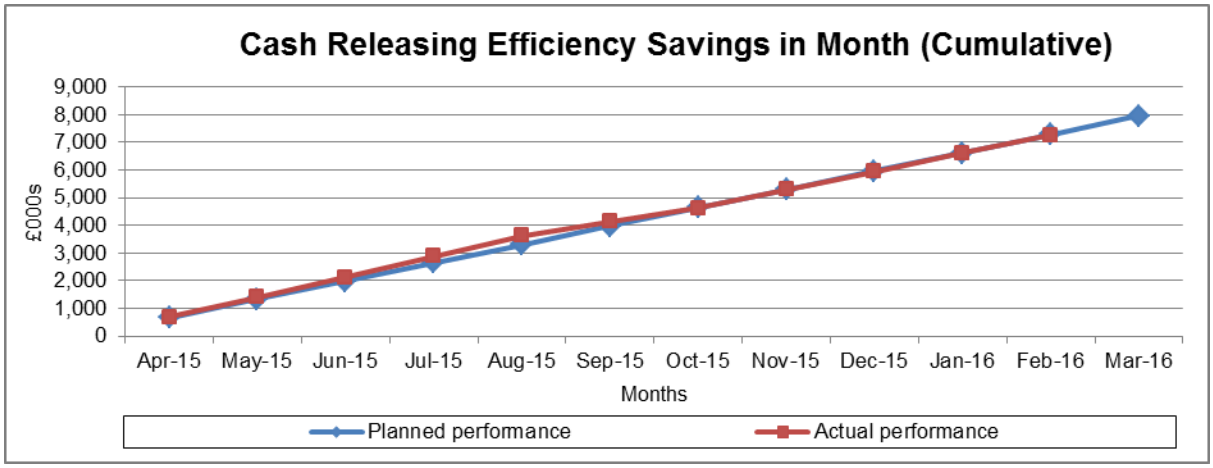
3.2 Cash Releasing Efficiency Savings

Total CRES identified at 29 February 2016 is £7,930k. The reduction in September and October was due to some schemes being deferred to

2016/17. At this stage it is not anticipated that there will be any further material changes against the CRES plan in 15/16.

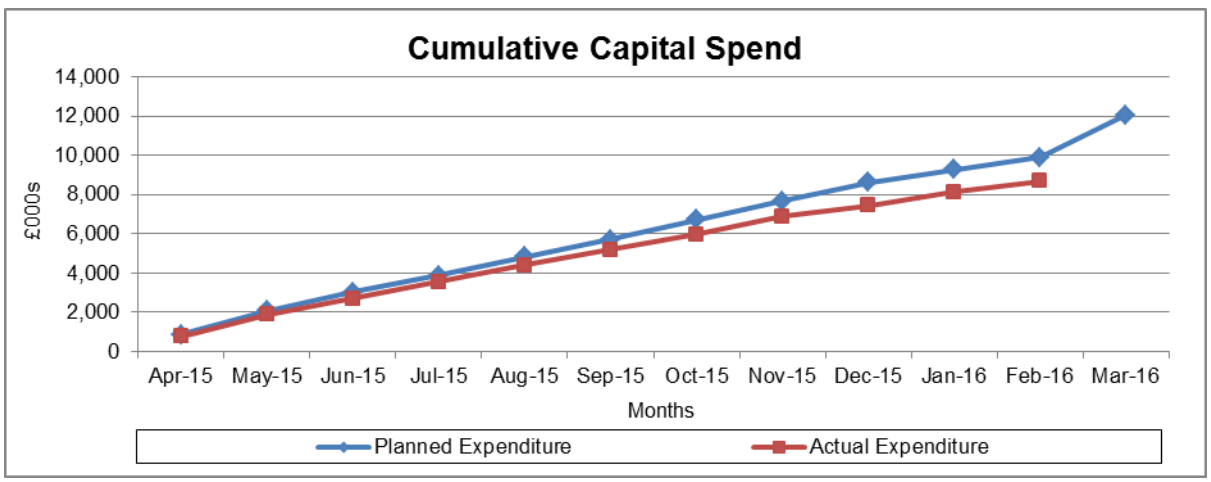


The monthly profile for CRES identified by Localities is shown below.



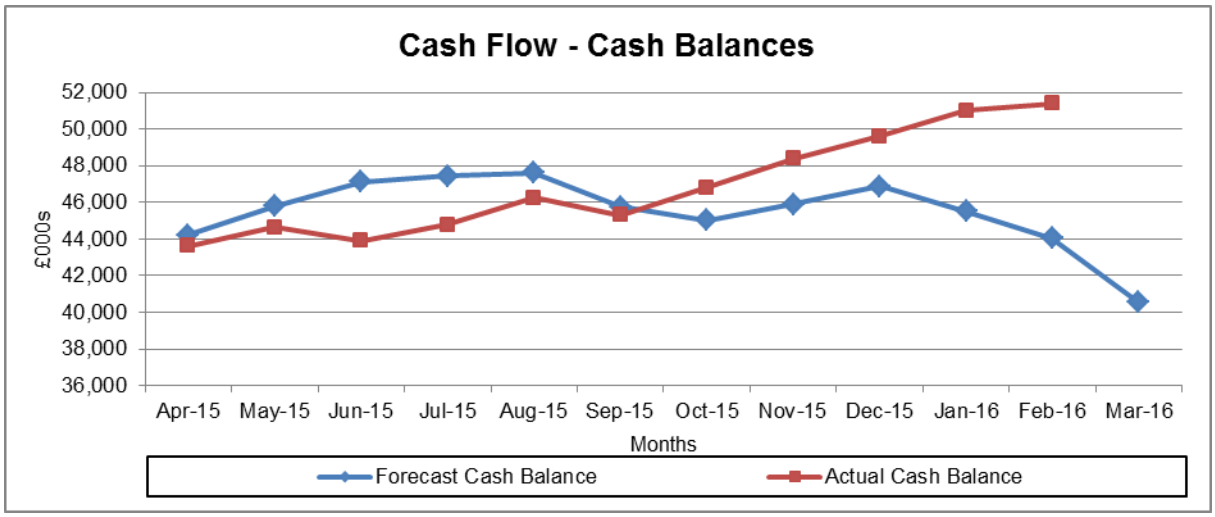
3.3 Capital Programme

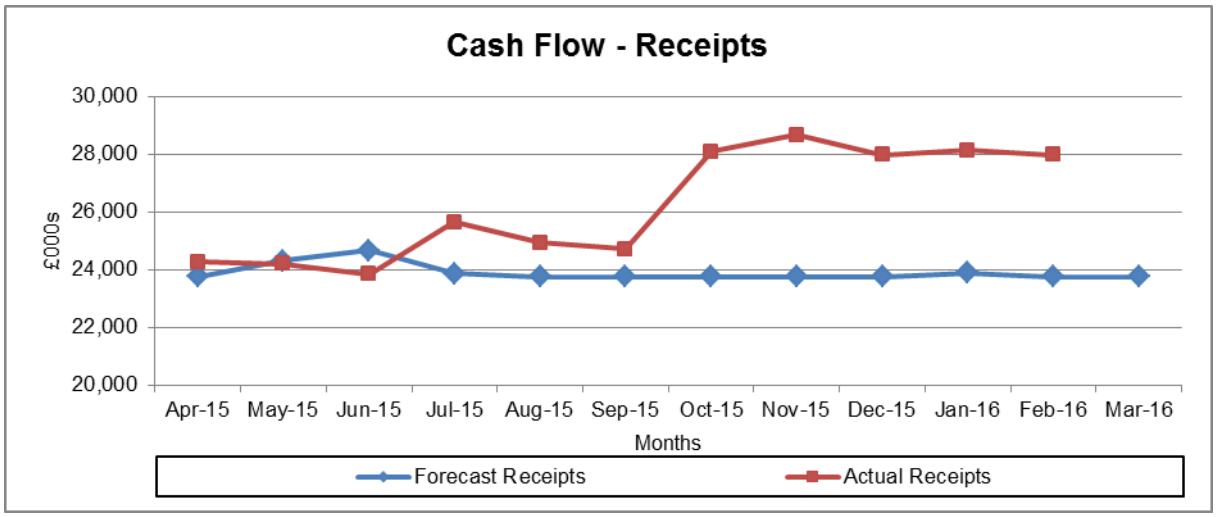
Capital expenditure to 29 February 2016 is £8,682k, and is behind plan. The Trust is forecasting capital expenditure to be 80% of plan at the financial year end due to the planned deferral of schemes into 2016/17.

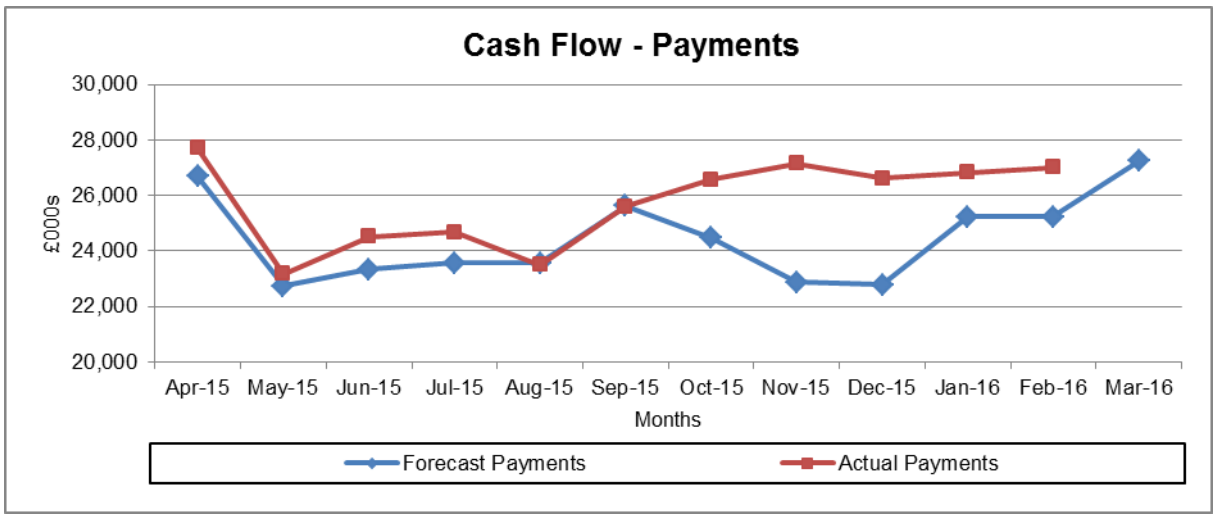


3.4 Cash Flow

Total cash at 29 February 2016 is £51,406k and is ahead of plan due to the planned deferral of capital schemes and working capital cycle variations following the start of the Trust's contract to provide MH & LD Services to the York and Selby locality.





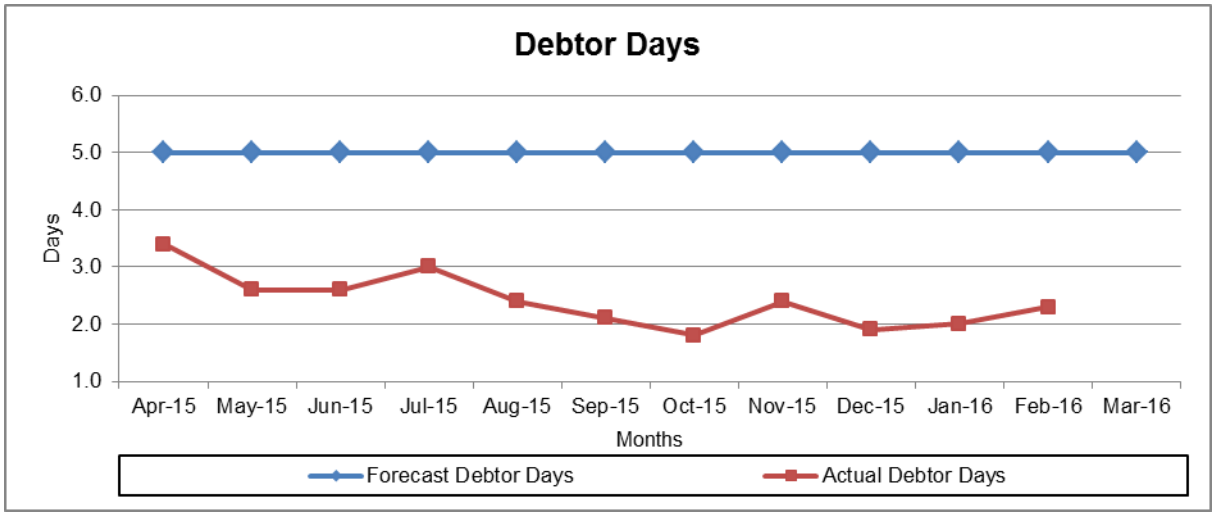


The increase within receipts and payments from October 2015 is due to additional revenue streams related to the York and Selby locality.

Other payment profile fluctuations over the year are for PDC dividend payments, financing repayments and payments for capital expenditure.

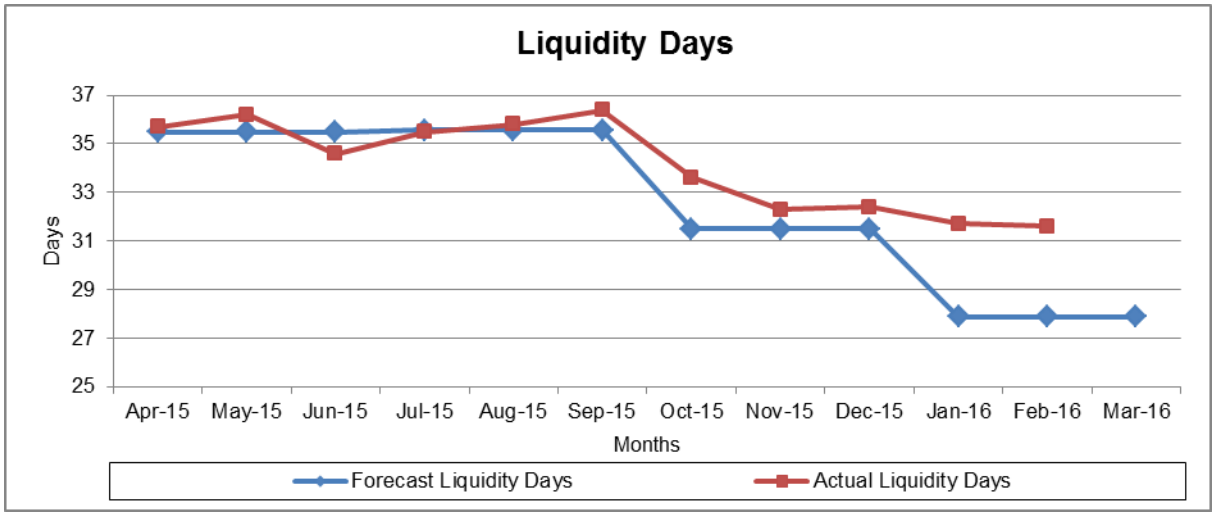
Working Capital ratios for period to 29 February 2016 were:

- Debtor Days of 2.3 days
- Liquidity of 31.6 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 74.89%
  Non NHS 30 Days – 97.41%



The Trust had a debtors' target of 5.0 days and actual performance of 2.3 days, which is ahead of plan.

3.4.1 The liquidity days graph below reflects the metric within Monitor's risk assessment framework. The Trust liquidity days ratio is marginally ahead of plan.



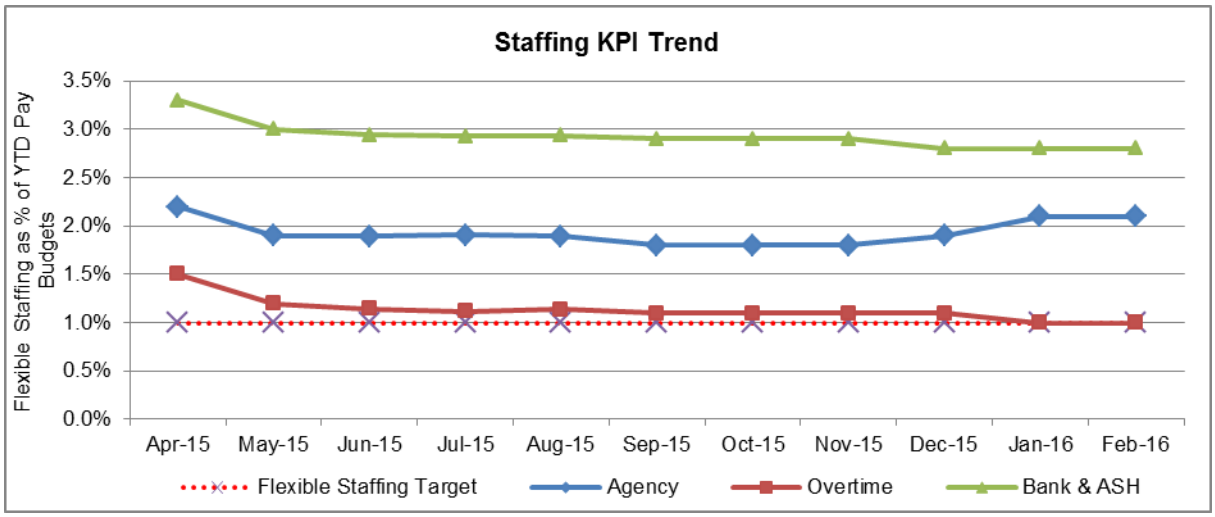
3.5 Financial Drivers

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

Tolerance	Oct	Nov	Dec	Jan	Feb
Agency (1%)	1.8%	1.8%	1.9%	2.1%	2.1%
Overtime (1%)	1.1%	1.1%	1.1%	1.0%	1.0%
Bank & ASH (flexed against establishment)	2.9%	2.9%	2.8%	2.8%	2.8%
Establishment (90%-95%)	94.0%	93.7%	93.0%	94.2%	93.1%
Total	**99.8%**	**99.5%**	**98.8%**	**100.1%**	**99.0%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for Agency and Overtime, and flexed in correlation to staff in post for Bank & ASH. For February 2016 the tolerance for Bank and ASH is 3.7% of pay budgets.

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



Additional staffing expenditure is 5.9% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (51%), enhanced observations (17%) and sickness (15%).

3.6 Monitor Risk Ratings and Indicators

3.6.1 The Financial Sustainability Risk Rating was assessed as 4 at 29 February 2016, and is in line with the restated planned risk rating.

3.6.2 Capital service capacity rating assesses the level of operating surplus generated, to ensure a Trust is able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.45x (can cover debt payments due 1.45 times), which is in line with plan and rated as a 2.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 31.6 days, this is in line with plan and is rated as a 4.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 2.9% and is rated as a 4.

3.6.5 The variance from plan assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. The Trust surplus is 0.5% ahead of plan and is rated as a 4.

3.6.6 The margins on Financial Sustainability Risk Rating are as follows:

- Capital service cover - to reduce to a 1 a surplus decrease of £2,799k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £24,595k is required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £5,136k is required.
- Variance from plan – to reduce to a 3 an operating surplus decrease of £1,257k is required.

Financial Sustainability Risk Rating at 29 February 2016

Monitors Rating Guide	Weighting %	Rating Categories			
		4	3	2	1
Capital service Cover	25	2.50	1.75	1.25	<1.25
Liquidity	25	0.0	-7.0	-14.0	<-14
I&E Margin	25	1%	0%	-1%	<=-1%
Variance from plan	25	0%	-1%	-2%	<=-2%

TEWV Performance	Actual		Annual Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service Cover	1.45x	2	1.37x	2	0
Liquidity	31.6 days	4	30.5 days	4	0
I&E Margin	2.9%	4	2.6%	4	0
Variance from plan	0.3%	4	0%	4	0

Overall Financial Sustainability Risk Rating	4.00

3.6.7 6.3% of total receivables (£161k) are over 90 days past their due date. This is above the 5% finance risk tolerance set by Monitor, but is not a cause for concern as negotiations are ongoing to resolve.

3.6.8 3.9% of total payables invoices (£423k) held for payment are over 90 days past their due date. This is below the 5% finance risk tolerance set by Monitor.

3.6.9 The cash balance at 29 February 2016 is £51,406k and represents 67.0 days of annualised operating expenses.

3.6.10 Actual capital expenditure is 88% of planned expenditure to date and is forecast to be 80% of plan at the financial year end due to the planned deferral of schemes into 2016/17.

3.6.11 The Trust does not anticipate the Financial Sustainability Risk Rating will be less than 3 in the next 12 months.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 29 February 2016 is a surplus of £5,243k, which is equivalent to 1.9% of turnover and is marginally ahead of plan after impairments.

6.2 Identified Cash Releasing Efficiency Savings at 29 February 2016 are in line with plan.

The Trust has identified schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for future years.

6.3 The Financial Sustainability Risk Rating for the Trust is 4 for the period ending 29 February 2016.

7. RECOMMENDATIONS:

7.1 The Board of Directors are requested to receive the report, to note the conclusions in section 5 and to raise any issues of concern, clarification or interest.

Colin Martin
Director of Finance

Item 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22nd March 2016**
TITLE:	**Board Dashboard as at 29th February 2016**
REPORT OF:	**Sharon Pickering, Director of Planning & Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to provide the latest performance for the Board Dashboard as at 29th February 2016 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. A separate appendix covering the York and Selby Locality is attached in Appendix B.

In terms of the Trust (excluding the York and Selby Locality) 10 of the 24 (42%) indicators are being reported as red in February 2016 which is an improvement on the position in January when 11 (46%) of the indicators were red. Of those, 6 are showing an improving trend over the last 3 months. In terms of the York and Selby Locality report 8 of the 11 (64%) of the indicators reported are showing as red which is one more than in January.

The key issues/risks continue to be:

- Access – Waiting Times (KPIs 1 & 2)
- Early Intervention in Psychosis (KPI 3)
- Psychological Therapies – Access (KPI 6) and Recovery (KPI 7)
- Out of Locality Admissions (KPI 12)
- Appraisal (KPI 19)

Recommendations:
It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

MEETING OF:	**Board of Directors**
DATE:	**22nd March 2016**
TITLE:	**Board Dashboard as at 29th February 2016**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 29th February 2016 in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 The key issues are as follows:

- This report includes the following 4 Appendices:
  - The usual Dashboard report produced from the IIC in Appendix A. For all but two of the three staffing indicators this does not include data relating to the York and Selby. These are KPI20 Compliance with Mandatory Training and KPI 21 Sickness Absence Rate
  - A separate dashboard for the locality of York and Selby is included within Appendix B where the information is available. This will be produced until the services in York and Selby move over to the Trust's PARIS system in April 2016
  - The Data Quality Scorecard is included in Appendix C. This does not include an assessment of the data quality relating to the York and Selby locality. As agreed this will be undertaken at the start of 2016/17 when the services transfer to the Trusts PARIS system.
  - Appendix D provides further details of unexpected deaths. The breakdown by locality is now included.
- For the Trust (excluding the York and Selby Locality) 10 of the 24 (42%) indicators are being reported as red in February 2016 which is an improvement of 1 on the position in January 2016. Of those10, 6 are showing an improving trend over the last 3 months. In terms of the York and Selby report 8 of the 11 (72%) indicators reported are showing as red which is one more than the previous month.

The key risks are as follows:

- Access - Both waiting time targets (KPIs 1 & 2) continue to show an underperformance as at the end of February although there has been an improvement on the position reported for January. Children and Young Peoples' (CYP) services, particularly in Durham and Darlington, continue to be the area of most concern. The level of staff vacancies and sickness in the CYP service in Durham and Darlington is a significant factor which is impacting on the position. The Executive Team approved an action plan from the service in terms of what they could do to improve the position. Teesside and North Yorkshire CYP services are implementing existing action plans, with Teesside expecting to achieve the target in CYP service by the end March.

It should be noted that the number of people yet to be seen who had already waited over 4 weeks as at the end of February increased in both Adult Mental Health and CYP and therefore it is likely that there will be a deterioration in performance against KPI1 at the end of March compared to February.

- Early Intervention in Psychosis – whilst the Dashboard shows that this target is being met this is based on an internal definition due to the delay in the publication of the national guidance. The final national guidance for this indicator has now been published. Using the national guidance the Trust achieved 68.8% of people being seen within 2 weeks in February which is above target. However it should be noted that there are a number of people who are still waiting and have already waited over 2 weeks as at the end of February which may impact on the performance levels in future months. Work is ongoing to understand this impact more and also with the services to ensure that recording of activity supports reporting against the final guidance.

- Psychological Therapies

  Whilst we are meeting the two waiting time targets (KPI 4 and 5) for the Trust, excluding York and Selby, we continue to be below target for Access (KPI 6) and Recovery (KPI 7). In terms of the Access target there has been a further improvement on the January position, to just below the target, with performance being at the highest level since June 2015. In addition the trend of deterioration seen in February of the previous two years has not been replicated. All three localities within North Yorkshire continue to achieve the access target.

  In terms of recovery there has been a deterioration in the position in February which is as a result of deterioration across a number of the CCG areas, particularly in North Yorkshire. Scarborough and Ryedale are reporting the lowest level of recovery of all the CCG areas. However a recent visit from the NHS England Expert Team identified that the service in Scarborough and Ryedale were doing everything that would be expected of them given the referrals they are receiving and the level of resources invested in the team.

  In terms of the York and Selby Locality there has been a deterioration in three of the four IAPT figures. It is thought that this is due to the transfer to PARIS as the electronic patient record which took place in February; however this will be monitored in future months to ensure it improves

- Out of Locality Admissions (OoL) (KPI 12). Whilst still over target there has been a further improvement in February to the lowest figures since November 2015. The year to date figure is 16.99% which is only 1.99% above target.

- Appraisal (KPI 19) – Performance is under target for the Trust (excluding York & Selby Locality) and has remained broadly the same as the figure

reported for January. The York & Selby Locality is reporting 56%. Development work has started to enhance the HR information available via the IIC to support more proactive performance management. In addition it has been identified that there may be issues relating to the inputting of appraisal information into ESR and therefore a survey has been undertaken to establish what factors may be impacting on the recording of appraisal information. The responses to this questionnaire are currently being evaluated in order to inform what further action could be taken to improve this.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

Sharon Pickering
Director of Planning Performance and Communications.

Background Papers:

Trust Dashboard Summary for TRUST

Strategic Goal 1: To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

	February 2016				April 2015 To February 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	98.00%	84.56%			98.00%	82.71%		98.00%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	87.33%			98.00%	86.58%		98.00%
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	50.00%	87.69%			50.00%	73.83%		50.00%
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	89.76%			75.00%	84.44%		75.00%
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	97.36%			95.00%	94.81%		95.00%
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	15.00%	14.65%			15.00%	13.47%		15.00%
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	45.12%			50.00%	45.98%		50.00%
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	95.00%	96.05%			95.00%	97.00%		95.00%
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.48%			95.00%	97.86%		95.00%
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.62%			98.00%	98.62%		98.00%
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	91.62%			85.00%	90.11%		85.00%

Trust Dashboard Summary for TRUST

Strategic Goal 2: To continuously improve the quality and value of our work

	February 2016				April 2015 To February 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	16.24%			15.00%	16.99%		15.00%
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	16.47%			15.00%	23.83%		15.00%
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	16.00	33.00			191.00	254.00		209.00
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	146.00	151.00			146.00	127.00		146.00
16) Percentage of appointments cancelled by the Trust	0.67%	1.25%			0.67%	1.09%		0.67%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.74			11.00	14.11		12.00
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	82.14%			75.00%	75.00%		75.00%

Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce

	February 2016				April 2015 To February 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	83.17%			95.00%	83.17%		95.00%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.58%			95.00%	88.58%		95.00%
21) Percentage Sickness Absence Rate (month behind)	4.50%	5.03%			4.50%	4.65%		4.50%

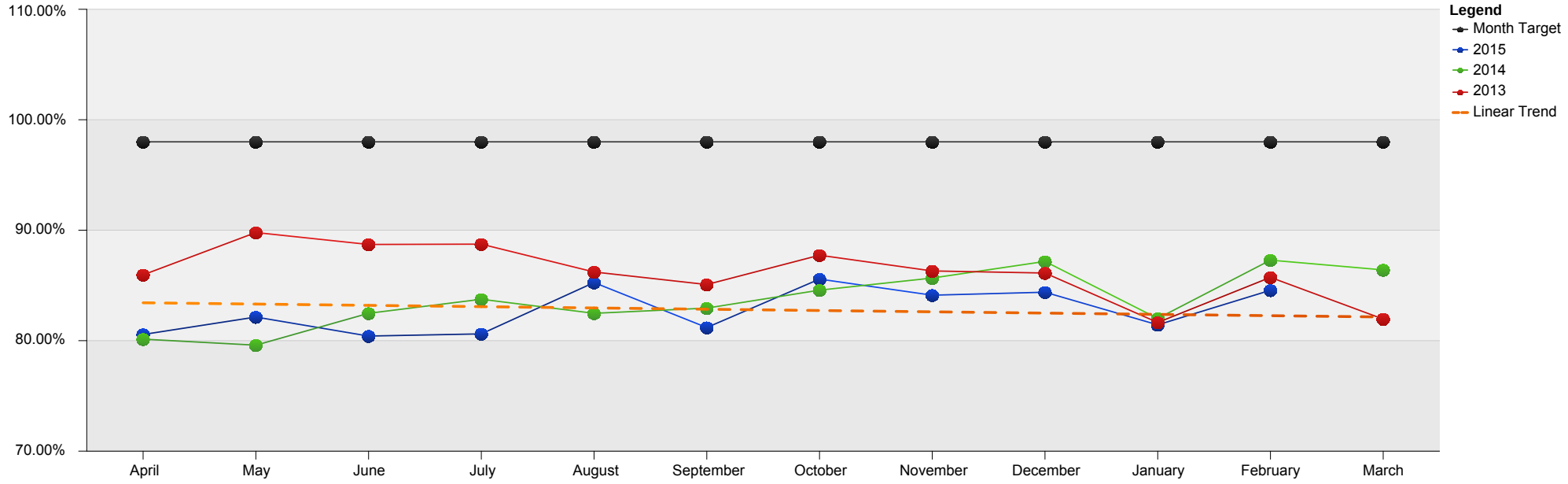
Trust Dashboard Summary for TRUST

Strategic Goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve

	February 2016				April 2015 To February 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00			0.00	0.00		0.00
23) Total number of External Referrals into the Trust Services	5,365.00	7,265.00			63,992.00	72,029.00		69,931.00
24) Delivery of our financial plan (I and E)	-192,700.00	-633,000.00			-5,342,300.00	-5,243,000.00		-4,784,000.00

Trust Dashboard Graphs for TRUST

1) Percentage of patients seen with 4 weeks for a first appointment (external referral)



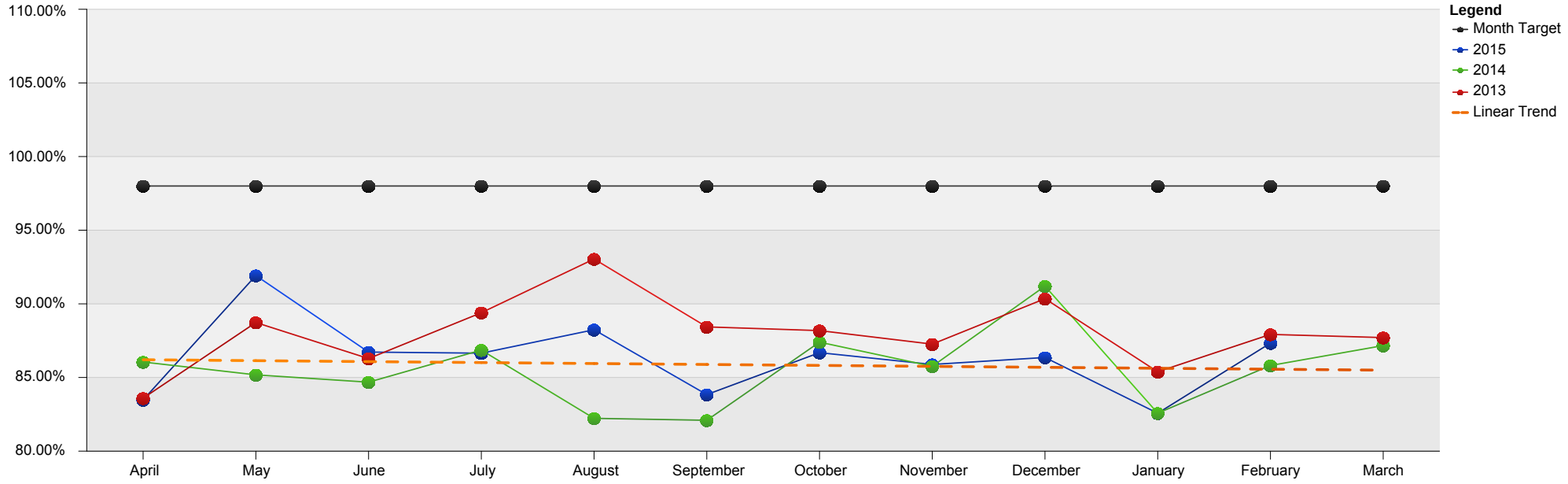
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	84.56%	82.71%	79.28%	78.04%	90.34%	89.63%	76.91%	75.04%	99.46%	99.79%		

Narrative

The Trust position February 2016 is 84.56%, which relates to 608 patients out of 3938 who had waited longer than 4 weeks for a first appointment. This is 13.44% below target, but an improvement on January 2016 performance. The Trust position for the financial year to date is 82.71%, which is 15.29% below target.The specific areas of concern are:• Durham & Darlington CYP at 31.88% (141 of 207 patients). Within this service, staff vacancies and sickness continue to impact on waiting times. • Teesside CYP at 67.12% (96 of 292 patients). The deterioration is due to vacancies and sickness. Recruitment has now taken place. Action plans are in place and the service remains on track to achieve the target by March 2016.• North Yorkshire MHSOP at 74.11% (87 of 336 patients), CYP at 64.04% (41 of 114 patients). There continues to be staffing issues including sickness and maternity leave in both teams. Plans are in place to address this which include; vacant posts out to advert, development of single point of access rotas and caseload management work being maintained. Based on past performance and February's performance, it is highly unlikely that we will achieve the annual target of 98%. The annual outturn for 2014/15 was 83.73%.

Trust Dashboard Graphs for TRUST

2) Percentage of patients seen with 4 weeks for a first appointment (internal referral)



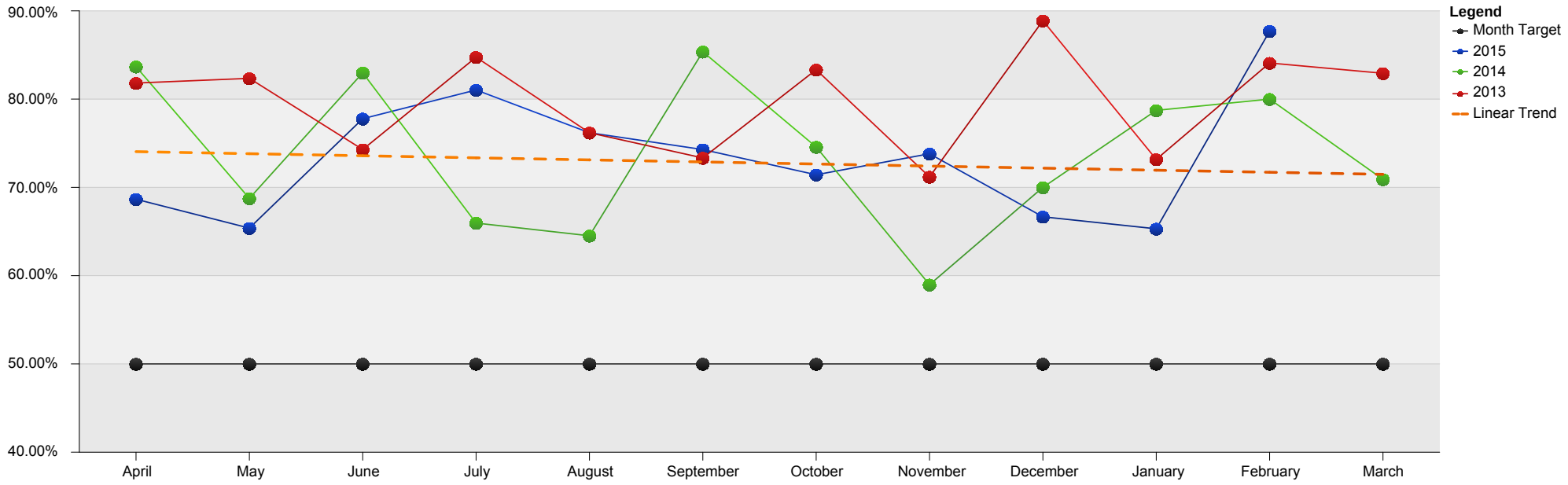
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	87.33%	86.58%	78.32%	80.71%	93.92%	92.28%	90.33%	89.26%	100.00%	56.52%		

Narrative

The Trust position for February 2016 is 87.33%, which relates to 266 patients out of 2100 that were not seen within 4 weeks of an internal referral. This is 10.67% below target but a significant improvement on January performance and the best position since August 2015. The Trust position for the financial year to date is 86.58%, which is 11.42% below target.The specific areas of concern are:• Durham & Darlington CYP at 58.50% (83 of 200 patients)• Tees CYP at 79.72% (29 of 143 patients)The issues impacting on the delivery of KPI1, also impact on the delivery of this KPI. Based on past performance and February's performance, it is extremely unlikely that we will achieve the annual target of 98%. The annual outturn for 2014/15 was 85.79%.

Trust Dashboard Graphs for TRUST

3) Percentage of people with first episode of psychosis treated with NICE care package in two weeks



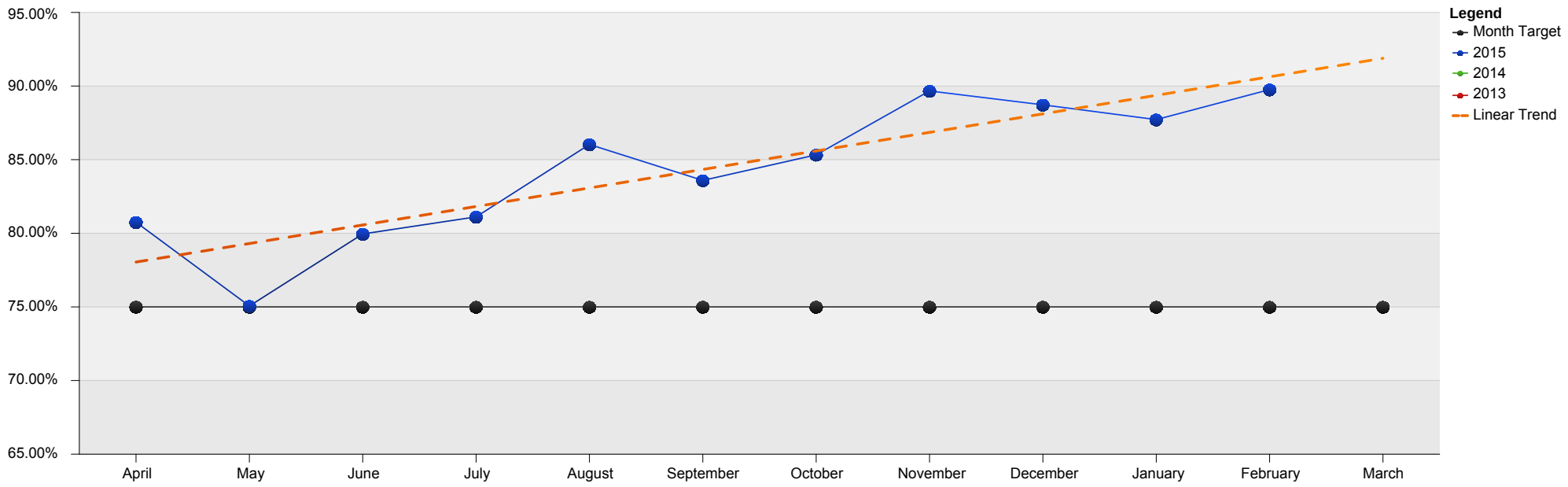
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	87.69%	73.83%	82.35%	65.62%	95.83%	82.01%	85.71%	72.53%	NA	NA		

Narrative

Note: The performance shown is not currently calculated using the national definition. The Trust position for February 2016 is 87.69%, which relates to 8 patients out of 65 that were not treated within 2 weeks of referral. This is 37.69% above target and an improvement on January 2016 performance. All localities are achieving target. The Trust position for the financial year to date is 73.83%, which is 23.83% above target. Based on past performance and February's performance it is anticipated that we will achieve the annual target of 50%. The annual outturn for 2014/15 was 74.22%.

Trust Dashboard Graphs for TRUST

4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.



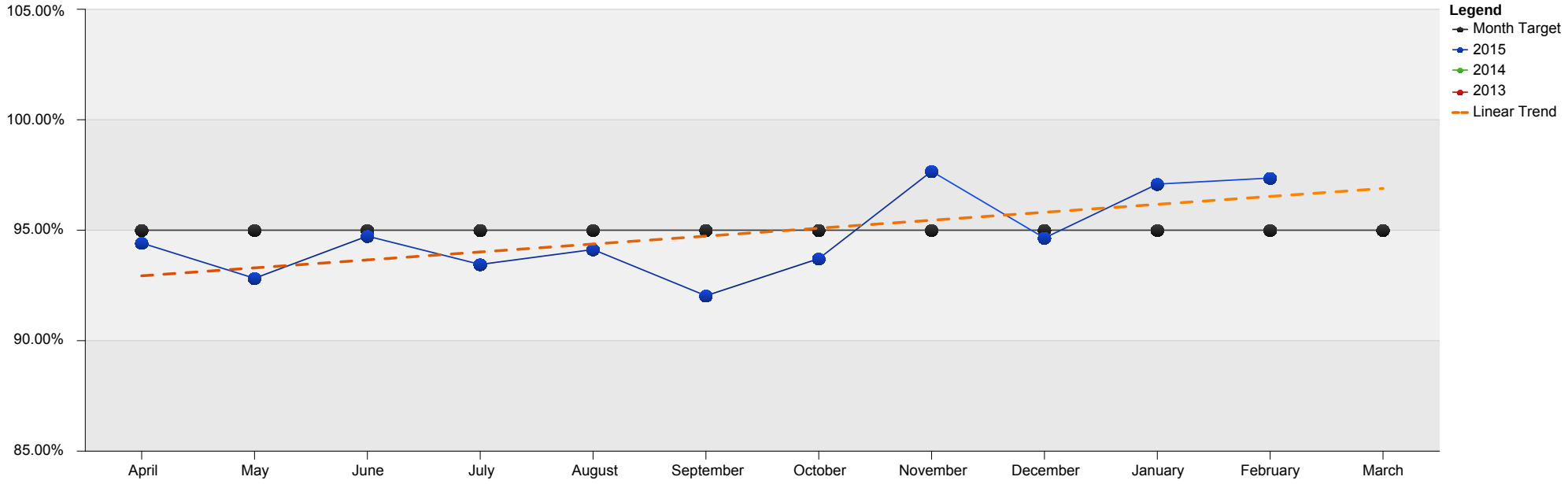
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	89.76%	84.44%	99.03%	98.49%	36.00%	54.03%	96.10%	77.18%	NA	NA		

Narrative

The Trust position for February 2016 is 89.76%, which relates to 194 patients out of 1894 that were not treated within 6 weeks of referral. This is 14.76% above target and an improvement on January 2016 performance. The Trust position for the financial year to date is 84.44%, which is 9.44% above target.Both Durham & Darlington (99.03%) and North Yorkshire (96.10%) report above target. Teesside reports significantly below target at 36% and a deterioration on January performance. The service are continuing to manage the close down of the service with as limited impact on targets as possible.Based on past performance, it is anticipated that we will achieve the annual target of 75%.Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

Trust Dashboard Graphs for TRUST

5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.

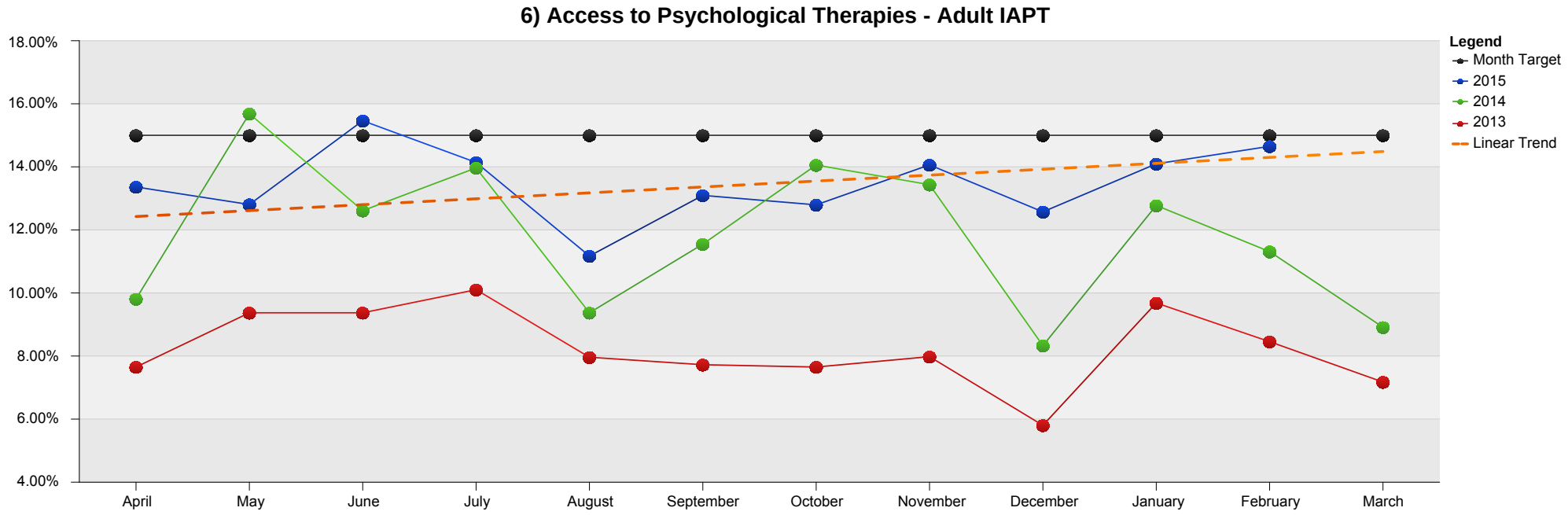


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	97.36%	94.81%	100.00%	99.84%	85.60%	81.07%	97.73%	93.67%	NA	NA		

Narrative

The Trust position for February 2016 is 97.36%, which relates to 50 patients out of 1898 that were not treated within 18 weeks of referral. This is 2.36% above target and an improvement on January 2016 performance. Both Durham & Darlington (100%) and North Yorkshire (97.73%) are achieving target. Teesside reports 85.60% which is impacting on the overall Trust position. The Trust position for the financial year to date is 94.81%, which is 0.19% below target. Based on current performance, there is a possibility that we will achieve the annual target of 95%. Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

Trust Dashboard Graphs for TRUST

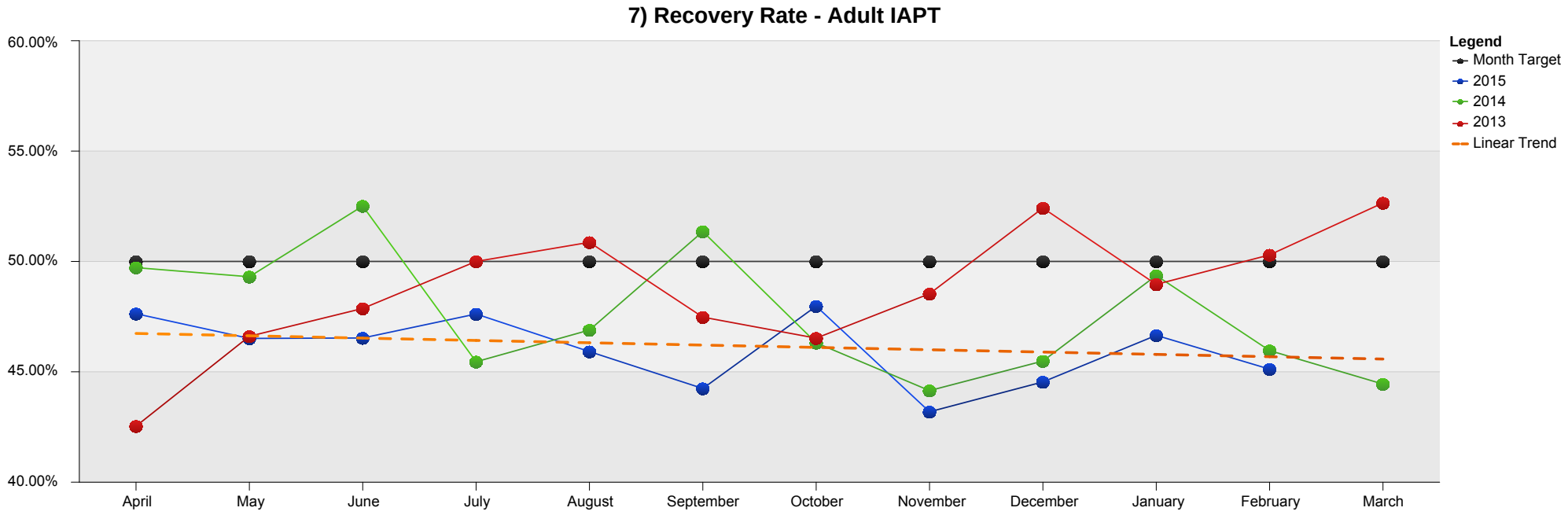


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	14.65%	13.47%	13.53%	12.67%	NA	NA	16.39%	14.72%	NA	NA		

Narrative

The Trust position for February 2016 is 14.65% which equates to 1318 people entering treatment from 8995 of the general population. This is 0.35% below the target of 15% and an improvement on January 2016 performance. The Trust position for the financial year to date is 13.47%, which is 2.33% below target. North Durham CCG (16.01%) are above target whilst, DDES CCG (11.19%) and Darlington CCG (13.90%) are below target. There remains a high number of referrals for step 2a treatment. Team Managers continue to manage waiting lists and the direct allocation model is now operational across all teams in order to improve efficiency for patients. Scarborough & Ryedale CCG (17.25%), Hambleton, Richmondshire & Whitby CCG (16.90%) and Harrogate & Rural CCG (15.71%) are above target. Vale of York CCG (13.25%) although continuing to improve is below target. Whilst there has been an increasing trend this year, there remains a risk that we will not achieve the annual target of 15%, unless further action is taken.The annual outturn for 2014/15 was 11.82%.

Trust Dashboard Graphs for TRUST



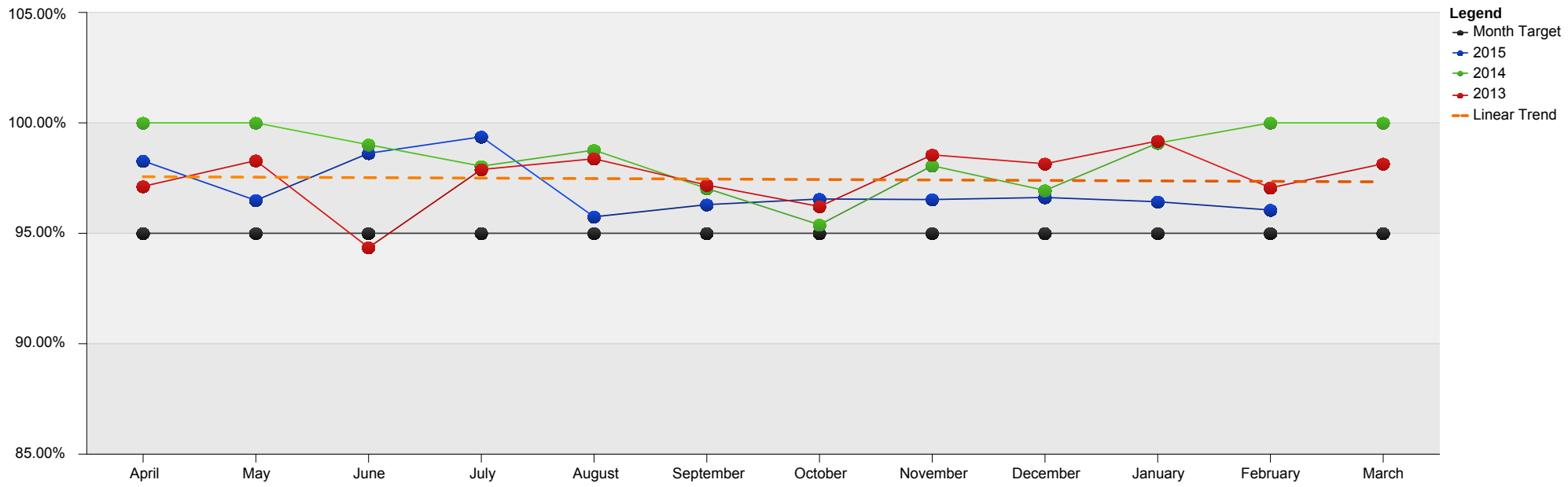
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	45.12%	45.98%	49.58%	45.85%	43.44%	44.30%	38.18%	47.13%	NA	NA		

Narrative

The Trust position for February 2016 is 45.12%, with 393 people out of 871 not achieving recovery. This is 4.88% below the target of 50% but a deterioration on January performance. All localities are failing to achieve target. The Trust position for the financial year to date is 45.98%, which is 4.02% below target.North Durham CCG (57.01%) and Darlington CCG (47.95%) have reported improvements in performance, whilst DDES CCG (41.71%) has reported a deterioration. An action plan has been developed and focused work is underway to look at individual's performance and share best practice across therapists. Hartlepool and Stockton CCG (36.36%) and South Tees CCG (49.25%) report improvements in performance. The action plan concerning recovery, which is agreed with commissioners, continues to be implemented. Harrogate & Rural CCG (43.02%), Hambleton, Richmondshire & Whitby CCG (39.32%) and Scarborough & Ryedale CCG (31.34%) have all reported deteriorations in performance. Deep dive work will take place across all North Yorkshire CCGs in the coming weeks to identify reasons for these deteriorations.Based on this and past performance, there is a risk that we will not achieve the annual target of 50%.The annual outturn for 2014/15 was 47.63%.

Trust Dashboard Graphs for TRUST

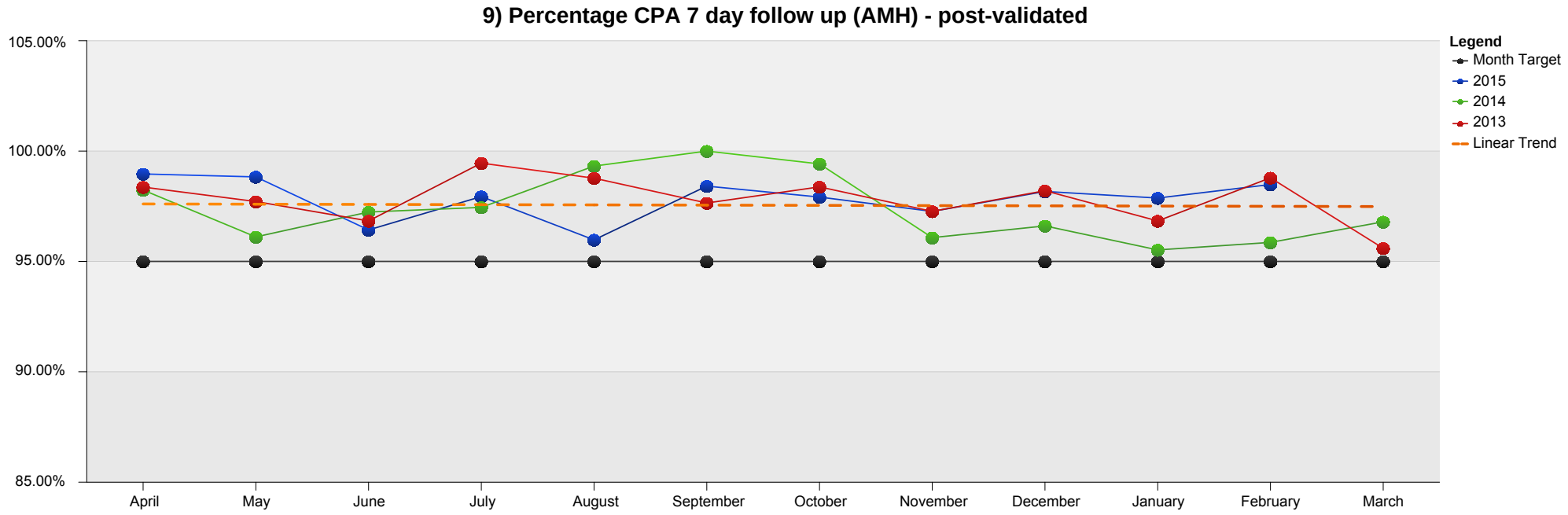
8) People seen by Crisis Services before admission - post-validated



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	96.05%	97.00%	91.43%	95.73%	98.70%	97.49%	95.00%	97.64%	NA	NA		

Narrative
The Trust post validated position for February 2016 is 96.05%, which relates to 6 patients out of 152 that were not seen by a Crisis Home Treatment Team prior to admission. This is 1.05% above the target but a slight deterioration on January's performance. The Trust post validated position for the financial year to date is 97%, which is 2% above target.Based on current and past performance, it is anticipated that we will achieve the annual target of 95%.The annual outturn for 2014/15 was 98.42%.

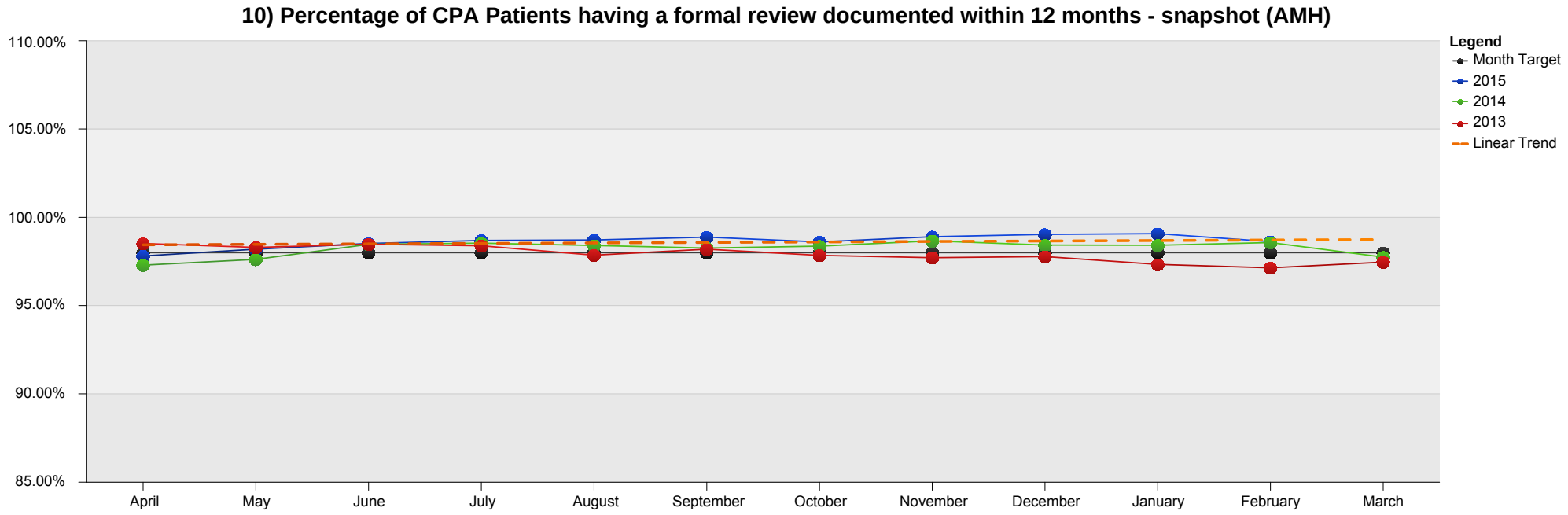
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) Percentage CPA 7 day follow up (AMH) - post-validated	98.48%	97.86%	100.00%	98.33%	97.87%	98.04%	97.30%	96.64%	NA	NA		

Narrative
The Trust post validated position for February 2016 is 98.48% which relates to 3 patients out of 198 that were not followed up within 7 days of discharge. This is 3.48% above the target and a slight improvement on January performance. The Trust post validated position for the financial year to date is 97.86%, which is 2.86% above target.Based on past performance, it is anticipated that we will achieve the annual target of 95%.The annual outturn for 2014/15 was 97.42%.

Trust Dashboard Graphs for TRUST



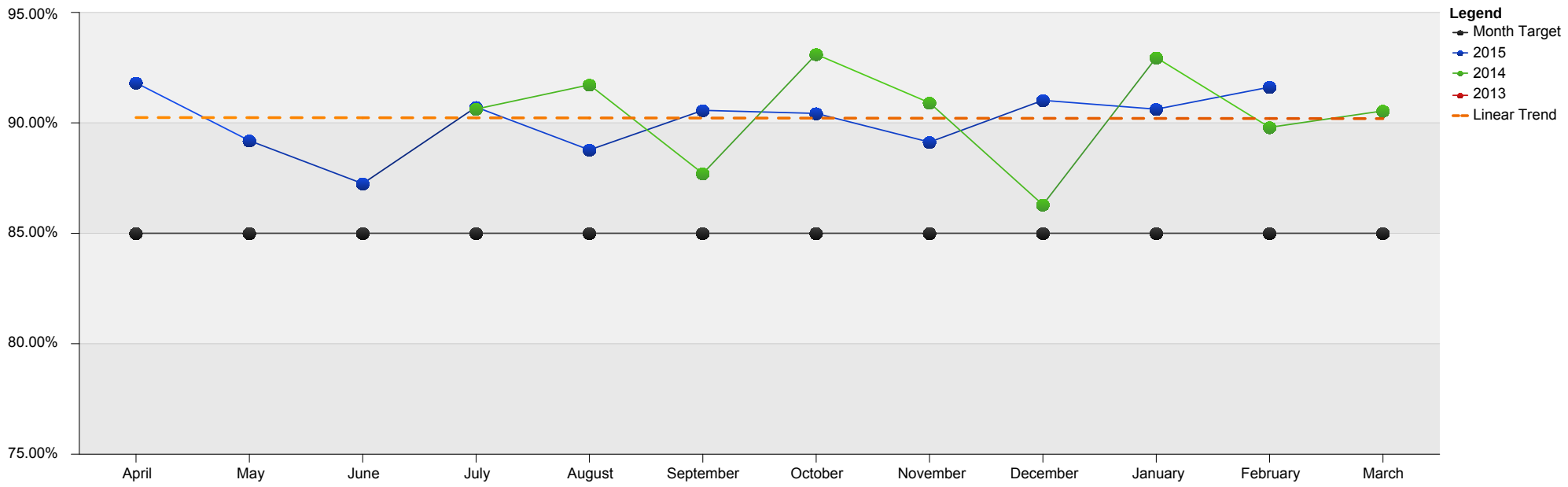
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.62%	98.62%	98.11%	98.11%	99.84%	99.84%	97.91%	97.91%	100.00%	100.00%		

Narrative

The Trust position for February 2016 is 98.62% which relates to 55 patients out of 3995 that had not had a formal review documented within 12 months. This is 3.62% above the Monitor target of 95%, 0.62% above the Trust target of 98% but a slight deterioration on January's performance. All localities are achieving target with the exception of North Yorkshire who are 0.11% below target. This is primarily attributable to the Hambleton & Richmondshire East CMHT team, a new team manager has just come into post and has begun monitoring this area closely. Improvements are expected in the coming months. Since May performance has consistently been above target and it is expected that we will achieve the annual target of 98%.The annual outturn for 2014/15 was 97.90%.

Trust Dashboard Graphs for TRUST

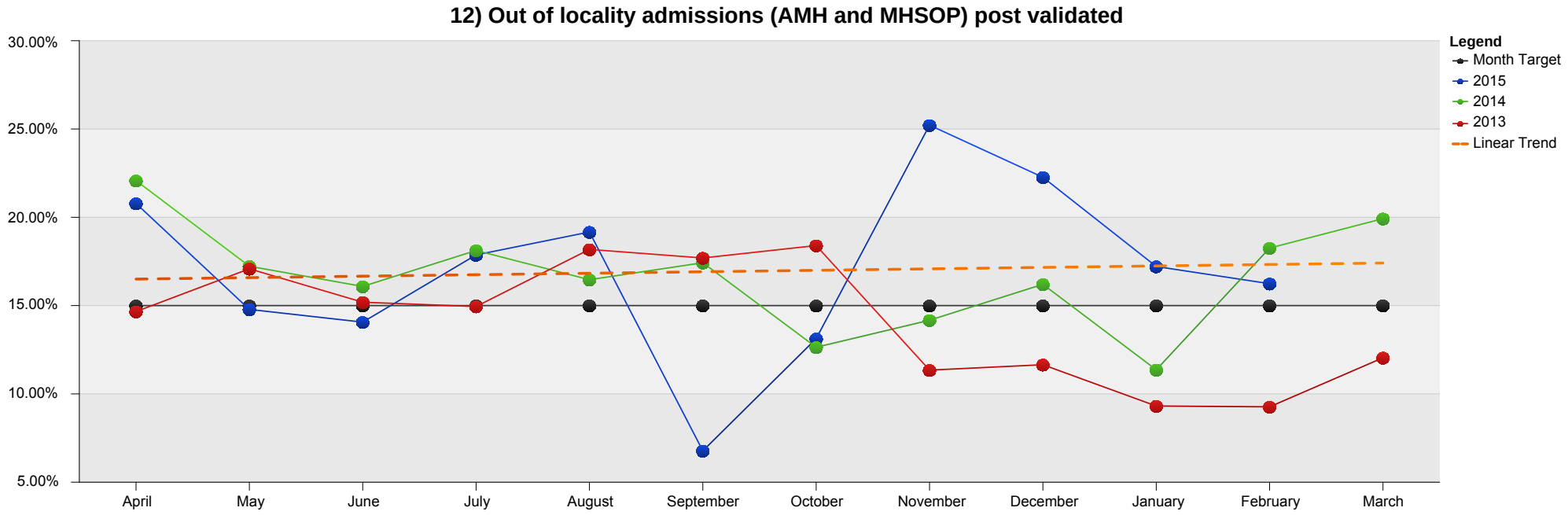
11) Community patients involved in the development of their care plan (month behind)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	91.62%	90.11%	89.55%	89.26%	93.31%	91.34%	88.60%	87.83%	100.00%	93.94%		

Narrative
The position reported in February 2016 relates to January performance. The Trust position for January 2016 is 91.62%, which relates to 56 patients out of 668 that stated they have not been involved in the development of their care plan. This is 6.62% above the target of 85% and an improvement on the performance reported for December. The Trust position for the financial year to date is 90.11%, which is 5.11% above target.Based on past performance it is anticipated that we will achieve the annual target of 85%.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).The annual outturn for 2014/15 was 90.58%.

Trust Dashboard Graphs for TRUST



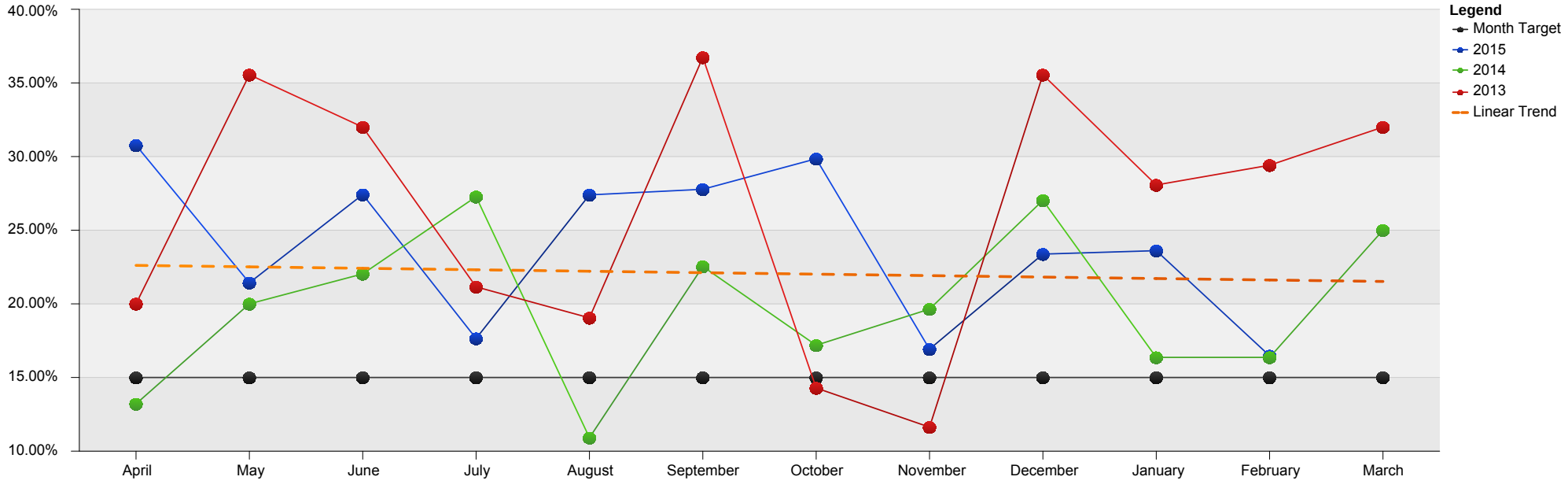
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	16.24%	16.99%	21.69%	17.59%	9.78%	10.60%	18.64%	24.89%	NA	NA		

Narrative

The Trust position for February 2016 is 16.47%, which relates to 38 admissions out of 234 that were admitted to assessment and treatment wards out of locality. This is 1.47% above the target of 15% but an improvement on the position reported in January. Durham and Darlington (21.69%) and North Yorkshire (20%) are above target. Tees are reporting 9.68%. The Trust position for the financial year to date is 16.99%, which is 1.99% above target.Of the 38 patients (AMH 26, MHSOP 12) admitted to an 'out of locality' bed, all were due to no beds being available at their local hospital The localities continue to investigate ways in which they can reduce OOL admissions.Although there continues to be an improvement and a reverse in the increasing trend since September, there is a risk that we will not achieve the annual target of 15%, unless further action is taken.

Trust Dashboard Graphs for TRUST

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



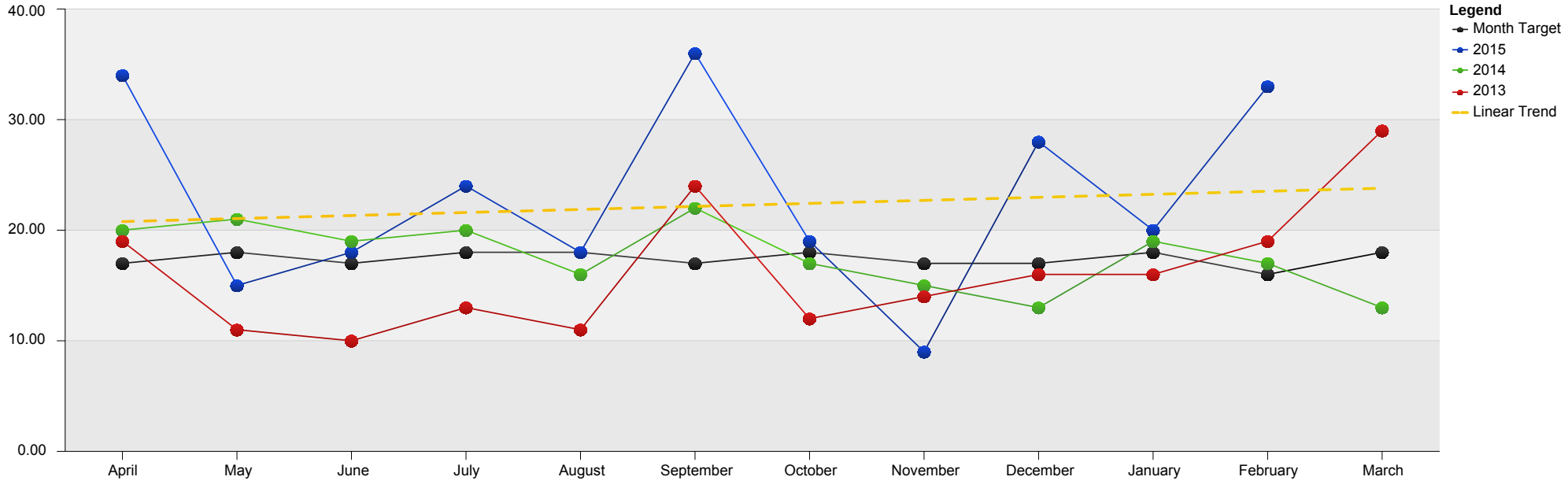
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	16.47%	23.83%	10.00%	21.74%	25.81%	23.13%	12.50%	26.91%	NA	NA		

Narrative

The Trust position for February 2016 is 16.47%, which relates to 14 patients out of 85 that were readmitted within 30 days. This is 1.47% above the target of 15% but an improvement on the position reported in January. The Trust position for the financial year to date is 23.83%, which is 8.83% above target.All of the 14 readmissions were spread across the three localities and were within AMH Services:• 3 (21.42%) were within Durham & Darlington • 8 (57.14%) were within Teesside.• 3 (21.42%) were within North Yorkshire The circumstances of the readmissions have been investigated and all were attributable to the severity of the symptoms and personal circumstances of the patients concerned. The services are completing a more in depth review in this area which will be reported to QUAC and Board in April 2016. Based on current and past performance, there remains a risk that we will not achieve the annual target of 15%.The annual outturn for 2014/15 was 19.89%.

Trust Dashboard Graphs for TRUST

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

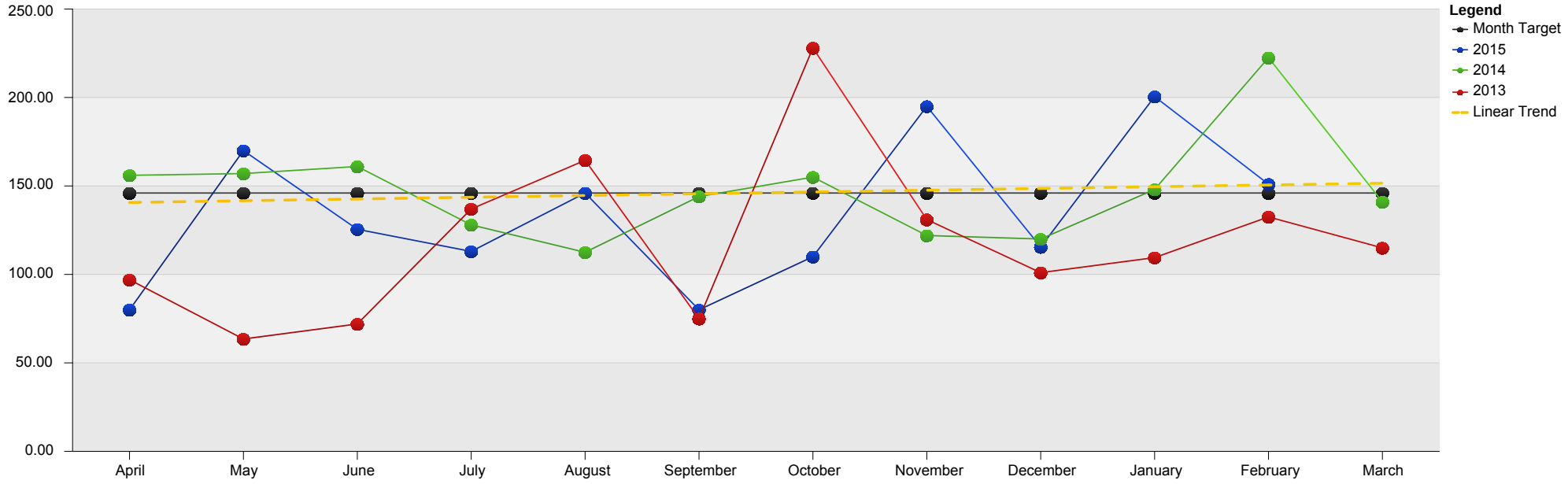


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	33.00	254.00	11.00	86.00	12.00	82.00	10.00	86.00	NA	NA		

Narrative
The Trust position for February 2016 is 33, which is 17 above the target of 16 and a deterioration on the position reported in January. The Trust position for the financial year to date is 254, which is 63 above target.Of the 33 patients• 11 (33.33%) were within Durham & Darlington (AMH)• 12 (36.36%) were within Teesside (AMH)• 10 (30.30%) were within North Yorkshire (9 AMH, 1 MHSOP)The circumstances of the readmissions have been investigated and all were attributable to the severity of the symptoms and personal circumstances of the patients concerned. The services are completing a more in depth review in this area which will be reported to QUAC and Board in April 2016.Based on past and current performance, there remains a risk that we will not achieve the annual target of 209.The annual outturn for 2014/15 was 219.

Trust Dashboard Graphs for TRUST

15) Median number of days between admissions (AMH & MHSOP) - Monthly

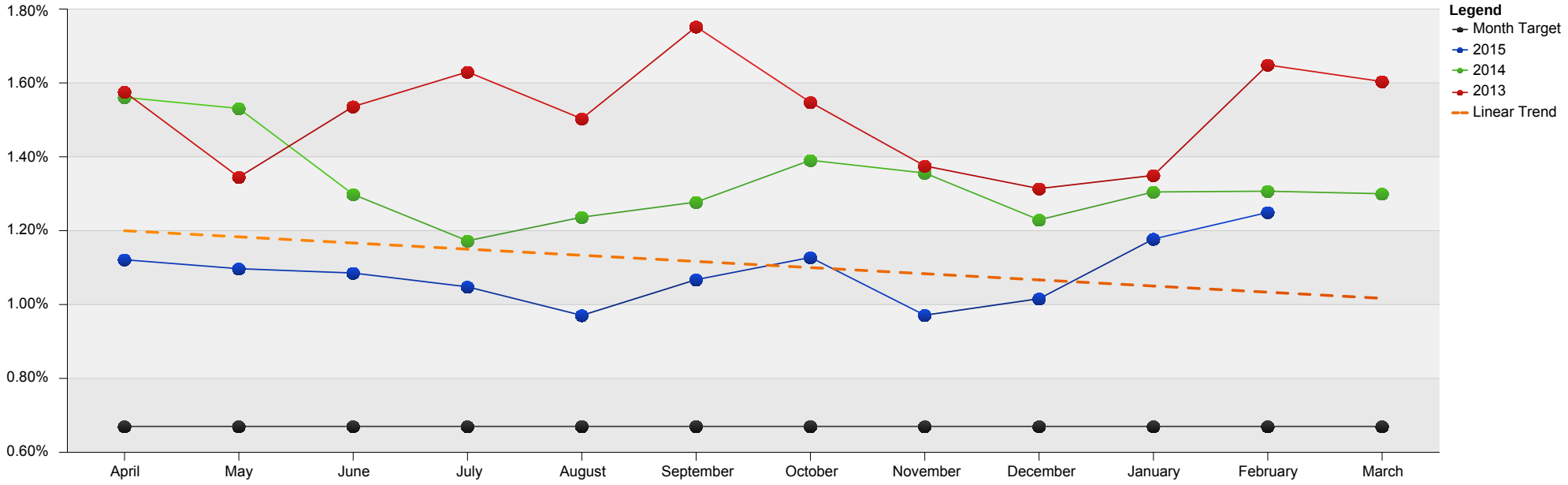


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	151.00	127.00	154.00	132.00	125.00	140.00	147.00	90.00	NA	NA		

Narrative
The Trust position for February 2016 is 151, which is 5 above the target of 146 but a deterioration on January performance. The Trust position for the financial year to date is 127, which is 19 above target.Based on past and current performance, there remains a risk that we will not achieve the target of 146.The annual outturn for 2014/15 was 139.

Trust Dashboard Graphs for TRUST

16) Percentage of appointments cancelled by the Trust



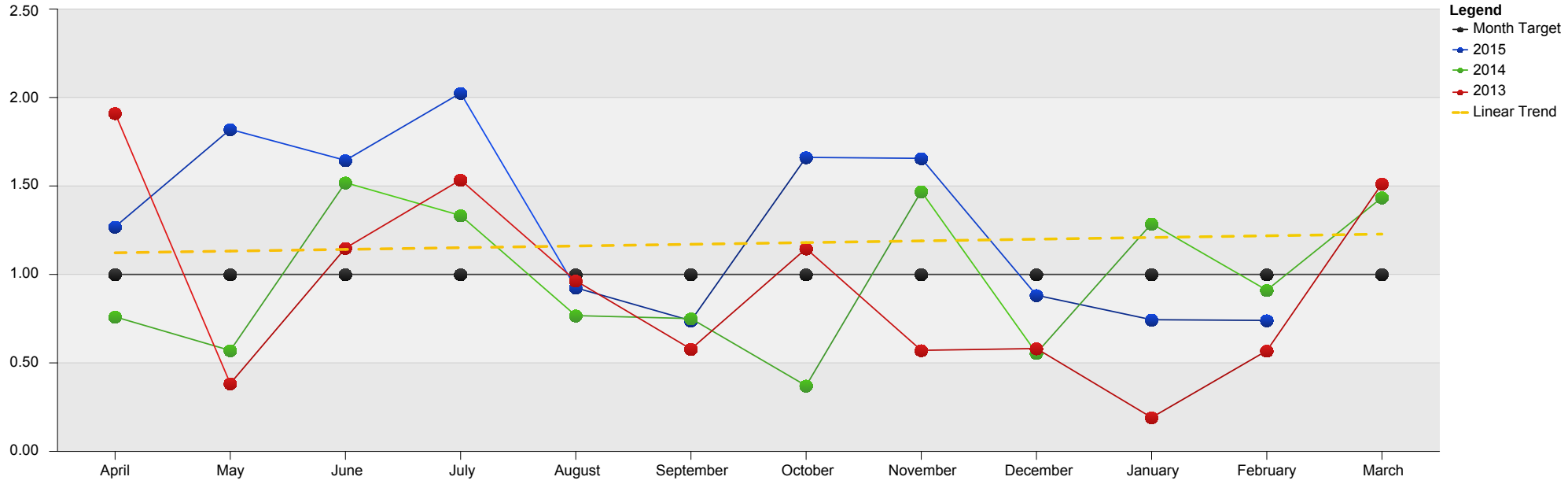
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of appointments cancelled by the Trust	1.25%	1.09%	1.33%	1.11%	1.17%	1.02%	1.44%	1.32%	0.23%	0.11%		

Narrative

The Trust position for February 2016 is 1.25%, which relates to 932 appointments out of 74599 that have been cancelled. This is 0.58% above the target of 0.67% and a deterioration compared to January performance. The Trust position for the financial year to date is 1.09%, which is 0.42% above target. Only Forensic services are achieving target.The Information Service Managers in all localities are continuing to address data quality issues within this area and work is underway to identify any further areas of concern. Based on current and past performance, there remains a risk that we will not achieve the annual target of 0.67% unless further action is taken.The annual outturn for 2014/15 was 1.33%.

Trust Dashboard Graphs for TRUST

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



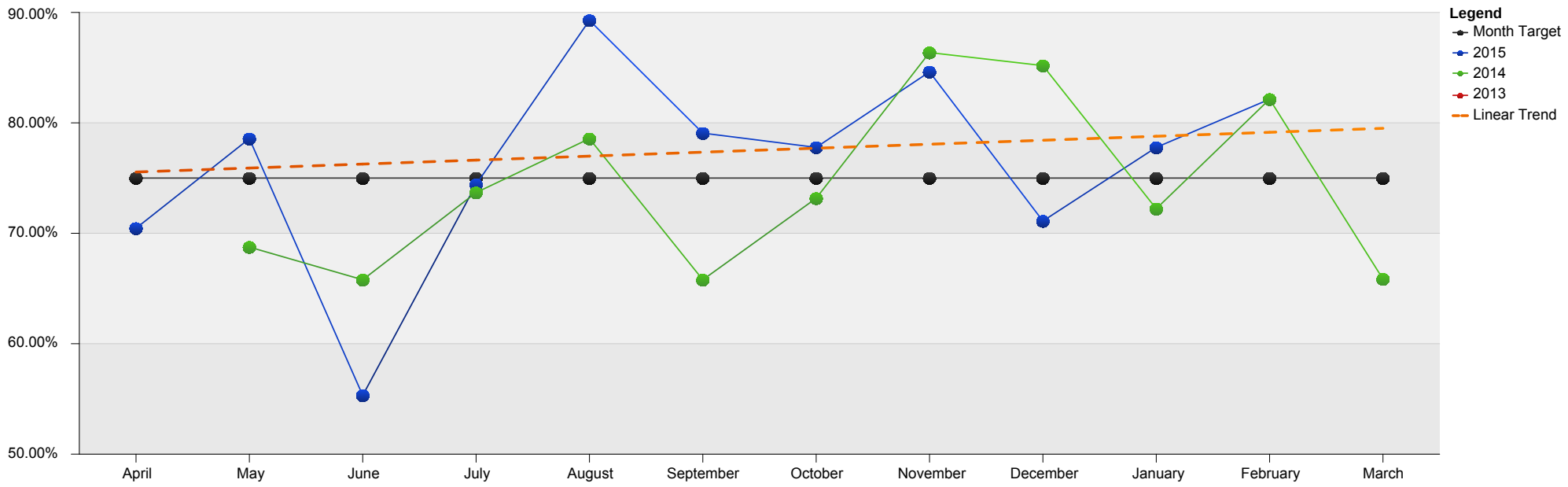
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.74	14.11	0.41	12.04	0.62	13.42	0.00	17.09	24.91	47.45		

Narrative

The Trust position for February 2016 is 0.74, which is 0.26 below the target of 1.00 but the same as January performance. This rate relates to 4 unexpected deaths, 1 in Teesside, 1 in Durham & Darlington and 2 in Forensic Services. The Trust position for the financial year to date is 14.11, which is 3.11 above target. Performance has improved across the year; however the number of deaths classed as serious incidents has primarily been higher than the equivalent months in 2014/15 & 2013/14. Based on this it is likely that we will exceed the annual target of 12.00.The annual outturn for 2014/15 was 12.16.

Trust Dashboard Graphs for TRUST

18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)

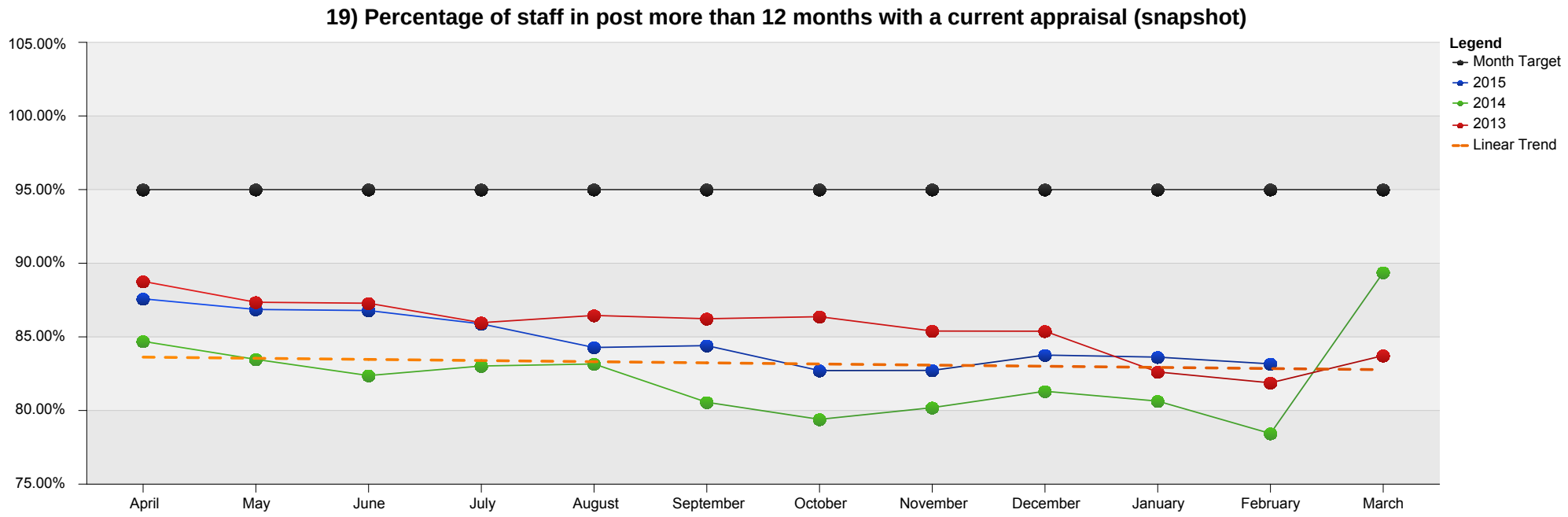


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	82.14%	75.00%	88.89%	88.33%	100.00%	86.11%	85.71%	72.73%	0.00%	40.00%		

Narrative

The Trust position reported in February relates to January performance. The Trust position for January 2016 is 82.14% with 6 wards out of 30 surveyed not scoring higher than 80%. This is 7.14% above the target of 75.00% and is an improvement on December's position. All localities are achieving target with the exception of Forensics who report at 0%. Only 3 patients returned surveys and these were on 3 different wards. Discussions continue within the service looking at ways return rates can be improved.All teams are monitoring surveys and work closely with Patient Experience to investigate any trends. The Trust position for financial year to date is 75%, which is on target. Performance at Trust level is reporting a slightly improving trend and should this continue we will achieve the annual target of 75%.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).The annual outturn for 2014/15 was 73.17%.

Trust Dashboard Graphs for TRUST



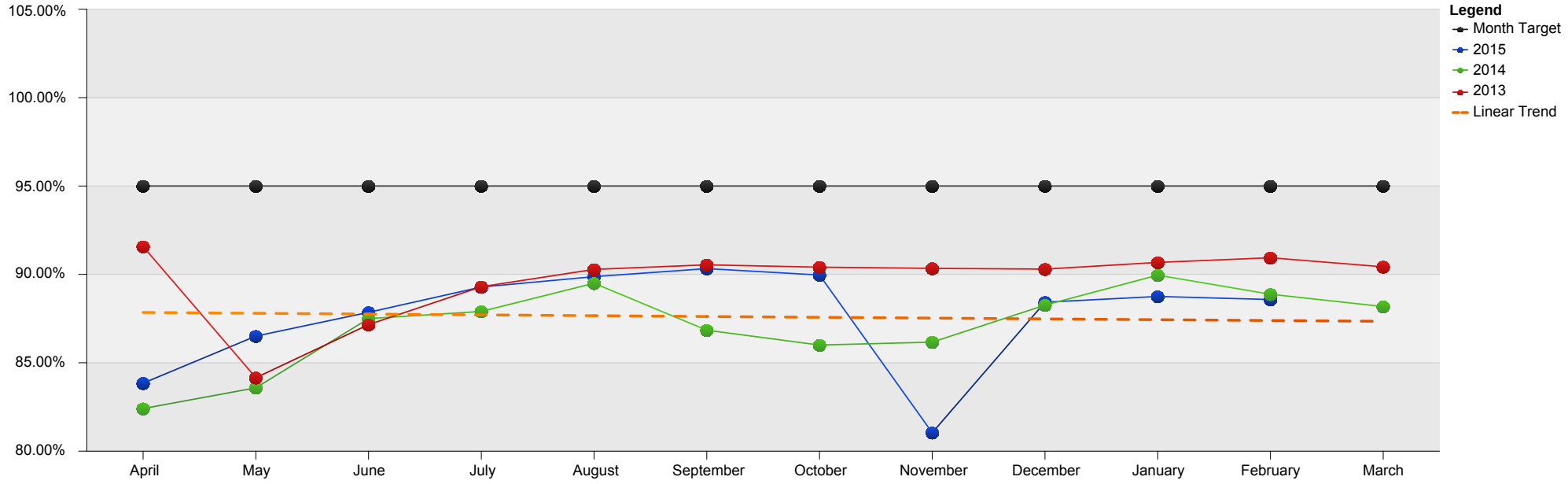
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	83.17%	83.17%	78.57%	78.57%	88.13%	88.13%	85.68%	85.68%	85.85%	85.85%	57.14%	57.14%

Narrative

The Trust position for February 2016 is 83.17% which relates to 871 members of staff out of 5174 that do not have a current appraisal. This is 11.83% below the target of 95%; which is comparable to the figure reported in January. The compliance figure excludes York and Selby, their figure is reporting at 56%.Managers are able to access compliance reports through the IIC to monitor performance against the target of 95%. Monitoring of compliance against the target is picked up at the Performance Improvement Group where Directors of Operations provide details of actions being taken to improve compliance. A survey monkey questionnaire was recently conducted to capture views on using manager self-service on ESR to establish what factors may be impacting on this performance in terms of recording appraisals. Over 200 managers completed the questionnaire, responses of which are currently being evaluated. 14 staff had their pay progression withheld at the end of February due to non-compliance of mandatory training and/or appraisal; 8 staff are due to have their increment withheld at the end of March. Despite performance consistently reporting higher than that during 2014/15, based on the deteriorating trend and February's performance there remains a significant risk that we will not achieve the annual target of 95%, unless further action is taken. The annual outturn for 2014/15 was 85.41%.

Trust Dashboard Graphs for TRUST

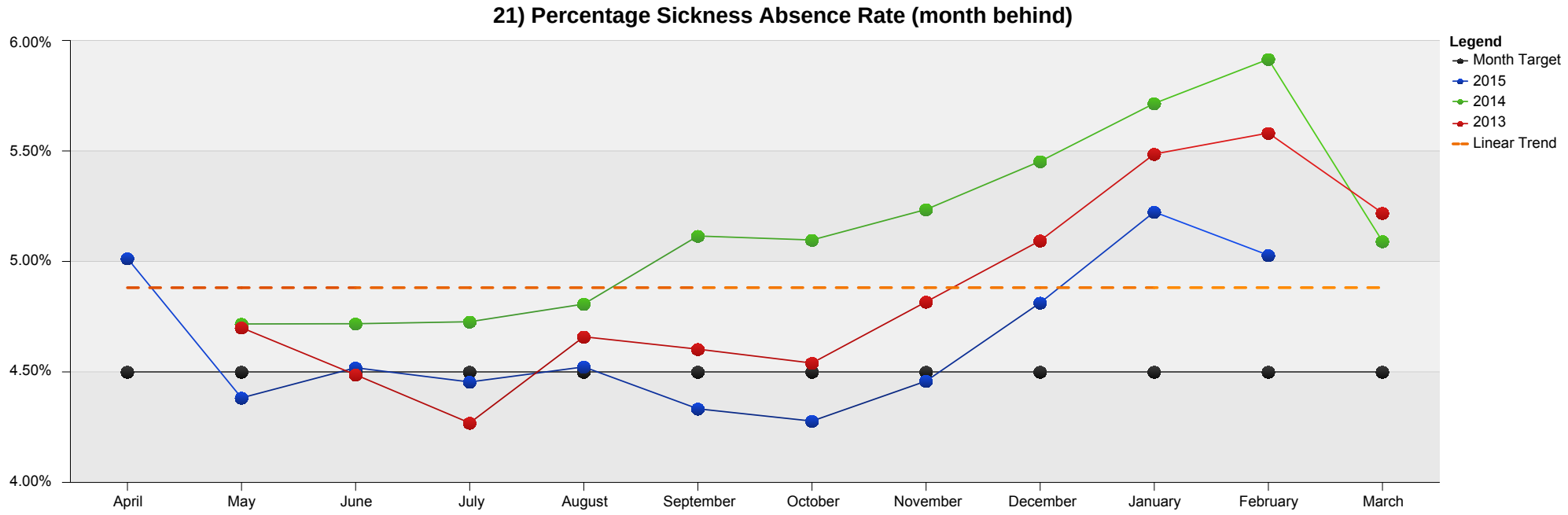
20) Percentage compliance with mandatory and statutory training (snapshot)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Percentage compliance with mandatory and statutory training (snapshot)	88.58%	88.58%	89.41%	89.41%	91.75%	91.75%	87.59%	87.59%	91.90%	91.90%	66.07%	66.07%

Narrative
The position for February 2016 is 88.58%. This is 6.42% below the target of 95% which is comparable to the figure reported in January 2016. The reported figure includes York and Selby. The compliance figure is 91% when York and Selby figures are excluded. Development work is underway to enhance the available HR related information available through IIC. It is envisaged that this will include more detailed information reports relating to appraisal and mandatory & statutory training that highlight competencies due to expire, in addition to those that have already expired. It is hoped this will support managers to proactively manage these key performance indicators.Based on past performance there remains a risk that we will not achieve the annual target of 95%, unless further action is taken.The annual outturn for 2014/15 was 82.29%.

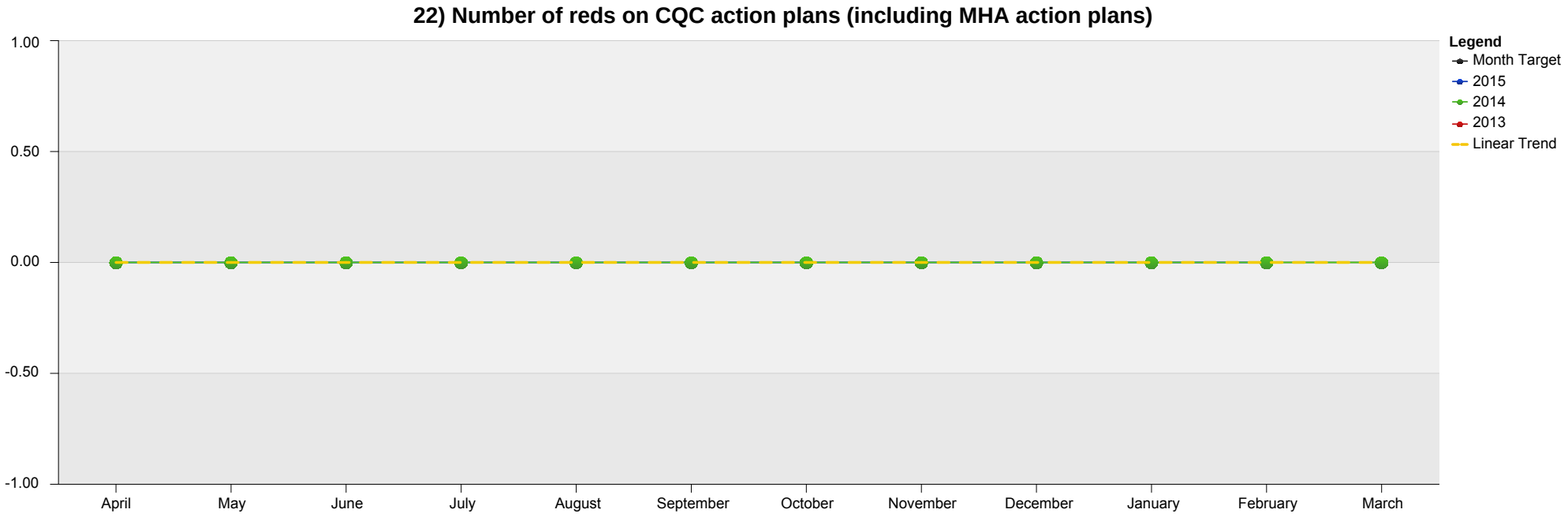
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Percentage Sickness Absence Rate (month behind)	5.03%	4.65%	5.79%	4.65%	5.21%	5.06%	5.17%	4.60%	4.89%	5.77%	5.53%	6.28%

Narrative
The Trust position reported in February relates to the January sickness level. The Trust position reported in February 2016 is 5.03%, which is 0.53% above the Trust target of 4.50%. The Trust position for the financial year to date is 4.65%. The figure includes York and Selby sickness information. The figures reduce to 4.47% when York and Selby information is excluded. The figure reported is below the sickness rate recorded for the same period last year which was 5.1% and for February 2014 which was 5.9%. Historically higher levels of sickness are reported between December and February. Based on past and current performance, we will not achieve the annual target of 4.50% but it is likely we will see an improvement on the 2014/15 annual outturn of 5.12%.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).

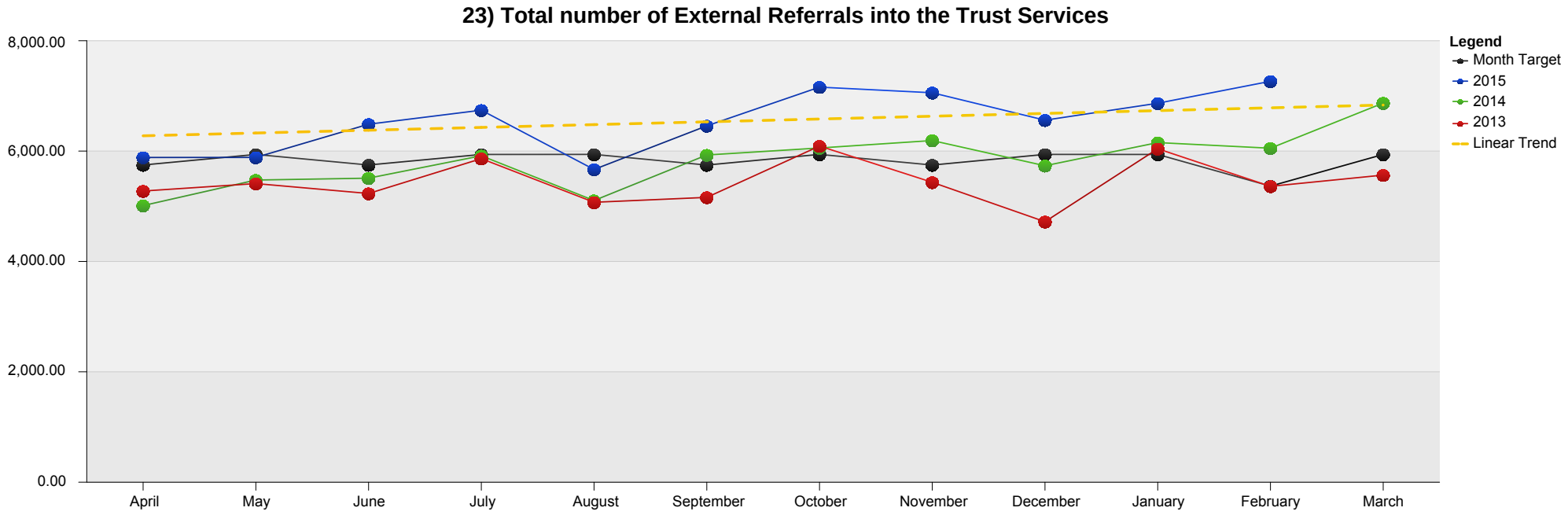
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Narrative
The Trust position for February 2016 is zero, which is consistent with 2014/15 reporting.Based on past performance and February's performance, it is anticipated that we will achieve the annual target.The annual outturn for 2014/15 was 0.

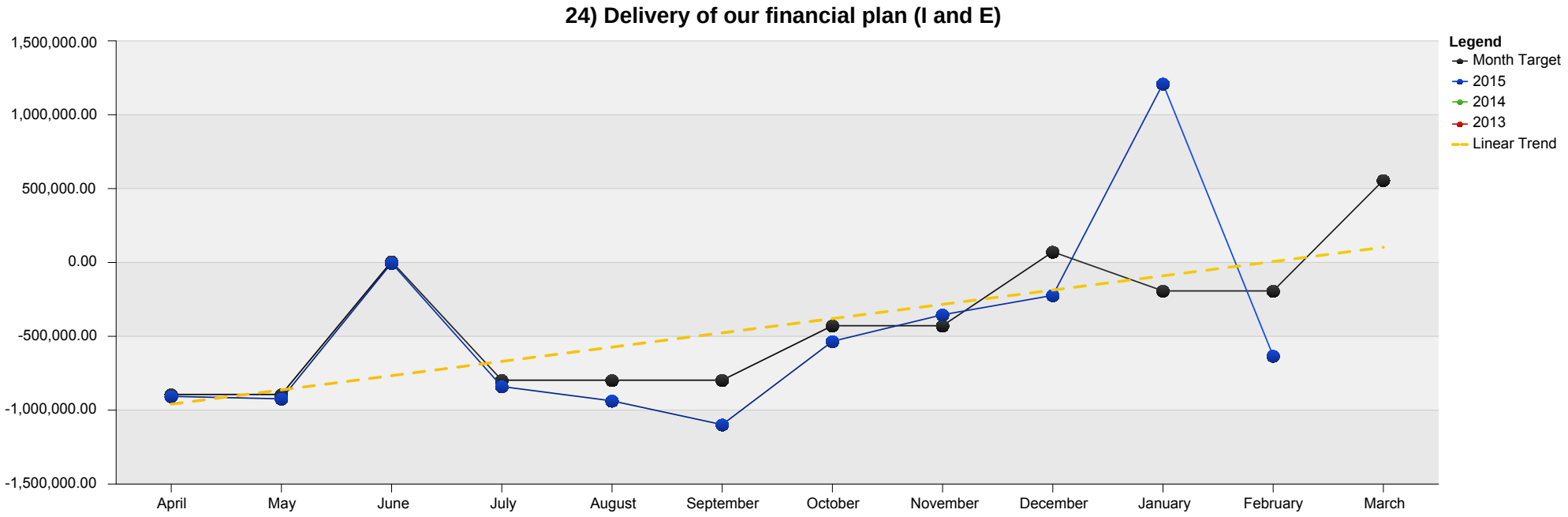
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
23) Total number of External Referrals into the Trust Services	7,265.00	72,029.00	2,044.00	21,296.00	2,061.00	21,644.00	2,050.00	20,882.00	783.00	6,616.00	319.00	1,558.00

Narrative
The Trust position for February 2016 is 7,265 which is 1900 above the Trust target of 5,365 and an increase on the number received in January. The Trust position for the financial year to date is 72,029 which is 8,037 above target. This increase in referrals is in line with patterns in previous years. The annual outturn for 2014/15 was 69,920.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
24) Delivery of our financial plan (I and E)	-633,000.00	-5,243,000.00	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The financial position shows a surplus of £5,243k for the period 1 April 2015 to 29 February 2016, representing 1.9% of the Trust's turnover and is £99k behind plan. This is largely due to the impairment of Trust properties being £1,287k above plan. Excluding impairments the Trust is ahead of plan by £1,188k.The forecast outturn for the Trust is a deficit of £1,959k; however this includes impairments £12,012k higher than anticipated following a planned 3 year review of Trust property.Excluding impairments, the forecast outturn for the Trust is a surplus of £10,053k which is £5,269k ahead of plan largely due to higher than planned contract income and a non-recurrent surplus within projects.

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 1: To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

	February 2016												April 2015 To February 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	98.00%	84.56%	98.00%	79.28%	98.00%	90.34%	98.00%	76.91%	98.00%	99.46%			98.00%	82.71%	98.00%	78.04%	98.00%	89.63%	98.00%	75.04%	98.00%	99.79%		
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	87.33%	98.00%	78.32%	98.00%	93.92%	98.00%	90.33%	98.00%	100.00%			98.00%	86.58%	98.00%	80.71%	98.00%	92.28%	98.00%	89.26%	98.00%	56.52%		
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	50.00%	87.69%	50.00%	82.35%	50.00%	95.83%	50.00%	85.71%	NA	NA			50.00%	73.83%	50.00%	65.62%	50.00%	82.01%	50.00%	72.53%	NA	NA		
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	89.76%	75.00%	99.03%	75.00%	36.00%	75.00%	96.10%	NA	NA			75.00%	84.44%	75.00%	98.49%	75.00%	54.03%	75.00%	77.18%	NA	NA		
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	97.36%	95.00%	100.00%	95.00%	85.60%	95.00%	97.73%	NA	NA			95.00%	94.81%	95.00%	99.84%	95.00%	81.07%	95.00%	93.67%	NA	NA		
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	15.00%	14.65%	15.00%	13.53%	NA	NA	15.00%	16.39%	NA	NA			15.00%	13.47%	15.00%	12.67%	NA	NA	15.00%	14.72%	NA	NA		
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	45.12%	50.00%	49.58%	50.00%	43.44%	50.00%	38.18%	NA	NA			50.00%	45.98%	50.00%	45.85%	50.00%	44.30%	50.00%	47.13%	NA	NA		
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	95.00%	96.05%	95.00%	91.43%	95.00%	98.70%	95.00%	95.00%	NA	NA			95.00%	97.00%	95.00%	95.73%	95.00%	97.49%	95.00%	97.64%	NA	NA		
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.48%	95.00%	100.00%	95.00%	97.87%	95.00%	97.30%	NA	NA			95.00%	97.86%	95.00%	98.33%	95.00%	98.04%	95.00%	96.64%	NA	NA		
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.62%	98.00%	98.11%	98.00%	99.84%	98.00%	97.91%	98.00%	100.00%			98.00%	98.62%	98.00%	98.11%	98.00%	99.84%	98.00%	97.91%	98.00%	100.00%		
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	91.62%	85.00%	89.55%	85.00%	93.31%	85.00%	88.60%	85.00%	100.00%			85.00%	90.11%	85.00%	89.26%	85.00%	91.34%	85.00%	87.83%	85.00%	93.94%		

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 2: To continuously improve the quality and value of our work

	February 2016												April 2015 To February 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	16.24%	15.00%	21.69%	15.00%	9.78%	15.00%	18.64%	NA	NA			15.00%	16.99%	15.00%	17.59%	15.00%	10.60%	15.00%	24.89%	NA	NA		
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	16.47%	15.00%	10.00%	15.00%	25.81%	15.00%	12.50%	NA	NA			15.00%	23.83%	15.00%	21.74%	15.00%	23.13%	15.00%	26.91%	NA	NA		
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	16.00	33.00	5.00	11.00	5.00	12.00	6.00	10.00	NA	NA			191.00	254.00	59.00	86.00	59.00	82.00	72.00	86.00	NA	NA		
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	146.00	151.00	146.00	154.00	146.00	125.00	146.00	147.00	NA	NA			146.00	127.00	146.00	132.00	146.00	140.00	146.00	90.00	NA	NA		
16) Percentage of appointments cancelled by the Trust	0.67%	1.25%	0.67%	1.33%	0.67%	1.17%	0.67%	1.44%	0.67%	0.23%			0.67%	1.09%	0.67%	1.11%	0.67%	1.02%	0.67%	1.32%	0.67%	0.11%		
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.74	1.00	0.41	1.00	0.62	1.00	0.00	1.00	24.91			11.00	14.11	11.00	12.04	11.00	13.42	11.00	17.09	11.00	47.45		
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	82.14%	75.00%	88.89%	75.00%	100.00%	75.00%	85.71%	75.00%	0.00%			75.00%	75.00%	75.00%	88.33%	75.00%	86.11%	75.00%	72.73%	75.00%	40.00%		

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce

	February 2016												April 2015 To February 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	83.17%	95.00%	78.57%	95.00%	88.13%	95.00%	85.68%	95.00%	85.85%	95.00%	57.14%	95.00%	83.17%	95.00%	78.57%	95.00%	88.13%	95.00%	85.68%	95.00%	85.85%	95.00%	57.14%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.58%	95.00%	89.41%	95.00%	91.75%	95.00%	87.59%	95.00%	91.90%	95.00%	66.07%	95.00%	88.58%	95.00%	89.41%	95.00%	91.75%	95.00%	87.59%	95.00%	91.90%	95.00%	66.07%
21) Percentage Sickness Absence Rate (month behind)	4.50%	5.03%	4.50%	5.79%	4.50%	5.21%	4.50%	5.17%	4.50%	4.89%	4.50%	5.53%	4.50%	4.65%	4.50%	4.65%	4.50%	5.06%	4.50%	4.60%	4.50%	5.77%	4.50%	6.28%

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve

	February 2016												April 2015 To February 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
23) Total number of External Referrals into the Trust Services	5,365.00	7,265.00	1,752.00	2,044.00	1,793.00	2,061.00	1,649.00	2,050.00	171.00	783.00		319.00	63,992.00	72,029.00	20,893.00	21,296.00	21,388.00	21,644.00	19,673.00	20,882.00	2,038.00	6,616.00		1,558.00
24) Delivery of our financial plan (I and E)	-192,700.00	-533,000.00	NA	NA	NA	NA	NA	NA	NA	NA			-5,342,300.00	-5,243,000.00	NA	NA	NA	NA	NA	NA	NA	NA		

Trust Dashboard Summary for York & Selby Locality

Strategic Goal 1: To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

		Feb-16				October 2015 - February 2016			Annual
		Target	Month	Status	Change on previous month	Target	YTD	Status	Target
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral								
2	Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral								
3	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	50.00%	50.00%		↓	50.00%	55.10%		50.00%
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral *	75.00%	72.85%		↓	75.00%	61.99%		75.00%
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral*	95.00%	93.38%		↓	95.00%	94.28%		95.00%
6	Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)*	15.00%	6.48%		↓	15.00%	8.55%		15.00%
7	Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery*	50.00%	52.78%		↑	50.00%	44.07%		50.00%
8	Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only)*	95.00%	88.24%		↑	95.00%	89.55%		95.00%
9	Percentage CPA 7 day follow up (AMH)*	95.00%	100.00%		–	95.00%	96.72%		95.00%
10	Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.40%		↑	98.00%	98.40%		98.00%
11	Percentage of community patients who state they have been involved in the development of their care plan (month behind)								

		Feb-16				April 2015 - January 2016			Annual
		Target	Month	Status	Change on previous month	Target	YTD	Status	Target
12	The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP)								
13	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)								
14	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)								
15	Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)								
16	Percentage of appointments cancelled by the Trust								
17	Number of unexpected deaths classed as a serious incident per 10,000 open cases								
18	Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)								
Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce									
19	Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	56.78%	●	🡻	95.00%	56.78%	●	95.00%
20	Percentage compliance with mandatory and statutory training (snapshot)	95.00%	66.07%	●	🡻	95.00%	66.07%	●	95.00%
21	Percentage Sickness Absence Rate (month behind)	4.50%	5.48%	●	🡻	4.50%	6.09%	●	4.50%
Strategic Goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve									
22	Number of reds on CQC action plans (including MHA action plans)								
23	Total number of External Referrals into the Trust Services								
24	Delivery of our financial plan (I and E)								

*** Indicators 4 - 9 contain data for VoY CCG only**

Data Quality Assessment

Appendix C

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at June 2015	Percentage	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
1	Percentage of patients who have not waited longer than 4 weeks for a first appointment	5						4				5					14	93%	93%	
2	Percentage of patients who have not waited longer than 4 weeks following an internal referral	5						4				5					14	93%	93%	
3	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	5						4				5					14	87%	93%	The Trust has developed a local KPI pending publication of national construction. There is an issue identified with allocation of a care co-ordinator which was required for this indicator, which has been monitored through the Data Quality group, but has temporarily been removed from the logic. Work has been undertaken with the services to improve reliability, therefore the score for data reliability has increased from 3 to 4.
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral		4					4				5					13	87%	87%	
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral		4					4				5					13	87%	87%	
6	Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)		4					4				5					13	87%	87%	
7	Recovery Rate – Adult IAPT: The percentage of people who complete treatment who are moving to recovery		4					4				5					13	87%	87%	
8	Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only)		4					4				5					13	87%	87%	Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches.
9	Percentage CPA 7 day follow up (adult services only)		4					4				5					13	87%	87%	Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches.
10	Percentage of CPA Patients having a formal review documented within 12 months – snapshot (adult services only)	5						4				5					14	93%	93%	
11	Percentage of community patients who state they have been involved in the development of their care plan (month behind)					1		4				5					10	67%	67%	All questionnaires are paper-based, except for some CAMHS units, where patients use a touch screen facility to record their comments. The manual questionnaires from Trust are sent to CRT and scanned into their system. Raw data files are received from CRT, which are accessed by IPT and uploaded into the IIC.
12	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated		4					4				5					13	87%	87%	
13	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						4				5					14	93%	93%	

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at June 2015	Percentage	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
14	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	5					5					5					15	100%	100%	
15	Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	5					5					5					15	100%	100%	
16	Percentage of appointments cancelled by the Trust	5									1	5					11	87%	73%	Whilst data reliability has been tested, a number of data quality issues identified by the Patient Experience Group and the localities have raised a significant concern; therefore the Data Quality Group has assessed reliability at 1. For example: • appointments being incorrectly recorded as cancelled • not all cancelled appointments being recorded • appointments not having outcomes recorded A working party is to be established to investigate the problem and produce longer term recommendations
17	Number of unexpected deaths classed as a serious incident per 10,000 open cases					1		4				5					10	67%	67%	Different sources in calculation - lower one used which is a manual process including a telephone call and data entered onto Datix (unexpected deaths)
18	Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)			3				4				5					12	80%	80%	Surveys for ward are via the hand held device. The devices are uploaded electronically (can sometimes be issues with the devices) direct to CRT. Patient Experience Team (PET) provided with ward based reports. PET open every ward report, identify the % and number completing, calculate the numerator manually then type this into the spreadsheet for each individual ward. Latter 2 processes open to human error.
19	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	93%	93%	
20	Percentage compliance with mandatory and statutory training – snapshot	5						4				5					14	93%	93%	
21	Percentage Sickness Absence Rate (month behind)	5							3			5					13	87%	87%	Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR and there are examples whereby managers are failing to end sickness in a timely manner or inaccurately recording information onto the system – this is picked up and monitored through sickness absence audits that the Operational HR team undertake.
22	Number of reds on CQC Action Plans (including MHA Action Plans)				2		5					5					12	73%	80%	Whilst static reports are emailed to the Trust, the information is maintained on an Excel spreadsheet. This is monitored and updated in conjunction with the services. Contingencies are now in place to ensure data is correctly reported and sourced on time and data is extracted from the spreadsheet onto the manual return for upload onto the IIC. Therefore, the score for data source has increased from 1 to 2.
23	Total number of External Referrals into the Trust Services	5					5					5					15	100%	100%	
24	Are we delivering our financial plan (I and E)		4				5					5					14	93%	93%	

Number of unexpected deaths and verdicts from the coroner April 2015 - March 2016

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death	1																				**1**
Natural causes	1					1															**2**
Hanging	3	1	2								1						1		1		**9**
Suicides	6	3	6										1				1				**17**
Open	1		1																		**2**
Drug related death	1	2																			**3**
Drowning																					**0**
Misadventure	1		1																		**2**
Awaiting verdict	11	8	6	2		1		1			1	2	2			1	4		1		**40**
Total	**25**	**14**	**16**	**2**	**0**	**2**	**0**	**1**	**0**	**0**	**2**	**2**	**3**	**0**	**0**	**1**	**6**	**0**	**2**	**0**	**76**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
7	10	9	10*	5	4	9	9	5	4	4	

** There was originally 11 reported within this month, however, one incident was susbequently downgraded by Commissioners*

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
30	22	20	4	0

Number of unexpected deaths and verdicts from the coroner 2014 / 2015

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

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes	1										1					1					**3**
Hanging	1	1	1													1					**4**
Suicides	14	8	3	1					1							1	3	2			**33**
Open																					**0**
Abuse of drugs																		1			**1**
Drowning																					**0**
Misadventure	1															1					**2**
Awaiting verdict	6	1	3			1	1				1					3	1				**17**
Total	**23**	**10**	**7**	**1**		**1**	**1**	**0**	**1**		**2**	**0**	**0**	**0**		**7**	**4**	**3**	**0**		**60**

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	2	7	7	4	4	2	8	3	7	5	8

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
33	15	10	2	0

ITEM NO. 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22nd March 2016**
TITLE:	**To approve the Information Governance Toolkit submission for 2015/16.**
REPORT OF:	**Colin Martin, Director of Finance and Information**
REPORT FOR:	**Decision**

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

Executive Summary:

The report identifies the IG Toolkit scores as predicted for the 31st March.

	Version12 2014-2015	Version 13 Predicted	Version13 2015-2016 14/3/16
Information Governance Management	**100%**	**100%**	**100%**
Confidentiality and Data Protection Assurance	**85%**	**85%**	**81%**
Information Security Assurance	**88%**	**88%**	**82%**
Clinical Information Assurance	**86%**	**86%**	**86%**
Secondary Use Assurance	**87%**	**87%**	**87%**
Corporate Information Assurance	**77%**	**77%**	**77%**
Total	**88%**	**88%**	**85%**

Recommendations:

The Board of Directors is asked to note the contents of this report and approve the IG Toolkit submission for 2015/16.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**22nd March 2016**
TITLE:	**To approve the Information Governance Toolkit submission for 2015/16.**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Board of Directors and the Information Strategy and Governance Group (ISGG) with assurance of the Trust's compliance across all sequences with the IG Toolkit. All sequences have to reach level 2 of the Toolkit and this has been achieved.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is a requirement for all NHS Trusts that adequate information governance is in place to ensure clinical and corporate business functions are compliant with both national legislation (Data Protection Act 1998) and the resulting government directives. The Trust's overall compliance in this area is monitored annually through the Information Governance Toolkit (IGT) assessment submitted through the Health and Social Care Information Centre (HSCIC).

3. KEY ISSUES:

3.1 Information Governance (IG)

The final out turn for the 2015/16 version 13 Toolkit will be as follows:

	Version12 2014-2015	**Version 13 Predicted**	**Version13 2015-2016 14/3/16**
Information Governance Management	**100%**	**100%**	**100%**
Confidentiality and Data Protection Assurance	**85%**	**85%**	**81%**
Information Security Assurance	**88%**	**88%**	**82%**
Clinical Information Assurance	**86%**	**86%**	**86%**
Secondary Use Assurance	**87%**	**87%**	**87%**
Corporate Information Assurance	**77%**	**77%**	**77%**
Total	**88%**	**88%**	**85%**

It should be noted that this reported outcome may change between the date of the report and the end of March. The Finance Director will update the Board of Directors if there are any changes to the reported outcome at its meeting on the 22nd March 2016.

3.2 Senior Information Risk Owner – Risk Management Report 2015/16

The annual report to the SIRO outlining the risk profile for information assets has been completed and is currently indicating an overall amber rating.

The main areas of concern remain the lack of engagement with the risk management systems and the number of incidents that are being raised due to disclosures made in error. Mitigating actions are being considered by ISGG in the coming months.

There have been five level 2 incidents reported to the Information Governance incident reporting tool and all are now closed except one. The Trust is awaiting any requirements to further report on the open incident from the ICO.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Completion of the Toolkit to an acceptable standard is monitored as part of the CQC evidence when an inspection takes place. In this way they are assured that the Trust has the correct governance and assurance processes in place to demonstrate adherence to the Data Protection Act 1998.

4.2 Financial/Value for Money:

There are no direct financial implications from this report. There are significant financial risks if information security breaches occur or information systems fail, impacting on the regulation and business of the Trust. The risk is also reputational and could affect the Trust's licence to practice depending upon the scale of a breach.

4.3 Legal and Constitutional (including the NHS Constitution):

There are no imminent changes in regulation either legal or constitutional that the Directors should be aware of at this time. The new DPA regulations will be expected to be introduced during 2018. However, there are no radically new systems to be put in place; rather that we will be changing from having the option to carry out some tasks e.g. privacy impact assessments to being required to complete as part of the legislation.

4.4 Equality and Diversity:

There have been no equality and diversity issues raised as part of the reporting of the IG Toolkit.

4.5 Other implications:

None identified

5. RISKS:

The continuing rise in the number of unauthorised disclosures is becoming a risk to the organisation because even though they are often individual human error incidents, brought about by rushing or printing in quantity and then mixing up papers, they represent a known escalating set of incidents that is not being effectively managed.

The issues will be part of a work programme of mitigating actions that will come to the Board in April.

6. CONCLUSIONS:

6.1 The Toolkit has been completed and achieved an overall score of 88%which is the same as last year.

7. RECOMMENDATIONS:

7.1 The Board of Directors is asked to note the contents of this report and approve the IG Toolkit submission for 2015/16.

Author: Colin Martin
Title Director of Finance and Information

Background Papers:

ITEM NO.13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**March 2016**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Martin Barkley**
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:

3 policies were approved for ratification:

CLIN-0009-v5 Mental Capacity Act 2005
CLIN-0013-001-v1 User of Visual and Audio Recordings in Clinical Procedures
CLIN-0085 v1 Risk Assessment for Venous Thromboembolism (VTE)

No policies with minor amendments

1 policy requested an extension to its review date to 1st March 2016 as it is undergoing significant revision.

8 guidelines and procedures were recommended for removal from the portfolio as the Trust will now use the Royal Marsden manual of clinical nursing procedures.

Recommendations:

The Board are asked to ratify the decisions made by EMT on 2 March 2016

DATE:	**March 2016**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Martin Barkley**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

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

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

3. KEY ISSUES:

3.1 The following reviewed policies have been ratified:

IPC-0001 v2 – Infection Prevention and Control Policy
Review date 2 March 2019

3.2 The following policies have undergone minor amendment:

IPC-0001-002 v2 Blood Borne Viruses (BBVs)
Review date 2 March 2019

IPC-0001-003.v2 CJD (Creutzfeldt-Jakob Disease) and patient management
Review date 2 March 2019

IPC-0001-004 v2 Clostridium Difficile Associated Diarrhea (CDAD)
Review date 2 March 2019

IPC-0001-007 v2 Infectious Diseases
Review date 2 March 2019

IPC-0001-014 v2 Sharps – Safe use and disposal of
Review date 2 March 2019

3.3 The following new guidance documents were ratified:

CLIN-0084-001.v1 Asthma Guidance
Review date 2 March 2019

CLIN-0084-002.v1 COPD Guidance
Review date 2 March 2019

CLIN-0084-003.v1 Cardiovascular Risks (Hypertension and High Cholesterol) Guidance
Review date 2 March 2019

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 meetings on 2 March 2016 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: Martin Barkley
Title: Chief Executive