Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 26TH JANUARY 2016 VENUE: THE DURHAM CENTRE, BELMONT INDUSTRIAL ESTATE, DURHAM, DH1 1TN AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meetings of the Board of Directors held on **24th November** and **15th December 2015**.		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To receive a briefing on key issues in the County Durham and Darlington Locality.	**Jo Dawson to attend**	**Presentation**
Item 7	To consider the six monthly "Hard Truths" Nurse Staffing Report.	**EM**	**Attached**

Performance (10.25 am)

Item 8	To consider the summary Finance Report as at 31st December 2015.	**CM**	**Attached**
Item 9	To consider the Trust Performance Dashboard as at 31st December 2015.	**SP**	**Attached**
Item 10	To consider the Trust Workforce Report as at 31st December 2015.	**DL**	**Attached**

Governance (10.50 am)

Item 11	To approve the Quarter 3, 2015/16 Risk Assessment Framework submission to Monitor.	**PB**	**Attached**
Item 12	To consider the publication of information on compliance with the public sector duty under the Equality Act 2010.	**DL**	**Attached**

Items for Information (11.05 am)

Item 13	To receive and note a report on the use of the Trust's seal.	**MB**	**Attached**
Item 14	Policies and Procedures ratified by the Executive Management Team.	**MB**	**Attached**

Item 15 To note that the next meeting of the Board of Directors will be held on Tuesday **23rd February 2016** in the Board Room, West Park Hospital Darlington at 9.30 am.

Confidential Motion (11.10 am)

Item 16 **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.

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

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
20th January 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 24TH NOVEMBER 2015 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. D. Jennings, Non-Executive Director
Mrs. B. Matthews, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Dr. N. Land, Medical Director
Mr. C. Martin, Director of Finance and Deputy Chief Executive
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mr. N. Ayre, York Mind
Mr. J. Robinson, Quintiles
Mr. P. Bellas, Trust Secretary
Prof. J. Reilly, Clinical Director for Research and Development (minute 15/316 refers)
Mrs. A. Coulthard, Director of Operations for North Yorkshire (on behalf of the Chief Operating Officer)
Mrs. J. Illingworth, Director of Quality Governance (on behalf of the Director of Nursing and Governance)
Mrs. J. Jones, Head of Communications
Ms. L. Currer, NHS Graduate Management Trainee

Ms. L. Cate, Ms. L. Chapman, Ms. V. Cosgrove, Ms. M. Costello and Mr. L. Cowan, student nurses.

15/309 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. B. Kilmurray, Chief Operating Officer, and Mrs. E. Moody, Director of Nursing and Governance.

15/310 MINUTES

Agreed *– that the public minutes of the meeting held on 27th October 2015 be approved as a correct record and signed by the Chairman.*

15/311 PUBLIC BOARD ACTION LOG

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

Mr. Levy reported that, further to minute 15/251 (29/9/15) and following discussions with Mr. Buckley (Director of Operations) and the Head of Service, it had been agreed that the introduction of recruitment and retention incentives in offender health services

should not be introduced, for the time being, as a recent recruitment exercise had provided confidence that they were unnecessary.

15/312 DECLARATIONS OF INTEREST

There were no declarations of interest.

15/313 CHAIRMAN'S REPORT

The Chairman:

(1) Drew attention to her report to the meeting of the Council of Governors held on 17th November 2015.

(2) Reported on her visit to Roseberry Park on 13th November 2015 during which she had:

(a) Spent time with staff in the Estates and Facilities Management Department and had been shown the efficient system they had developed for managing the stores.

(b) Observed a "Swartz Round" on staff experience of the CQC inspection.

Mrs. Bessant advised that these events provided staff with a therapeutic environment to talk about and share their experiences.

15/314 GOVERNOR ISSUES

No issues were raised.

15/315 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 1st October 2015 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 5th November 2015.

Mrs. Pickering reported that the Trust had been invited to provide a six month progress report on the priorities in the Quality Account to the Overview and Scrutiny Committees for County Durham, Darlington and Hartlepool.

15/316 RESEARCH AND DEVELOPMENT

Consideration was given to the report which:

(1) Provided information on research and development activity for the period April 2014 to March 2015 including the Durham University Mental Health Research Group Annual Report for 2014 (Appendices 1a and 1b to the covering report).

(2) Provided an update on key progress areas during the course of 2015/16.

(3) Sought approval of the Trust's Research and Development Strategy 2015 – 2020 (as set out in Appendix 2 to the report).

Prof. Reilly drew attention to the key issues included in the report as follows:

(1) Research was well embedded in the Trust with a strong ethical basis and significant involvement of service users and carers.

(2) Overall research had faired quite well in a tough financial environment; however, there was an increasing emphasis on ensuring it was undertaken efficiently and effectively.

(3) The Trust's strategy and influence were built on its tremendous success in recruiting participants. Whilst recruitment to National Institute for Health Research (NIHR) studies had been lower in 2015/16 than in the past, the Trust had continued to recruit to important clinical trials which would feed into clinical practice e.g. NICE guidelines.

(4) In the future there would be a greater focus on research activity led by the Trust's own clinicians and senior academics.

(5) The opportunities and challenges for the Trust moving forward to its next stage of development were set out in the Research and Development Strategy. Strong partnerships with the universities were recognised as key to delivering its objectives.

(6) The implementation plan for the Strategy had been approved by the Executive Management Team on 18th November 2015.

(7) The expansion into York and Selby provided a real opportunity for assessing how far the Trust had come in taking forward its approach to research and development. Early indications were encouraging with the Trust collaborating in a major clinical trial, led by Prof. Simon Gilbody of York University's School of Health Science, on enhanced smoking cessation intervention in severe mental illness.

(8) The next five years were likely to be challenging but research and development activity was considered to be crucial to the continued improvement of clinical care by the Trust.

In response to questions Prof. Reilly advised that:

(1) The most exciting area for research for him, personally, was on primary care in mental health as it was based on delivering the best outcomes for the largest number of people. Work in this area, including that being undertaken by Dr. David Ekers, was challenging assumptions and would have a significant influence on clinical practice.

(2) Although some large scale studies would still be undertaken, the move from national specialty based research networks to regional networks had resulted in smaller, more localised and bespoke studies becoming increasingly important.

This change was recognised in the Strategy with the Trust's focus moving from collaboration to leadership in research and to achieving a more balanced profile of external funding.

(3) York University's reputation and track record in broader health research would provide opportunities for the Trust particularly with regard to finding solutions to common problems between organisations and exploring new models of care.

(4) If the Trust did not undertake research there would be significant impacts on service users.

The benefits of research could be seen in the following areas:

(a) Participation in research being a major influence on clinicians wishing to join the Trust.
(b) The opportunity for thousands of services users to receive ground breaking treatments through clinical trials.
(c) There was evidence that organisations actively involved in research provided better care.

(5) The Higher Education Research Excellence Framework provided an approach to the measurement of the cost/benefit of research.

Under the Framework universities needed to demonstrate the impact of research and the Trust had an important contribution to make in supporting this.

The Trust's reputation was also important in attracting grant funding. This issue was recognised in the strategic objective to move from collaboration to leadership in research.

(6) Comparing the Trust to others was challenging as it depended on how success was measured.

The only national measure was participation in clinical trials. In 2014/15 the Trust had been sixth nationally on this measure but it was unlikely to maintain this position due to the reducing number of NIHR studies.

(7) The Trust had been quite successful in translating research into clinical practice due to the studies undertaken and the partnerships established between academics and clinicians.

However, he recognised that it would be helpful to provide assurance to the Board on this issue, including the changes to NICE guidelines arising from research undertaken. He undertook to consider the evidence which could be used to support this taking into account the inevitable time lag between the research being conducted and its impact on clinical practice.

The Chairman considered that the research being undertaken was very exciting and, on behalf of the Board, thanked Prof. Reilly and his colleagues for their work.

Agreed -

(1) that the Annual Report on Research and Development 2014/15 be received and noted; and
(2) that the Research and Development Strategy 2015 - 2020 (as set out in Appendix 2 to the report) be approved.

Action: Dr. Land

15/317 NURSE STAFFING REPORT

The Board received and noted the report on nurse staffing for October 2015 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. Illingworth drew attention to the following matters contained in the report:

(1) Compared to September 2015 the number of "red" rated wards had increased to 49, from 43, and the average fill rate for registered nurses for daytime shifts had decreased from 90.3% to 89.7%.

On this matter it was noted that:

(a) The changes in the monthly position were attributed to the transfer of services in York and Selby to the Trust as the Locality accounted for 7 of the "red" rated wards.

(b) The County Durham and Darlington Locality consistently had the lowest number of "red" rated wards.

(c) Forensic services had the highest number of "red" rated wards but the number had decreased from 20 in September 2015 to 14 in October 2015.

(2) The fill rates by ward for the month with:

(a) Jay Ward having the lowest fill rate.

It was noted that sickness absence and maternity leave had contributed to this position.

(b) Westerdale South Ward having both the highest fill rates and use of bank staff.

(3) The comparatively high use of agency staff in the York and Selby and North Yorkshire Localities with Worsely Court, in the former Locality, being the highest individual user of those staff.

(4) The information on staffing data and a range of quality metrics by ward included in Appendix 6 to the report.

The Board noted that:

(a) The number of incidents involving the use of control and restraint at the Westwood Centre had reduced from 134 in September 2015 to 78 in October 2015. This change was attributed to action taken to address challenging behaviour, particularly self-harm, by increasing the number of nursing staff on the Ward at night.

(b) The four SUIs during the month had occurred on different wards. Rowan Ward and Springwood, which both had high agency usage, accounted for two of the incidents.

(c) Seven complaints had been received including:

- One for Rowan Ward which had high agency usage.
- One for Bransdale Ward which had low staffing levels and bank usage.
- One for Cedar Ward which had low staffing levels.

(5) No direct correlation had been found between staffing levels and quality but the matter would be kept under review.

The Non-Executive Directors raised the following matters:

(1) Whether there was a correlation between incidents and staffing levels, for example, whether the reduction in the number of incidents at the Westwood Centre was due to the increase in staffing or might be for some other reason.

Mrs. Illingworth responded that further information on this matter would be provided in the next six month nurse staffing report.

Action: Mrs. Moody

(2) The position the Trust had inherited in York and Selby, which had impacted on the overall position on the staffing metrics, and the actions being taken to address this.

In response it was noted that:

(a) The Trust had been aware of the position on the use of temporary staffing in the Locality prior to the transfer.

(b) Difficulties in recruiting and retaining nursing staff were common to all mental health trusts and the Trust was actively engaged in recruiting as many nurses as possible.

(c) Plans were in place to improve staff recruitment and retention and to grow the staff bank in the Locality.

(d) In September 2015 a decision had been taken to engage additional agency staff for three months in recognition that wards were short staffed; however, since that time, some staff had been redeployed following the closure of wards at Bootham Park Hospital. This would mean that additional staff would need to be recruited when the AMH inpatient units in the Locality re-opened.

(3) The appropriateness of including data on York and Selby in the overall staffing data for the time being.

The Chairman considered that the data on York and Selby should be kept separate from that for the other Localities until it could be integrated without impacting on the Board's understanding of the staffing position across the Trust.

Mrs. Illingworth took this on board.

Action: Mrs. Illingworth

On this matter it was noted that:

(a) Staff in the Locality had moved onto the ESR system during October so confidence in the data would improve.

(b) Only minimal data on patient activity was recorded on the PARIS system in the Locality.

(c) Work to address this, and bring the use of the system into line with the other Localities, was due to commence in February 2016.

(4) The implications of the cap on agency spending on the Trust.

Mr. Martin provided assurance that the agency cap did not present significant risks to the Trust as total expenditure on agency staffing was only 0.5% of the total staffing budget (against the cap of 3%) and the use of agency registered nurses was low compared to other staff groups.

(5) The risks arising from the situation at the Westerdale South Ward which had had the highest fill rate for the third month in a row.

In response it was noted that:

(a) The Ward was the busiest in the Trust and the number of admissions had increased during October 2015.

(b) Whilst the Ward had high sickness levels, the main contributory factor to the high fill rates was the need for enhanced observations.

Mrs. Illingworth undertook to provide further information on this matter in the next Nurse Staffing Report.

Action: Mrs. Illingworth

(6) The reporting of staffing issues within SUI reports.

Mrs. Illingworth took on board a request from the Chairman that SUI reports should explicitly state whether or not the staffing situation on a ward had contributed to the incident.

Action: Mrs. Illingworth

15/318 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 27th July 2015 (Appendix 2 to the above report).

(2) The key issues considered by the Committee at its meeting held on 26th October 2015.

In response to a question it was noted that the acronym "MHBPOS" stood for "mental health based place of safety" i.e. a Section 136 Suite.

15/319 FRANCIS 2 ACTION PLAN

Further to minute 15/201 (23/7/15), the Board received and noted a progress report on the implementation of actions arising from the Francis Report for the period up to 31st October 2015.

Clarity was sought on the proposals to remove certain IT related actions from the action plan.

On this matter it was noted that:

(1) The actions related to the continuing development of the PARIS system and, as such, they could never be reported as completed.

(2) The actions would be taken forward through the PARIS development programme.

(3) No statutory or regulatory risks would arise from the removal of the actions as the Trust had not been required to develop the action plan and it was not performance managed externally.

(4) The actions included in the action plan had been developed in consultation with staff and stakeholders and it was, therefore, important for there to be transparency on the progress made in response to their contributions.

(5) The proposal to remove the actions recognised that that the issues had become "business as usual".

In addition, at the request of the Chairman, Mr. Barkley undertook to prepare the next progress report as a final "stock take" with those items remaining outstanding and those being taken forward through other workstreams being highlighted.

Action: Mr. Barkley

15/320 WAITING TIMES ACTION PLAN

Further to minute 15/132 (26/5/15) the Board received and noted a progress report on the Waiting Times Action Plan.

An update against the original action plan, which had been developed for AMH services, was provided as Appendix 1 to the covering report; however, the report also provided a commentary on specific issues and actions being undertaken to address them within each Locality.

Mrs. Coulthard reported that:

(1) There had been an overall improvement on waiting times; however, there were still variations across all Localities.

(2) Plans were in place to address the variations including through the work being undertaken on community productivity.

The Board discussed the following matters:

(1) The level of assurance provided by the report as there appeared to be inconsistencies in the data.

Mrs. Pickering considered that, whilst there were some minor anomalies, the degree of detailed scrutiny on waiting times provided confidence in the general robustness of the data.

(2) The level of confidence that waiting time targets would be achieved for certain teams.

The Chairman highlighted that, for certain targeted teams, performance had decreased in October 2015 but they were still expected to achieve target in early 2016.

Mrs. Coulthard responded that the introduction of shorter assessment slots would support achievement of targets.

In response to a question on the risks arising from this approach, Mr. Barkley assured the Board that further slots would be offered to patients if needed.

(3) Concerns that actions taken to address waiting times could create pressure elsewhere.

It was noted that there was evidence of this issue across the NHS. The Trust was, therefore, mindful that all aspects of the pathway needed to be considered in tackling waiting times and this was being taken forward through work on community productivity.

(4) The improvement work being undertaken to support action on waiting times.

In response to a question it was noted that progress on the improvements identified at the Kaizen event to reduce recording times in December 2015 would be measured through the standard report out processes.

Mrs. Coulthard undertook to provide the Chairman with details of the event.

Action: Mrs. Coulthard

Dr. Land informed the Board that the report out on the Kaizen event on access services within AMH, on 20th November 2015, had provided him with encouragement that significant time could be saved and additional capacity created in teams.

(5) Whether a step change in performance could be expected in March 2016 with the reduction of recording time from 3 hours to 1 hour with the implementation of standard work documentation through version 6 of the PARIS system.

Mr. Martin advised that:

(a) The changes to the system would reduce the complexity of documentation.
(b) Although, at present, there were variations in recording times between practitioners, the changes were expected to halve recording times.
(c) With the changes to the standard documentation there should be a step change in recording times from April 2016 onwards.

15/321 COMPOSITE STAFF ACTION PLAN

Further to minute 15/133 (26/5/15), the Board received and noted a progress report on the Composite Staff Action Plan.

Mr. Levy:

(1) Reminded the Board that the action plan was based on feedback provided by the Investors in People assessment in 2014, the Annual Staff Survey and the staff Friends and Family Test.
(2) Advised that:
  (a) Most of the actions were being achieved in accordance with plan.
  (b) Some delays had been experienced as a result of corporate staff being required to support the transfer of services in York and Selby; however, he was confident that the relevant actions would be completed by year end.
(3) Drew attention to the work being undertaken in the Localities, as highlighted in the report, which provided assurance on the good progress they were making.

In response to a question, Mr. Levy advised that:

(1) Although the action plan had been developed prior to the Trust's expansion into York and Selby, the actions were equally relevant to that Locality.
(2) It was hoped that the actions could be implemented in the Locality as close as practicable to the rest of the Trust; however, the Locality would be in a better position to do this once a couple of key appointments had been made.

15/322 CORE STANDARDS FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

Consideration was given to a report which provided assurance on the Trust's compliance with NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

The report also sought the Board's ratification of the Trust's self-assessment against the standards (as set out in Appendix 1 to the report) based on full compliance with the exception of two standards which would be addressed in the short/medium term.

Arising from the report:

(1) It was noted that the timescales for achieving compliance with standards 42 and 43 was December 2015, and not 2016, as stated in the report.

(2) Mr. Hawthorn asked if he could observe an emergency planning exercise.

Action: Mr. Kilmurray

(3) The Chairman considered that, in future years, it would be appropriate for the Audit Committee to review and provide assurance to the Board on the self-assessment ratings.

Action: Mr. Kilmurray

Agreed – *that the self-assessment ratings (as set out in Appendix 1 to the report) be ratified and submitted to NHS England.*

Action: Mr. Kilmurray

15/323 FINANCE REPORT AS AT 31ST OCTOBER 2015

The Board received and noted the Finance Report as at 31st October 2015.

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

(1) Financial performance was tracking close to plan.

(2) The review of CRES schemes for 2015/16 had been completed; however, the year-end position might be more positive than forecast due to progress on schemes scheduled for the forthcoming year.

(3) The increase in the cash flow during October 2015 was due to the receipt of income under the York and Selby contract and the high level of accruals.

On this matter it was noted that:

(a) The contract was based on a break even position and this had been achieved in October 2015.

(b) Monitor had not requested a revised plan in response to the transaction but had asked for narrative reporting in the quarterly submissions under the Risk Assessment Framework.

(c) There were difficulties in providing visibility on the York and Selby Contract on the graph on cash flow.

(d) There would be greater assurance on the normal cash flow pattern as the year progressed.

(4) Rent was only payable on those parts of Bootham Park Hospital used by the Trust; however, although all contracted income was being received, additional costs were being incurred due to the provision of those services, previously

provided at the Hospital, elsewhere. At present income and expenditure under the Contract were in balance but discussions on this matter were due to be held with the CCG in December 2015.

15/324 PERFORMANCE DASHBOARD AS AT 31ST OCTOBER 2015

The Board received and noted the Performance Dashboard Report as at 31st October 2015.

It was noted that the number of indicators with upward trends had increased on the previous month and there had also been a general improvement in the Trust's position, overall, since the start of the year.

Mrs. Pickering:

(1) Drew attention to the position on KPI 5 ("Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral") which was "red" rated with a downward three month trend.

(2) Advised that:

(a) Performance on the indicator would be reported in the Quarter 3 return to Monitor under the Risk Assessment Framework; however, it would not be used in the assessment of the Governance Risk Rating until 2016/17.

(b) The Tees IAPT service was having a significant impact on present performance; however, as the service had now ceased taking referrals, staff resources could be reallocated from assessment to treatment to address this.

(c) With the Tees service due to cease and in view of performance in the other Localities it was expected that the Trust would achieve target by year end.

In response to a question it was noted that:

(1) The County Durham and Darlington IAPT service was achieving the national target.

(2) The provision of additional staffing resources including the potential relocation of staff from the Tees IAPT service as it was wound down, would improve performance in the North Yorkshire IAPT service.

The focus of discussions was on value of indicators 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").

It was noted that these indicators had been introduced to aid understanding of "out of locality" admissions and also provided proxy measures for assessing the performance of inpatient services.

However, Dr. Land questioned the appropriateness of the indicators as it was now recognised that treatment in the community with short admissions to inpatient services, as and when required, was beneficial for service users with certain conditions.

In view of this, Board Members considered that it was necessary to have a greater understanding of the context of the indicators and the relevance of their targets.

The Board noted that Mrs. Pickering had already asked for an analysis of trends on the indicators by Locality due to the volatility of the data and it was considered that this work should be expanded to include the impact of admission and discharge arrangements on patients and carers and by cluster for a two month period.

The Board asked for the information to be presented to the Quality Assurance Committee, at its meeting to be held on 4th February 2016, with a report being provided to the Board Meeting to be held on 23rd February 2016. It was noted that this timeframe would also allow the data to be reviewed by the Specialty Development Groups.

Action: Mrs. Pickering

15/325 PERFORMANCE DASHBOARD INDICATORS 2016/17

Further to minute 15/C/304 (27/10/15) consideration was given to the proposed Trust Dashboard key performance indicators for 2016/17.

Mrs. Pickering reported that:

(1) The proposed indicators (as set out in Appendix B to the report) were based on the output of discussions at the Board Business Planning event held on 6th and 7th October 2015 (as set out in Appendix A to the report) and the views of the Executive Management Team.

(2) Proposed targets for the indicators would be presented to the Board for approval in due course.

Arising from the report:

(1) The Chairman welcomed the proposed reduction in the number of indicators.

(2) Clarity was sought on the reasons why a number of indicators applied to AMH and MHSOP only and not to all Specialties.

Mrs. Pickering explained that the relevant indicators either related to inpatient services, where AMH services and MHSOP accounted for the majority of activity, or were linked to the introduction of PbR in those Specialties.

(3) Whether the 21 indicators proposed were sufficient.

It was noted that, in addition to the Board Dashboard, Ward and Team Dashboards were in place which contained additional metrics.

(4) In response to questions it was noted that:

(a) The EMT considered that indicators 5 (“Percentage of patients re-admitted to Assessment & Treatment wards within 30 days”) and 6 (“Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards”) were appropriate but it was recognised that the analysis being undertaken in accordance with minute 15/324 above would assist with the development of the targets.

(b) The indicator “cash against plan” provided an early warning of potential financial risks.

(c) The indicator "Caseload turnover" would measure changes in the Trust's entire caseload, both inpatient and community, and provide an indication of potential risks on other indicators e.g. staffing.

Agreed *– that the indicators set out in Appendix B to the report be approved for inclusion in the 2016/17 Trust Dashboard.*

Action: Mrs. Pickering

15/326 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report as at Quarter 2 2015/16 including:

(1) Proposed changes to the Business Plan as set out in Appendix 1 to the report.
(2) The approval of a target of zero for metric 19 ("Excess cost of employing medical agency versus substantive").

The Chairman commended the authors for the quality of the report.

In response to a question on indicator 28 ("Attendance rate at Health and Wellbeing Boards"), which was rated "red", Mr. Barkley advised that, as formal local authority meetings, the Trust had identified representatives and deputies but there were occasions when neither of them could attend.

Agreed -

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

(2) that the target for indicator 19 ("Excess cost of employing medical agency versus substantive") be zero.

Action: Mrs. Pickering

15/327 LOCALITY BRIEFING – NORTH YORKSHIRE

Mrs. Coulthard (Director of Operations) gave a presentation on the key issues facing the North Yorkshire Locality.

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

In addition Mrs. Coulthard highlighted the three main concerns of the Locality as follows:

(1) The long-term viability of services.
(2) The skill base.
(3) Medical recruitment.

Arising from the presentation the Board discussed:

(1) The extent that the further development of the Trust's relationship with York University, following the expansion into York and Selby, would assist address the concerns about recruitment in the Locality.

On this matter:

(a) It was considered that the increased profile of the Trust in York would support recruitment.

(b) Dr. Land advised that medical staff recruitment in York was quite healthy and the expansion of the Trust provided opportunities to explore the introduction of different models e.g. staff working across both the North Yorkshire and York and Selby Localities.

(c) Mrs. Coulthard reported that, in terms of nurse recruitment, the Trust had more to offer than its competitors (e.g. opportunities to be involved in quality improvement) and was recognised as a good employer.

(2) The approach to be taken to securing the long-term viability of services.

Mrs. Coulthard advised that:

(a) Many of the services provided by the Locality (e.g. assessment and care co-ordination) were very good but the low levels of expenditure on mental health services created significant challenges in responding to additional demands.

(b) To overcome this, the Trust was seeking to build alliances and develop partnership arrangements to promote the value of mental health services.

The Chairman thanked Mrs. Coulthard for the presentation and asked her to pass on the Board's appreciation for the work undertaken by her staff.

15/328 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

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

15/329 DATE AND TIME OF NEXT MEETING

It was noted that a special meeting of the Board of Directors would be held, in public, at 9.30 am on Tuesday 15th December 2015 in the Board Room, West Park Hospital, Darlington.

15/330 CONFIDENTIAL MOTION

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

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

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

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."

Following the transaction of the confidential business the meeting concluded at 1.10 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annex 1

North Yorkshire Locality Board Presentation 25 November 2014

Adele Coulthard

Director of Operations

making a difference together

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

- Proud
  - CQC Feedback
  - Awards
  - Service developments
    - Harrogate 136 Suite opened
    - Single Point of Access in CAMHS
    - Capital developments
  - IAPT achievements
  - Staff enthusiasm
  - Clinical Leadership
- Progressing
  - T3 CAMHS
    - Future in Mind developments in Eating Disorders
  - T4 CAMHS
    - Education provision
  - Memory Service model
  - Urgent Care Pathway review in AMH
  - Use of IIC and PbR data
  - Clinical Leadership

To continuously improve the quality and value of our work.

- QIS
  - LD 3P and model redesign
  - CAMHS improvements
  - SWR Memory Service
- Participation in research growing
- Productivity
  - Data helping us to ask the right questions

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

- Recruitment Issues
  - Qualified Nursing Staff
  - Medical staff in certain geographic areas
  - Bespoke recruitment initiatives
- Retention Issues
  - Retirements
- Skill, compassion and motivation issues
  - Locality Head of Nursing in place
  - Low levels of sickness

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

- Local
  - One Local Authority and 5 Borough Councils
  - Three CCGs (two others on the boundary) and one Partnership Commissioning Unit
  - Three Acute Trusts
  - One PACS Vanguard
  - One HWBB
  - Three Transformation Boards
  - Three System Resilience Groups one of which is an Emergency Care Improvement Programme
  - Three CVS Partnerships
  - North Yorkshire Police
  - Yorkshire Ambulance Service
- National
  - No formal links nationally
- International
  - No formal links internationally

To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of our communities.

- Performance
  - Waiting times
  - IAPT prevalence targets
  - Financial Balance – locum and agency costs
  - Out of Area admissions reducing
- LMGB
  - Works well – good sense of team
  - QAGs – improving and engaging local clinicians
  - Challenges of geography

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 15TH DECEMBER 2015 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
Mrs. B. Matthews, 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:
Mr. N. Ayre, York Mind
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications

15/339 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. D. Jennings, Non-Executive Director.

15/340 DECLARATIONS OF INTEREST

Mrs. Pickering declared an interest in the proposed reconfiguration of organic inpatient services in County Durham (minute 15/C/353 refers).

No matters were raised which placed an impediment on Mrs. Pickering's participation in the discussions on the above matter.

15/341 CHAIRMAN'S REPORT

The Chairman reported on her visit to Westerdale South Ward, including the presentation of a "Living the Values" Award, and Westerdale North Ward on 7th December 2015.

The Board noted that the visit had been very positive.

Mr. Levy advised that Westerdale South Ward had achieved the highest score in the last quarter's results of the staff Friends and Family Test.

15/342 GOVERNOR ISSUES

No issues were raised.

15/343 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 5th November 2015 (tabled at the meeting).

The Board noted that Mrs. Matthews' name had been omitted from those present at the meeting.

(2) The key issues discussed by the Committee at its meeting held on 3rd December 2015.

The Non-Executive Directors raised the following matters:

(1) The number of serious incidents at the end of November 2015, which had exceeded the overall figure for 2014/15, with the actual position at 20.61 per month (112 incidents per average monthly caseload of 54,347) against a target of 14.15.

Mrs. Moody advised that this issue had been discussed by the Quality Assurance Committee and further work was being undertaken to further understand the position.

(2) The potential implications of the registration of Holly Unit at West Park Hospital as a children's home with Ofsted including the alignment with CQC registration requirements.

On this matter it was noted that:

(a) The unit required registration with both the CQC and Ofsted.
(b) A gap analysis was being undertaken to seek to understand the relationship between the regulatory regimes including any inconsistencies,
(c) There would be financial implications due to registration fees being required by both regulators.
(d) Support on this matter was being provided by:
- Surrey and Borders NHS Foundation Trust which operated a similar facility.
- The Director of Social Services of Stockton Borough Council on the requirements for registered managers of children's homes.

(3) The review of Bootham Park Hospital commissioned by Margaret Kitching, Chief Nursing Officer of the North of England.

Mrs. Moody advised that:

(a) The review had been initially requested by the CQC and focussed on the processes which had led to the closure of the Hospital on 30th September 2015.
(b) All relevant parties had an opportunity to contribute to the review.

15/344 NURSE STAFFING REPORT

The Board received and noted the report on nurse staffing for November 2015 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:

(1) Apologised for the late circulation of the report; however, this had been unavoidable as the data had only become available on 11th December 2015.

(2) Drew attention to the following key issues included in the report:

(a) There had been a deterioration in forensic services with the number of wards rated "red" across all metrics increasing to 24; the same number as in August 2015.

(b) Cedar Ward in North Yorkshire had the lowest fill rate; however, this was due to the e-roster not reflecting the actual establishment for registered nurses during night-time shifts.

(c) The second lowest fill rate was observed on Kingfisher/Heron/Robin Wards. These wards showed a significant deterioration on previous months.

(d) The wards showing fill rates in excess of their budgeted establishment. Of these:

- Westerdale South Ward continued to have the highest fill rate and the results of a "deep dive" review of the reasons for this, undertaken in accordance with minute 15/317 (24/11/15), were provided in Appendix 8 to the report.

  It was noted that the Ward had encountered a number of difficulties in the last 6 months that had impacted on the staffing numbers; however, during the period the number of incidents had not increased; there have been no serious incidents; the Ward had had a comparatively low rate of falls and fractured neck of femur; and there had only been two complaints, both of which had now been resolved.

- Picktree Ward had the second highest fill rate.

  Mrs. Moody advised that no explanation for this had yet been received from the service, due to the early reporting date; however, further information would be provided in the next report.

  Action: Mrs. Moody

  Mrs. Pickering considered that, from the information gathering exercise to support the consultation on the reconfiguration of organic inpatient services in County Durham and Darlington, the issues on this Ward might be similar to those experienced on Westerdale South Ward.

(e) The information on bank staff useage, as a proportion of actual hours, provided in Appendix 6 to the report.

It was noted that the main reasons for high bank usage were vacancies, long term sickness absence and to provide enhanced observations.

(f) Agency usage which at 0.41% of the total hours worked was relatively low.
(g) The 36 PALS issues highlighted in Appendix 6 to the report of which only one related to care and treatment.
(h) The staffing position in York and Selby which, in accordance with minute 15/317, was provided separately in Appendix 7 to the report.

It was noted that information on agency usage in the Locality had not been available at the time of the preparation of the report and this accounted for the low fill rates shown in the Appendix. This information had now been received and the data would be corrected.

Mr. Barkley asked for an updated version of the report to be published on the Trust's website.

Action: Mrs. Moody/Mr. Bellas

Arising from the report:

(1) The Chairman suggested that, where meetings were held earlier in the month than usual, it might be beneficial to circulate reports separately to Board Members rather than including them on agendas.

Mrs. Moody agreed to consider this approach taking into account the requirement to publish the information on the NHS Choices website.

Action: Mrs. Moody

(2) It was noted that the statement "Unregistered staff on day shifts and registered nurses on night shifts are showing as 'red' …", with regard to the month on month analysis of overall fill rates for October and November 2015 in section 3.2 of the report, was incorrect as both months were "green" albeit with downward trends.

(3) The Non-Executive Directors sought clarity on the reasons for the increase in "red" rated wards between October and November 2015 in the York and Selby Locality.

In response it was noted that:

(a) It was too early to draw conclusions on this matter as, at present, the information was provided manually by the wards rather than being produced through the e-rostering system.
(b) The figures for October 2015 had been provided by Leeds and York Partnership NHS Foundation Trust and agency usage had appeared high.
(c) A number of "red" rated wards had been expected as there had been 18 vacancies for qualified nurses when the services had transferred to the Trust.

15/345 ANNUAL REPORT ON MEDICAL EDUCATION

The Board received and noted the Annual Report on Medical Education.

In introducing the report Dr. Land:

(1) Advised that medical education was a substantial part of the work of the organisation with income of approximately £4m being generated from the 150

junior doctor placements and the 364 placements for medical students provided annually.

(2) Paid tribute to Dr. Jim Boylan (Director of Medical Education) and Mr. Bryan O'Leary (Associate Director of Medical Development) for their tireless work on improving the quality of medical education.

(3) Drew attention to the positive feedback provided by the GMC Trainee Survey with the Trust being ranked:
   (a) 11th nationally.
   (b) The number one Trust in the North East for the last three years.
   (c) In the top ten on five indicators and in the top three for mental health trusts nationally for Foundation Year 2 doctors.

(4) Highlighted the key achievements for the year detailed in the report.

Mr. Barkley also reported that Dr. Kennedy (Post Graduate Tutor at the Hull York Medical School) had praised Mr. O'Leary and his department for the support they provided.

Dr. Land advised that the expansion into York and Selby provided significant opportunities for the Trust to further develop its relationship with York Medical School and enabled greater contact with trainee doctors in the region.

Arising from the report:

(1) The Chairman considered that the Clinical Assessment of Skills and Competencies (CASC) Club Event which provided an excellent approach to learning in a supportive environment.

   It was noted that:
   (a) In developing the event, Dr. Boylan had recognised that some Core Trainees tended to pass academic exams but struggled with the CASC exams.
   (b) The event, which provided opportunities for them to practise their clinical skills and receive detailed feedback on the day from senior Consultants, had been very successful with the pass rate almost doubling to 80%.

(2) The Non-Executive Directors sought clarity on equality and diversity issues in relation to medical education.

   On this matter Dr. Land provided assurance on the Trust's approach to supporting trainees from abroad including a pre-core training programme which had been developed to assist them adapt to life in Britain and the NHS.

15/346 CULTURE METRICS

Further to minute 15/68 (24/3/15) the Board received and noted a report on the Trust's culture metrics as at October 2015.

In introducing the report Mr. Levy drew attention to:

(1) The inclusion of a breakdown of the scores by Locality, with the exception of the York and Selby Locality, for the first time in accordance with minute 15/C/304 (27/10/15).

(2) The increase in the Commitment to Quality Value score from 74.5%, in March 2015, to 81.8%.
(3) The decrease in the Wellbeing Value score from 72.2%, in March 2015, to 69.2%.

The Board noted that the sickness absence rate was at its lowest level but the score on this metric might highlight issues which could be influential in the future.

Mr. Levy also reported that, further to previous discussions, details of the NHS Cultural Barometer had recently been received. He considered that this tool, which was based on a staff survey, should not replace the Trust's culture metrics.

Board Members raised the following matters:

(1) The impact of the expansion of the DATIX system for incident reporting on the culture metric results.

On this matter:

(a) Mrs. Moody reported that, as discussed at the meeting of the Quality Assurance Committee held on 3rd December 2015, the expansion of the system had increased staff awareness resulting in more incidents being reported.
(b) Mr. Levy advised that:
- No changes had been made to the construction of the metrics in response to the expansion of the system.
- Increased reporting of incidents should be viewed positively.

(2) Whether the changes to the culture metric scores were statistically significant.

It was noted that there had been significant changes to the scores for the Commitment to Quality Value and the Wellbeing Value. Changes to the scores for other metrics were not considered to be material.

(3) Whether trends on the culture metrics were being examined.

Mr. Levy responded that the work on this matter had been held in abeyance pending information on the NHS Cultural Barometer but, now that it had been received, a review of how reporting of the culture metrics could be made more useful would now commence.

Action: Mr. Levy

(4) The measurement of violence and aggression under the Wellbeing Value.

Mrs. Moody considered that the Trust had a high level of reporting of aggression where there was low or no harm and considered that the component of the metric should be refined to reflect this.

(5) The relationship between the Overall Staff Experience metric and those for the Respect and Wellbeing Values as there seemed to be a disconnect between the separate elements of the measures.

Mr. Levy provided clarity that the overall staff experience score was based solely on responses to the staff survey and was not derived from the scores for the other metrics.

(6) Whether any qualitative analysis was being undertaken to support understanding of the Wellbeing Value.

Mr. Levy advised that:

(a) An in-depth report on staff well-being was due to be presented to the Quality Assurance Committee at its meeting to be held on 4th February 2016.

Action: Mr. Levy

(b) Whilst the report would focus on stressors to staff, both in terms of processes and behaviours, within the Trust it would also reflect the impact of working for the NHS in general.

(7) Whether reporting against the NHS Cultural Barometer would be mandatory.

It was noted that the Executive Directors were not aware of any requirement for mandatory reporting against the NHS Cultural Barometer and it was considered that many of its aspects were already covered by the Staff Friends and Family Test.

(8) The value of the culture metrics.

The Chairman considered that that the culture metrics were useful when visiting services and in the context of other information provided to the Board.

15/347 DIRECTORS' VISITS

Further to minute 15/C/239 (18/8/15) Mr. Barkley reported that, following discussions by the Executive Management Team, it was proposed to increase the frequency of Director's visits from bi-monthly to monthly; however, in doing so, it was considered that the additional visits should:

(1) Provide Directors of Operations with more opportunities to visit services in their own Localities.
(2) Be limited to Board and EMT members only.

In response to questions:

(1) It was noted that the arrangements for the additional visits would be the same as those already held e.g. during the afternoons of the second Mondays of the relevant months.
(2) Mr. Barkley invited Board Members to email him by 5.00 pm on 21st December 2015 if there were any particular services they wished to visit during the forthcoming year.
(3) It was recognised that the Non-Executive Directors had other time commitments and their attendance at the additional visits should be considered desirable rather than mandatory.

***Agreed** – that the revised arrangements for Directors' visits, as proposed by the Executive Management Team, be approved.*

Action: Mr. Barkley

15/348 INTEGRATED GOVERNANCE FRAMEWORK

Further to minute 15/46 (24/2/15) consideration was given to proposed amendments to the Integrated Governance Framework including revisions to the Risk Management Policy to support the implementation of the risk management module of the DATIX system.

Agreed *– that the revised Integrated Governance Framework be approved.*

Action: Mr. Bellas

15/349 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 26th January 2016 in The Durham Centre, Belmont Industrial Estate, Durham.

15/350 CONFIDENTIAL MOTION

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 11.00 am.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th January 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	See also minute 15/C/267 - 29/9/15
30/09/2014	14/284	A briefing to be provided to a Board Seminar on Equality and Diversity	MB/DL	Dec-15	Completed
24/03/2015	15/68	Provision of a report on the updated culture metrics	DL	Dec-15	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	
29/09/2015	15/252	An analysis of the number of incidents of control and restraint compared to temporary staff usage to be provided in the next six monthly nurse staffing report	EM	Jan-16	See agenda item 7
27/10/2015	15/293	The Board to discuss the closure of the Governance Action Plans	MB	~~26/01/2016~~ Apr-16	
24/11/2015	15/316	Approval of the Research and Development Strategy 2015 - 2020	NL	-	Approved
24/11/2015	15/317	Information to be provided in the next six month nurse staffing report on whether there is a correlation between incidents and staffing levels (e.g. whether the reduction in the number of incidents at the Westwood Centre was due to the increase in staffing or for some other reason)	EM	Jan-16	See agenda item 7

Date	Minute No.	Action	Owner(s)	Timescale	Status
24/11/2015	15/317	Nurse staffing data for York and Selby to be reported separately from that for the other Localities until it can be integrated without impacting on the Board's understanding of staffing levels across the Trust	JI	-	Completed
24/11/2015	15/317	Information on the risks arising from the high fill rate at Westderdale South Ward to be provided in the next Nurse Staffing Report	JI	-	Completed
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	15/320	Information on the Kaizen event on reducing recording times to be provided to the Chairman	AC	Feb-16	
24/11/2015	15/321	Mr. Hawthorn to be invited to observe an emergency planning exercise	BK	-	Completed
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	15/321	Approval of the self-assessment ratings of the Core Standards for Emergency Preparedness, Resilience and Response for submission to NHS England	BK	-	Approved
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	Feb-16	
24/11/2015	15/325	Approval of the 2016/17 Trust Performance Dashboard metrics	SP	-	Approved
24/11/2015	15/326	Approval of changes to the Business Plan as set out in Appendix 1 to the Strategic Direction Performance Report	SP	-	Approved
24/11/2015	15/326	Approval of the target for Strategic Direction Performance Report metric 19 ("Excess cost of employing medical agency versus substantive")	SP	-	Approved
15/12/2015	15/344	Information on the reasons for the fill rate on Picktree Ward being above the budgeted establishment to be provided in the next Nurse Staffing Report	EM	Jan-16	See agenda item 7

Date	Minute No.	Action	Owner(s)	Timescale	Status
15/12/2015	15/344	Revised version of the December Nurse Staffing Report to be published on the Trust's website	EM/PB	Jan-16	
15/12/2015	15/344	Consideration to be given to circulating the nurse staffing reports separately to Board Members, rather than including them on agendas, when Board meetings are held earlier in the month than usual	EM	-	Completed
15/12/2015	15/346	Reporting of the culture metrics, including the provision of information on trends, to be reviewed	DL	Apr-16	
15/12/2015	15/346	An in-depth report on the Staff Wellbeing Value culture metric to be provided to the QuAC	DL	Feb-16	
15/12/2015	15/347	Approval of revised arrangements for Directors' visits	MB	-	Approved
15/12/2015	15/347	Approval of revisions to the Integrated Governance Framework	PB	-	Approved

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Durham and Darlington Locality Board Presentation
26th January 2016

Jo Dawson

Acting Director of Operations

making a difference together

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

- Waiting times for children and young people
- Older people's beds
- Multi agency strategies eg dementia, mental health, CYP
- Recovery College and "pop ups"
- Development of all age crisis and liaison services
- Recovery focused care in Eating Disorders and emerging local and regional approaches

To continuously improve the quality and value of our work.

- Productivity
  - Overall plans
  - “Deep dive” team and emerging lessons
- QIS programmes of work eg
  - Crisis Services Kaizen Plan and acute flow
  - MHSOP wards (activities, interventions)
  - CYP processes and pathways
  - LD specialist health team

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

- Locality Head of Nursing now in post
- Some specific recruitment challenges:
  - Some Consultant posts
  - CYP nurses
- Development of flexible and innovative approaches
- Stress Vulnerability work in teams

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

- Local
  - 2 Local Authorities
  - 3 CCGs and 6 Federations – especially aligned CPN work
  - 1 Acute Trust
  - Voluntary Sector
  - Work with NTW
- National
  - Input into NICE Guidelines and other national work, eg IAPT, profile of research (David Ekers)
- International
  - Europsy, European Trauma Network

To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of our communities.

- Financial Issues
  - Current financial position and specific challenges around flexible staffing, non staff spend (drugs), agency medical staff for key posts, previous undelivered CRES, local commissioners' financial challenges
  - But… investment eg liaison, aligned professionals, Future in Mind
- LMGB
  - Embedding lessons from CQC and other external inspections, internal and external reviews and feedback from users, carers, stakeholders etc
  - QAGs managing broad range of issues

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th January 2016**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

The purpose of the report is to advise the Board of a 6 monthly review (1st June 2015 to 30th November 2015) of issues, trends and quality indicators in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report excludes the recently acquired services within York and Selby.

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

- Forensic Services has seen a noticeable change in the number of HCA's that they are budgeted for (reduction of 27.3 WTE). This is the full year impact of agreed 2015/16 CRES
- Sickness, Vacancies and Maternity leave were cited as the biggest factors impacting on staffing.
- Westerdale South were cited as the highest users of additional duties.
- The 6 month average shows the actual hours worked exceeding the planned hours across all months.
- The month on month trend shows deterioration for the registered nurse fill rates, although this is deterioration the percentages are still within tolerance. HCA fill rates are showing an improvement.
- Cedar (NY) are cited as having the lowest fill rate. This is in relation to the incorrect set up of HealthRoster which has previously been reported.
- High bank usage relates to 6 wards in 3 localities.
- Agency usage is predominantly within North Yorkshire.
- All wards are using overtime to fill shifts however, those in excess of 4% equates to 27 wards. Durham & Darlington localities have been cited as using the most overtime.

- In terms of the triangulation:
  - Cedar Ward had an SUI, level 3 incident and highlighted as a high user of control restraint in addition to high bank and creation of additional duties.
  - Picktree Ward had an SUI, L4 incident and pressure ulcers in addition to high bank and creation of additional duties.
  - Westwood had an SUI, level 3 incident, high control and restraint in addition to creation of additional duties and missed breaks.
  - Cedar (NY) had an SUI, level 3 incident, complaints and high control and restraint in addition to a low fill rate and high agency usage.
  - Rowan ward had an SUI, L4 incident, L3 incident, complaint, falls, pressure ulcers in addition to high agency usage
  - Rowan lea had an SUI, L4 incident, L3 incident, complaint, falls, pressure ulcers in addition to high overtime.
  - Westerdale South had a complaint, falls and medication errors in addition to creating additional duties and agency usage.

Analysis would suggest that there are no direct risks or implications to patient safety from the staffing data. Detailed analysis has been provided in full within the appendices of this report

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**26th January 2016**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of a 6 monthly review (1st June 2015 to 30th November 2015) of issues, trends and quality indicators in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review).

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 65 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

The format of the report includes the 9 safe nursing indicators as outlined in the NICE Guidance for Safe staffing for nursing in adult inpatient wards in acute hospitals. Although the indicators are acute focussed there are some that can be applied to mental health and learning disabilities settings. In the absence of any guidance specific to mental health and learning disabilities this has provided a foundation to build upon.

The report provides a summary following detailed analysis of the emerging themes relating to safe staffing whilst the detail narrative is provided in full at appendix 1.

3. KEY ISSUES:

3.1 A number of developments have arisen during the period of this 6 monthly review which should be taken into consideration regarding the monthly nurse staffing reports.

3.2 Staffing and Establishments

3.2.1 A mental health framework has been devised on establishing staffing levels; the framework is available now as an interactive website and includes

suggested calculation tools and issues for Boards to consider. It has been agreed to pilot these tools within Durham and Darlington localities in Q4 2015.

3.2.2 The budgeted staffing establishments as at 1st June 2015 and the 30th November 2015 have been obtained from HealthRoster and have been used to compare the actual establishments in post. Attached at appendix 1 is the full narrative with the detailed breakdown provided at appendix 2 of this report. The key points are as follows:

- Durham & Darlington – RN budgeted establishment has increased by 0.20 in November when compared to June. Actual RN's in post has decreased by 1.8WTE. The reduction is across a number of wards. In terms of HCA's a reduction of 5.7WTE can be observed, this is largely in relation to Bek, Talbot and Ramsey who have reduced their HCA's by 5.40 WTE as part of the transforming care and bed reductions from 16 beds to 11.
- North Yorkshire – RN budget has increased slightly by 3.5WTE. Actual in post has decreased by 0.10WTE when compared to June. With regards to HCA's an increase of 2.3WTE can be observed. Actual HCA's in post has decreased slightly by 1.10WTE when compared to June. The largest variances can be ovserved in relation to The Newberry Centre and Evergreen. The Newberry Centre have articulated that a new community team has been established and staff from Newberry have applied and have being successful in obtaining those. In terms of recruiting those posts, newly qualified staff have been successful but can't start until they qualify in January and then they will be subject to preceptorship. With regards to the Evergreen Centre the staffing have been increased as a result of increasing the beds from 12 to 16.
- Forensic Services – Increase of 8WTE RN can be observed in terms of budget when compared to June. Actual in post has decreased by 11.70 WTE. HCA budget has reduced 27.3 WTE when compared to June 2015. Actual HCA in post has reduced by 4.80WTE when compared to June 2015. During the reporting period Kingfisher/Heron and Robin have closed a ward reducing the number of beds / staffing which accounts for a bulk of the HCA and RN variances. The remainder of the variance cannot be attributable to a single organisational change to there being small numbers across multiple wards. Recruitment has been an issue that has impacted upon recruitment.
- Teesside – RN budget remains unchanged during the reporting period. Actual RN in post has reduced by 0.80WTE. In terms of HCA the budget remains unchanged during the reporting period. An increase of 0.30WTE can be observed in terms of those HCA's in post. The information shows an additional 3.0WTE in actual staffing on Westerdale South as a result of the increased patient acuity. All the other variances cannot be attributable to one change

4.0 Workforce Variances

4.1 Sickness, vacancies and maternity leave were all cited as the biggest factors impacting on staffing availability. Appendix 3 contains the full breakdown.

4.2 Where a patients observation levels change this requires additional duties to be created which are over and above the budgeted establishments. During the reporting period there were 6925 shifts created which is an increase on the same period last year whereby 6528 shifts were created.

4.3 Westerdale South was highlighted as the biggest user of additional duties in the reporting period.

5.0 Planned versus Actual Hours Worked

5.1 During the reporting period the actual hours worked exceeds the planned when reviewed on a month by month basis.

5.2 The 6 month average shows that there were 31 wards who had fill rates of less than 89.9% for registered nurses on daytime shifts and only 1 ward for un-registered.

5.3 The night time position averaged across the 6 month period showed that there were 4 wards who had fill rates of less than 89.9%for registered nurses and 0 wards for un-registered.

5.4 The month on month trend shows the average fill rate for registered nurses on day (2.4%) and night (3.8%) shifts has deteriorated from June 2015 to November 2015. Although there is a deterioration the fill rates are still within tolerance. All other fill rate indicators are showing an improvement

5.5 Cedar (NY) has been highlighted as having the lowest fill rate, although the incorrect set up of HealthRoster has been cited as the reason for this.

6.0 Bank, Agency and Overtime

6.1 The highest users of bank equated to 6 wards from 3 localities within the reporting period.

6.2 Agency usage is evident from within 4 wards the majority of which are from the North Yorkshire locality.

6.3 All wards are using overtime however those that showing ‘red’ for this indicator i.e. greater than 4% this equates to 27 wards covering all localities. Durham & Darlington are using the most overtime whilst Teesside and Forensic Services are using the least.

7.0 Quality Indicators

7.1 Triangulation of staffing data against SUI’s, level 4 incidents; complaints and control and restraint data has been undertaken and the full data can be found at appendix 5 of this report.

7.2 The analysis would suggest that there are no direct risks or implications to patient safety from the staffing data.

7.3 Incidents where staffing had been used to categorise an incident on datix has been examined within this report. During the reporting period, 53 incidents were raised of which most were raised in North Yorkshire. The majority of incidents cited inadequate staffing levels.

8.0 SAFE NURSING INDICATORS

8.1 In addition to the quality metrics, 9 safe nursing indicators have been examined and triangulated against the staffing fill rate, bank, agency, overtime and mandatory training. Full details can be found in appendix 6 of this report.

8.2 One of the safe nursing indicators relates to missed breaks, a thorough analysis of the HealthRoster system has identified that there was 7,414 shifts within the reporting period where unpaid breaks had not been taken.

8.3 The reasons why breaks are not taken is not currently captured within the electronic rosters. In some cases staff are being compensated with time owing or paid overtime for breaks not been taken.

8.4 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.

It is recommended that the monthly safe staffing report should be expanded to take account of missed breaks. A task and finish and finish group led by HR has recently been established which will provide focus on staff breaks and adherance to EU Working time directives.

9. IMPLICATIONS:

9.1 Compliance with the CQC Fundamental Standards:

No direct risks or implications to patient safety or CQC compliance from the staffing data have been identified in this 6 monthly report.

9.2 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. An emerging issue is one of qualified night cover.

This work is being progressed and will be a feature of next financial years Safe Staffing project referred to above. Key areas for consideration will be:

- Effective rostering
- Bank, agency and overtime usage
- Patient contact hours

- Staffing escalation procedures
- Flexible staffing requirements

9.3 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.

9.4 Equality and Diversity:

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

9.5 Other implications:

There are no other implications identified

10.0 RISKS:

The current lack of an evidence based tool for workforce planning and monitoring in mental health and learning disability settings 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 in Autumn 2016.

In June 2015 NICE was asked to suspend further work on the safe staffing programme as work was to be taken forward by NHS Improvement in conjunction with NHSEngland. A previously unpublished draft of a NICE evidence review of nurse staffing in in-patient mental health settings has recently been released following a freedom of information review. This concluded that there is no evidence to specifically describe how minimum staffing levels or ratios may support safer staffing in mental health inpatient settings and very little evidence on environmental and organisational factors, approaches or toolkits for identifying safe staffing requirements. This presents a risk that we are unable to consistently review safe staffing levels within an agreed framework leading to an inconsistent professional judgement approach.

11.0 CONCLUSIONS:

11.1 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.

11.2 A review of safe staffing will be undertaken during the financial year 2016/17 in line with awaited national guidance which will refine the usage of the data further.

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

12.0 RECOMMENDATIONS:

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

- It is proposed that the review framework and tools are piloted within Durham and Darlington and a report will be presented outlining the key findings.

- The monthly report should be expanded to include incidents whereby staffing has been used to categorise the incident and any areas where breaks are not being taken.

Emma Haimes, Head of Quality Data
Elizabeth Moody, Director of Nursing and Governance
January 2016

Appendix 1

Safe Staffing Report

1.0 Staffing and Establishments

1.1 It had been anticipated that there would be NICE guidance relating to safe staffing in Mental Health services later this year. This work has now been transferred to NHS Improvement in conjunction with NHS England and the work on establishing what should be the right balance of staff is being led by the Mental Health Taskforce. A letter from the Chief Nursing Officer (11th June 2015) set out the rationale for the change which included factors such as the need to take into account all staff involved in mental health care, not just nurses, the importance of time spent with patients and their families, and the local variation in services which makes it difficult to apply a one size fits all approach.

1.2 As part of the Compassion in Practice (the 6C's of nursing) a mental health safe staffing framework has been devised. This is expected to feed into the Taskforce work on establishing staffing levels. The framework is available now as an interactive website, and includes suggested staffing calculation tools and some issues for Boards to consider. The website is available at this address http://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf

1.3 Interestingly this guidance summarises some of the key differences between mental health and other NHS services when considering staffing levels, including that a higher proportion of actual interventions are required, and these are more likely to be reactive and unplanned.

1.4 The framework reports on the recent testing of staffing level calculation tools, in particular the Hurst Ward Multiplier tool. The first level of usage of this tool, to assist with local determination of staffing levels, is freely available via the website, with two higher levels of participation linked to national benchmarking also available at an additional cost. The tool takes clinical dependency levels of service users into account along with variables such as headroom, and generates a suggested establishment and skill mix. It is reported as sufficient to meet NQB safe staffing requirements at this level. The framework also points out that in addition to the use of these tools, Boards and managers need to exercise judgement, and there are ten indicators which it is suggested Boards take into account to assure themselves of the robustness of their staffing establishment calculations.

1.5 The framework also includes a suggested six step process for conducting a workforce review.

1.6 The Nursing and Governance Directorate has identified Durham and Darlington localities to be used as a pilot use the evidence based tools for determining balanced staffing levels. A report in terms of the findings will be produced and shared.

1.7 The budgeted staffing establishments as at 1st June 2015 and the 30th November 2015 have been obtained from HealthRoster and have been used to compare the actual establishment in post, the findings are as follows:

- ***Durham & Darlington:***
  - The budgeted establishment within Durham & Darlington for registered nurses in June 2015 was 136.10 WTE compared to 136.30 in November 2015; this is an increase of 0.20. Actual registered nurses in post in June 2015 were 137.60 compared to 135.80 which is a decrease of 1.8 WTE's.

  - The budgeted establishment for unregistered staff in June and November 2015 was 202.80. Actual unregistered nurses in post as at 1st June 2015 was 202.40 compared to 196.70 in November 2015 which is a reduction of 5.7 WTE's.

- ***North Yorkshire***
  - The budgeted establishment within North Yorkshire for registered nurses in June 2015 was 119.90 WTE compared to 123.40 in November 2015; this is an increase of 3.5. Actual registered nurses in post in June 2015 were 115.20 compared to 115.10 in November which is a decrease of 0.10 WTE's.

  - The budgeted establishment for unregistered staff in June 2015 was 153.40 and 155.70 in November 2015. Actual unregistered nurses in post as at 1st June 2015 was 156.10 compared to 157.20 in November 2015 which is a increase of 1.10 WTE's.

- ***Forensic Services***
  - The budgeted establishment within Forensic Services for registered nurses in June 2015 was 186.00 WTE compared to 194.00 in November 2015; this is an increase of 8.0. Actual registered nurses in post in June 2015 were 182.30 compared to 170.60 in November which is a decrease of 11.70 WTE's.

  - The budgeted establishment for unregistered staff in June 2015 was 373.40 and 346.10 in November 2015. Actual unregistered nurses in post as at 1st June 2015 was 332.00 compared to 327.20 in November 2015 which is a reduction of 4.80 WTE's.

- ***Teesside***
  - The budgeted establishment within Teesside for registered nurses in June and November 2015 was 126.80 WTE. Actual registered nurses in post in June 2015 were 128.10 compared to 127.30 in November which is a decrease of 0.80 WTE's.

  - The budgeted establishment for unregistered staff in June and November 2015 was 214.60. Actual unregistered nurses in post as at 1st June 2015 was 201.30 compared to 201.60 in November 2015 which is a slight increase of 0.30 WTE's.

1.8 Attached at appendix 2 is the full breakdown of budgeted and actual establishments by locality and ward.

2.0 Workforce Variances

2.1 It is important to consider the workforce variances when looking at establishments. Within the reporting period there were:

- 15 wards who had maternity absence greater than 5% loss of the actual hours
- 27 wards who had sickness absence rates greater than 5 % loss of actual hours
- 16 wards who had vacancies greater than 10% loss of actual hours
- 6 wards who had bank usage greater than 39.9% of actual hours worked
- 3 wards who had agency usage greater than 4% of actual hours worked

2.2 This illustrates some of the factors cited as impacting on staffing availability with sickness, vacancies and maternity highlighted as having the biggest impact. The full ward breakdown is outlined in full in appendix 3 of this report.

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

Month	Number of duties	Number of hours
June	1,113	12,010
July	1,345	14,039
August	965	9,768
September	852	8,957
October	1,318	13,708
November	1,332	13,508
Total	**6,925**	**71,990**

- This table highlights a fluctuating picture per month of the number of additional duties being created.
- 6925 additional duties were created within the reporting period this is an increase on the same period last year whereby 6528 duties were created.

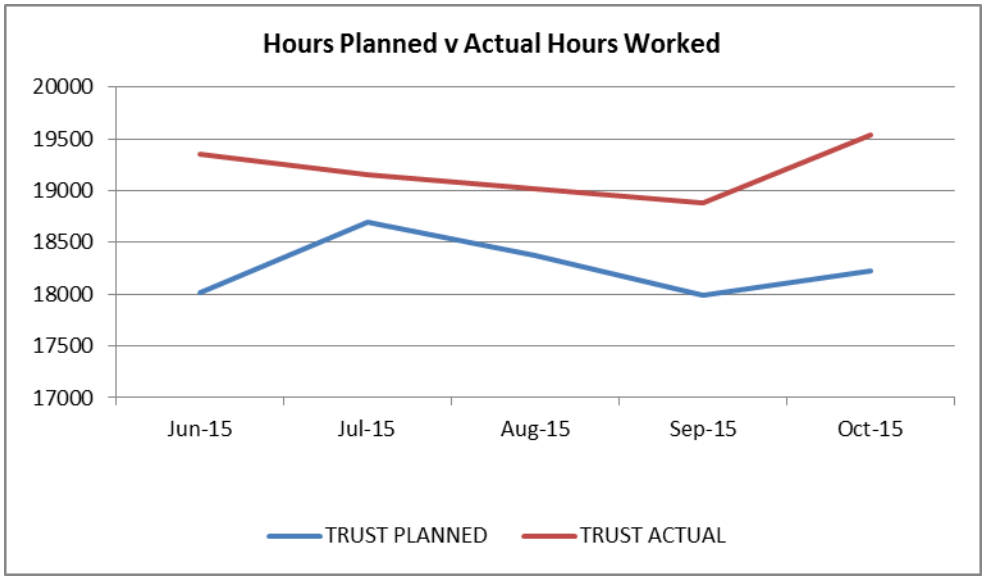
2.4 The highest creators of additional duties with a reason of 'enhanced observations' were in the following areas:

Ward / Team	Number of Duties	Number of Hours
Westerdale South	979	8540.50
Cedar Ward	558	6571.25
Birch Ward	478	5664.50
Merlin	436	4821.75
Bankfields Court	337	3946.00
Picktree Ward.	374	3696.50
Bedale Ward	292	3379.25
Westwood Centre	302	3237.75

Further analysis of the usage of 'enhanced observations' in relation to budgeted establishments is required to fully understand the level of clinical need and practices at ward level and to seek an effective solution to bank usage.

3.0 Planned versus Actual Hours Worked

3.1 Moving on to look at the Actual Hours worked versus the planned staffing. The table below shows a line graph to articulate the Trust position across the reporting period:



3.2. It is important to highlight that at no point during the 6 month review did the actual hours meet the planned.

3.3. Appendix 4 of the report shows the average fill rate (1st June 2015 to 30th November 2015) for both days and nights for both registered and non-registered staff.

3.4 The 6 monthly position shows that there were 31 wards who had fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts. Health care assistants on daytime shifts there was only 1 ward who had a fill rate below 89.9%.

3.5 In terms of the night time shifts the 6 monthly position shows that there were 4 wards who had fill rates of less than 89.9% (shown as red) for registered nurses and health care assistants there were 0 wards who had a fill rate below 89.9%.

3.6 The month on month trend covering the reporting period is outlined 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
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	90.30	↑	113.60	↑	98.20	↑	112.60	↑
Oct-15	89.80	↓	119.00	↑	99.01	↑	113.80	↑
Nov-15	90.72	↑	118.47	↓	96.82	↓	114.52	↑

From the table it is important to highlight the following:

- The average fill rate for registered nurses on day shifts has deteriorated from 93.12% in June 2015 when compared to 90.72% in November 2015 (2.4% decrease). Although this calculation shows a deterioration this is still within acceptable tolerance.

- The average fill rate for health care assistants on day shifts has improved from 109.50% in June 2015 to 118.47% in November 2015 (8.97% improvement).

- The average fill rate for registered nurses on night shifts has deteriorated from 100.62% in June 2015 when compared to 96.82% in November 2015 (3.8% decrease). Although this calculation shows a deterioration this is still within acceptable tolerance.

- The average fill rate for health care assistants on night shifts has improved from 112.27% in June 2015 when compared to 114.52 in November 2015 (2.25% improvement).

3.7 The overall total red rated occurrences utilising the average fill rate (i.e. less than 89.9%) was 36 occurrences. The table below shows the breakdown by locality:

Locality	Total Number of Red Occurrences
Durham & Darlington	4
Teesside	7
North Yorkshire	7
Forensic Services	18

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

3.8 The 6 month average highlights Cedar (NY) as having the lowest fill rate of 55.5% for registered nurses on nights. Cedar (NY) has been consistently reported within the monthly reports as either having the lowest or second lowest fill rate. The reason given is due to the incorrect set up of the electronic roster in that this is set up for 2 registered nurses to work when they are only utilising 1. This example alone cannot be used as an outlier within this 6 monthly report due to the reasons given.

3.9 The second lowest fill rate utilising the 6 month average highlights Overdale Ward with a fill rate of 67.1% for registered nurses on day shifts. This is due to there being 1 registered nurse vacancy; cover is being provided utilising neighbouring wards or HCAs as a last resort.

3.10 The following wards are also showing red utilising the 6 month average as follows:

Ward	Red Fill Rate	Comments
Bransdale Ward	67% for RN on days	Historically Bransdale have reported that this is due to 1 vacancy and having 1 RN on an alternative to suspension
Newberry Centre	70.1% for RN on days	Newberry have historically advised that this is due to a reduction in bed occupancy; sickness and vacancies
Bilsdale Ward	70.3% for RN on days	Historically Bilsdale have reported that this is due to sickness and maternity leave. They have also advised flexing their staff to cover any shortfall.
Oak Ward	71.3% for RN on days	Historically sickness and annual leave have been reported for any shortfall
Jay Ward	72.2% for RN on days	Historically Jay has reported the flexing of HCAs to cover any shortfall.
Bedale Ward	74.7% for RN on days	Bedale have historically advised that they have 1 vacancy, 1 on long term sick as well as short term sickness.
Ward 15	75.9% for RN on days	Historically Ward 15 has reported flexing of their HCA's to cover any shortfall.
Ward 14	76.0% for RN on days	Ward 14 has historically advised that this is due to a vacancy and sickness.
Harrier / Hawk	76.8% for RN on days	Historically Harrier/Hawk has advised that they have 1 qualified on long term graduated return from sickness and not able to work on the ward. 1 qualified moved to another ward due to being pregnant. Second nurse at times is moved to cover other wards if/when we have one
Thistle Ward	76.8% for RN on days	Thistle have advised that they frequently lend the second qualified to neighbouring wards
Springwood	77.4% for RN on days	Historically Springwood has described a number of vacancies and long term sickness as contributory factors for any shortfall in fill rates.
Rowan Ward	79.9% for HCA on days	Rowan Ward has described historically of vacancies and sickness contributing to any shortfall in fill rates.
Brambling Ward	78% for RN on days	Historically Brambling have advised that they frequently flex the HCAs to cover any shortfall.
Swift Ward	78.3% for RN on days	Swift have also advised previously that they flex the HCAs to cover any shortfall.

4.0 Bank, Agency and Overtime

4.1 Appendix 3 highlights the use of bank staffing as a proportion of actual hours worked averaged over the 6 month period. These are 'RAG' rated independently of the overall fill rate. Those wards using greater than 39.9%% bank staffing to deliver their fill rates are identified below:

Locality	Ward	Bank Usage %
Durham & Darlington	Cedar Ward	54.00%
Forensics	Merlin Ward	53.37%
Durham & Darlington	Picktree	46.21%
Forensics	Brambling Ward	46.35%
Teesside	Bedale Ward	43.67%
Durham & Darlington	Birch Ward	42.36%

- This equates to 6 wards in 3 separate localities.

4.2 There are 24 wards who reported as Amber and 35 wards reported as Green.

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

4.4 In terms of Agency Appendix 3 highlights that agency staff has been used within 4 wards. The numbers of which are relatively low as shown below:

Locality	Ward	Agency Usage %
North Yorkshire	Cedar (NY)	8.75%
North Yorkshire	Rowan Ward	7.45%
North Yorkshire	Springwood	13.2%
Teesside	Westerdale South	1.06%

- This equates to 4 wards, the majority of which are from within the North Yorkshire locality.

4.5 It is important that overtime is also considered when reviewing safe staffing indicators. Appendix 3 highlights the hours classified as 'overtime' as a percentage of total hours worked and are 'RAG' rated independently of the overall fill rate. The wards using in excess of 4% overtime are highlighted as follows:

Locality	Ward	Overtime Usage %
North Yorkshire	Abdale House	14.1%
Teesside	Baysdale	10.7%
Durham & Darlington	Bek, Talbot and Ramsey	8.4%
North Yorkshire	Rowan Lea	8.0%
Durham & Darlington	Birch Ward	8.0%
Durham & Darlington	Primrose Lodge	7.7%
Durham & Darlington	Tunstall Ward	7.5%
Teesside	Bankfields Court Unit 2	7.5%
Durham & Darlington	Elm Ward	7.1%
Forensic Services	Thistle Ward	6.8%

Durham & Darlington	Maple	6.7%
Teesside	Bedale Ward	6.5%
North Yorkshire	Ward 14	5.9%
Durham & Darlington	Hamsterley	5.7%
North Yorkshire	Westwood Centre	5.4%
Durham & Darlington	Cedar	5.2%
North Yorkshire	Springwood	5.2%
Durham & Darlington	Holly	5.0%
Teesside	Aysgarth	4.7%
Forensic Services	Northdale Centre	4.6%
Durham & Darlington	Farnham Ward	4.6%
Durham & Darlington	Roseberry Wards	4.6%
Forensic Services	Clover / Ivy	4.3%
Durham & Darlington	Picktree	4.3%
North Yorkshire	Rowan Ward	4.3%
North Yorkshire	Cedar (NY)	4.1%
Forensic Services	Oakwood	4.0%

- 27 wards were rated as Red for overtime worked and cover all localities within the Trust.
- Durham and Darlington are using overtime the most whilst Teesside and Forensic Services are using overtime the least
- There are 14 wards who were rated as Amber and 24 wards who were rated as Green for overtime worked

5.0 Quality Indicators

5.1 In turning to the triangulation of staffing data with other safety indicators at appendix 5 an overview can be found of all quality indicators. Firstly there were 17 SUI's that occurred in in-patient areas within the 6 month period. These are summarised below utilising the bank fill rate and staffing fill rates as comparative data:

No. of SUI's	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	HCA Days	RN Nights	HCA Nights
1	Cedar Ward	54.0%	113.6%	100.0%	191.5%	158.0%
1	Picktree Ward	46.2%	98.8%	100.6%	165.9%	127.5%
1	Mallard Ward	34.1%	89.6%	102.2%	122.6%	139.9%
1	Westwood Centre	26.8%	103.9%	101.8%	124.3%	190.4%
1	Springwood	18.4%	77.4%	106.1%	141.5%	133.8%
1	Harrier / Hawk	18.4%	76.8%	101.0%	97.5%	98.8%
1	Ward 15	17.0%	75.9%	99.6%	120.9%	104.6%
1	Danby Ward	16.6%	96.9%	111.1%	104.3%	93.7%
2	Cedar (NY)	16.2%	92.6%	55.5%	144.2%	157.6%
2	Rowan Ward	14.3%	106.9%	122.3%	79.7%	101.8%
1	Rowan Lea	7.6%	82.8%	109.8%	106.3%	101.4%
1	Hamsterley Ward	7.1%	87.3%	102.1%	144.5%	105.8%
1	Farnham Ward	6.9%	108.0%	103.3%	113.3%	102.8%
1	Oak Ward	4.1%	71.3%	98.9%	101.4%	103.2%
1	Westerdale North	3.2%	100.1%	101.7%	125.1%	103.6%

- Within the reporting period Cedar and Picktree Wards have both had an SUI and a red bank fill rate. When compared to the staffing fill rates both wards are showing green for days and blue for nights.
- Mallard Ward had an SUI and are showing as 'Amber' for their bank usage. They also had a 'red' fill rate for RN days and staffing in excess of their budgeted establishment for both staff groups for night shifts.
- Westwood Centre had an SUI and a 'Amber' rating for their bank usage. They also had staffing in excess of their budgeted establishment for nights across both staff groups. All days shifts are reporting as 'Green'.
- Danby Ward, Cedar (NY) and Roward Ward although they have a green rating for bank usage they have a 'green' fill rate for RN days. Cedar (NY) has a red fill rate for HCA days whilst Rowan Ward is blue for HCA days. Fill rates in excess of the budgeted establishment for night duties on Westwood Centre and Cedar (NY). Rowan Ward has a red fill rate for RN nights.
- Rowan Lea, Hamsterley and Oak Ward although they have had SUI's occurring and showing 'green' for bank usage they also show red for RN days. Hamsterley and Westerdale North have blue fill rates in relation to RN nights.

The Patient Safety investigation team have been asked to specifically consider staffing levels and skill mix in relation to their investigation of inpatient SI's to support more robust triangulation of staffing data and aid root cause analysis.

5.2 There were a total of 14 Level 4 incidents that occurred within the reporting period. These are summarised below utilising the bank fill rate and staffing fill rates as comparative data:

No. L4 Incidents	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	HCA Days	RN Nights	HCA Nights
1	Picktree Ward	46.2%	**98.8%**	**100.6%**	**165.9%**	**127.5%**
1	Maple Ward	39.2%	**100.3%**	**102.2%**	**119.2%**	**132.0%**
4	Mallard	34.1%	**89.6%**	**102.2%**	**122.6%**	**139.9%**
1	Sandpiper	30.8%	**91.2%**	**87.6%**	**104.3%**	**120.5%**
1	Kirkdale Ward	17.6%	**90.9%**	**101.5%**	**103.0%**	**112.4%**
1	Rowan Ward	14.3%	106.9%	122.3%	79.7%	101.8%
1	Esk Ward	13.8%	**91.4%**	**100.8%**	**112.7%**	**99.3%**
3	Rowan Lea	7.6%	82.8%	109.8%	106.3%	101.4%
1	Westerdale North	3.2%	100.1%	101.7%	125.1%	103.6%

- Picktree Ward had a level 4 incident within the reporting period also had a red bank fill rate but showed green for all day shifts and blue for all night shifts.
- Mallard, Sandpiper and Rowan wards had an amber bank fill rates, they also had a red fill rate within one of the metrics and staffing in excess of their budgeted establishments.
- Maple Ward although they had level 4 incidents within the reporting period and an amber bank fill rate they all showed green in relation to their staffing fill rates.
- Kirkdale Ward although they had a level 4 incident that occurred, they showed as green for all indicators including bank.
- Rowan Ward had a level 4 incident that occurred also had staffing in excess of their budgeted establishment for HCA Days and a red fill rate for RN nights.
- Rowan Lea had 3 level 4 incidents within the reporting period they showed green for their bank usage but did show red for RN Days. All other metrics were reported as green.

- Westerdale North although they had 1 level 4 incident they showed green for all indicators with the exception of RN nights.

5.3 There were 60 level 3 self-harm incidents occurred within the reporting period. These are summarised below utilising the bank and staffing fil rates as comparative data:

No. L3 (self-harm) Incidents	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	HCA Days	RN Nights	HCA Nights
2	Cedar Ward	54.0%	113.6%	100.0%	191.5%	158.0%
4	Brambling	46.4%	78.0%	104.3%	125.7%	118.1%
2	Maple Ward	39.2%	100.3%	102.2%	119.2%	132.0%
4	Bransdale	37.0%	67.0%	93.8%	140.6%	110.0%
5	Swift Ward	36.3%	78.3%	101.1%	120.1%	123.9%
1	Jay Ward	32.6%	72.2%	104.9%	109.1%	108.1%
2	Clover / Ivy	30.9%	95.9%	100.0%	111.7%	114.2%
2	Sandpiper Ward	30.8%	91.2%	87.6%	104.3%	120.5%
5	Westwood Centre	26.8%	103.9%	101.8%	124.3%	190.4%
3	Overdale	25.3%	67.1%	97.6%	151.7%	111.4%
1	Bilsdale	20.5%	70.3%	94.1%	137.8%	101.8%
4	Stockdale	20.0%	87.7%	102.4%	120.4%	101.5%
1	Newberry Centre	18.1%	70.1%	91.5%	117.2%	92.7%
2	Kirkdale	17.6%	90.9%	101.5%	103.0%	112.4%
2	Ward 15	17.0%	75.9%	99.6%	120.9%	104.6%
5	Cedar (NY)	16.2%	92.6%	55.5%	144.2%	157.6%
2	Bankfields Court	15.3%	81.9%	95.4%	114.7%	101.1%
4	Lincoln Ward	14.8%	97.5%	99.1%	101.2%	112.2%
1	Rowan Ward	14.3%	106.9%	122.3%	79.7%	101.8%
2	Esk Ward	13.8%	91.4%	100.8%	112.7%	99.3%
2	Tunstall Ward	8.7%	96.4%	97.8%	116.4%	109.5%
1	Rowan Lea	7.6%	82.8%	109.8%	106.3%	101.4%
2	Primrose Lodge	5.5%	87.4%	107.7%	107.1%	103.9%

- Cedar ward had 2 self-harm incidents that occurred within the reporting period and a red bank fill rate. Cedar Ward showed green for their staffing for day shifts and had staffing in excess of their budgeted establishment for night shifts across both staff groups.
- Brambling had 4 self-harm incidents and also had a red bank fill rate and showed red for RN days and blue for RN nights.
- Clover / Ivy although they had a self-harm incident and showed ‘Amber’ for their bank usage all staffing indicators were green.
- Bransdale, Swift, Sandpiper, Westwood, Overdale, Bilsdale and Stockdale all of whom had self-harm incidents also showed as amber for their bank usage. In addition they had two metrics within the staffing fill rates that showed either as red or blue or a combination of both.
- Maple and Jay who had self-harm incidents and showed as amber for their bank usage they only had one staffing indicator that showed either as red or blue
- Cedar (NY), Rowan and Ward 15 all were green for their bank usage had staffing indicators of 2 or more that were either red or blue or a comination of both.
- Bankfields Court, Rowan Lea and Primrose Lodge all showed as greed for their bank usage they did have one metric (RN Days) whereby they showed as red.

- Kirkdale, Lincoln, Esk and Tunstall although they had self-harm incidents occurring within the reporting period they showed green across all staffing bank metrics.

5.4 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 95 incidents raised citing issues with staffing of which 53 were in relation to in-patient services and 42 were in relation to community based teams which would be considered out with this report.

5.5 The incidents citing staffing problems were from the following localities:

Locality	No. of Incidents
North Yorkshire	50
Durham & Darlington	14
Teesside	17
Forensics	14

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

- The majority were raised highlighting that there were inadequate staffing within the ward for a particular shift
- There were 8 occasions whereby the incidents were raised because staff were unable to take their breaks.
- Due to staffing, wards would be unable to provide a response should this be required during the course of the shift.
- 3 incidents were completed highlighting that there was no qualified present during the shift. This related to Forensic Services during the month of June whereby during 3 night shifts there was no second qualified available on the shifts in question.
- Occasions whereby there would be insufficient staffing to undertake physical restraint should this be required during the course of the shift.
- Other reasons were highlighted and include:
  - No second qualified being on duty
  - Unable to carry out regular reviews for those patients on seclusion or supervise patients
  - Inadequate competency / skills to undertake tasks on ward
  - Issues with medication, obtaining a doctor and prescribing

5.7 It is recommended that further monitoring of this occurs within the monthly safe staffing reports. Further discussion is required 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.

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

No. of Complaints	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	HCA Days	RN Nights	HCA Nights
2	Westerdale South	74.0%	99.6%	100.3%	270.3%	215.8%
1	Merlin	53.4%	102.7%	83.9%	137.9%	165.9%
1	Brambling	46.4%	78.0%	104.3%	125.7%	118.1%
1	Bedale Ward	43.7%	74.7%	103.7%	176.0%	122.4%

1	Birch Ward	42.4%	113.8%	100.0%	125.4%	169.7%
2	Maple	39.2%	100.3%	102.2%	119.2%	132.0%
2	Bransdale	37.0%	67.0%	93.8%	140.6%	110.0%
1	Jay Ward	32.6%	72.2%	104.9%	109.1%	108.1%
1	Northdale	29.1%	84.1%	104.0%	90.4%	91.4%
1	Kestel / Kite	24.7%	82.0%	95.0%	92.7%	98.8%
1	Lustrum Vale	24.5%	92.7%	105.7%	115.1%	100.8%
2	Kingfisher/Heron/Robin	24.2%	81.2%	87.6%	90.2%	99.7%
1	Stockdale	20.0%	87.7%	102.4%	120.4%	101.5%
1	Harrier / Hawk	18.4%	76.8%	101.0%	97.5%	98.8%
1	Newberry Centre	18.1%	70.1%	91.5%	117.2%	92.7%
1	Ward 15	17.0%	75.9%	99.6%	120.9%	104.6%
1	Cedar (NY)	16.2%	92.6%	55.5%	144.2%	157.6%
1	Bankfields Court	15.3%	81.9%	95.4%	114.7%	101.1%
1	Rowan Ward	14.3%	106.9%	122.3%	79.7%	101.8%
2	Esk Ward	13.8%	91.4%	100.8%	112.7%	99.3%
1	Roseberry Ward	9.0%	92.9%	100.5%	96.1%	100.3%
1	Tunstall	8.7%	96.4%	97.8%	116.4%	109.5%
2	Rowan Lea	7.6%	82.8%	109.8%	106.3%	101.4%
2	Farnham Ward	6.9%	108.0%	103.3%	113.3%	102.8%

- Westerdale South had 2 complaints raised within the reporting period and have a red fill rate for bank usage. In addition they have staffing above their budgeted staffing establishment for night shifts across both staff groups.
- Merlin, Brambling and Bedale Ward all of which had complaints raised and are all showing red for their bank usage. In addition they have at one staffing indicator identified as red and blue indicators for night shifts worked.
- Birch ward have a red indicator for bank usage and are showing as blue for nights worked.
- Bransdale and Stockdale had complaints raised in the period and a amber rating for bank usage. They also have a red indicator for RN days and a blue indicator for RN nights.
- Jay, Northdale and Kestrel / Kite all have an amber rating for bank usage and red ratings for RN days. All other indicators are showing 'green'.
- Lustrum Vale although they had a complaint and a amber rating for bank, all other indicators are showing as 'green.
- Harrier / Hawk, Newberry Centre, Ward 15, Cedar (NY), Bankfields Court, Rowan Ward and Rowan Lea all have a green indicator for bank usage and a red or blue or a combination of both for a staffing fill rate indicator.
- Esk, Roseberry, Tunstall and Farnham although they had complaints raised they are all showing as 'green' for their bank usage and staffing fill rate indicators.

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

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

Ward	Locality	Incidents of Restraint				Bank Usage
		Incidents	PRO used	Other	Restraint Total	
Westwood Centre	North Yorkshire	428	57	864	921	26.8%

Newberry Centre	North Yorkshire	127	8	202	210	18.1%
Bankfields Court	Teesside	121	3	187	190	15.3%
The Evergreen Centre	North Yorkshire	106	6	182	188	17.0%
Swift Ward	Forensic Services	110	3	177	180	36.3%
Brambling	Forensic Services	91	4	140	144	46.4%
Cedar	Durham & Darlington	61	13	126	139	54.0%
Sandpiper Ward	Forensic Services	54	13	120	133	30.8%
Cedar (NY)	North Yorkshire	69	10	122	132	16.2%
Bek, Talbot & Ramsey	Durham & Darlington	81	11	103	114	10.1%

- Westwood had 428 incidents of restraints during the reporting period with 57 episodes of Prone restraint used and 864 were classified as other types of restraints. In addition they also have an amber bank fill rate.
- All other wards although they did have incidents that resulted in the use of restraint their totals were way below that of the Westwood Centre.
- Brambling, Cedar and Sandpiper Ward although they had fewer incidents which resulted in the use of restraint they did have a 'red' bank fill rate.

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

	Day		Night	
Ward	Fill rate between planned and actual (Registered)	Fill rate between planned and actual (HCA)	Fill rate between planned and actual (Registered)	Fill rate between planned and actual (HCA)
Westwood Centre	**103.9%**	**101.8%**	**124.3%**	**190.4%**
Newberry Centre	**70.1%**	**91.5%**	**117.2%**	**92.7%**
Bankfields Court	**81.9%**	**95.4%**	**114.7%**	**101.1%**
The Evergreen Centre	**96.6%**	**102.3%**	**112.0%**	**108.4%**
Swift Ward	**78.3%**	**101.1%**	**120.1%**	**123.9%**
Brambling	**78.0%**	**104.3%**	**125.7%**	**118.1%**
Cedar	**113.6%**	**100.0%**	**191.5%**	**158.0%**
Sandpiper Ward	**91.2%**	**87.6%**	**104.3%**	**120.5%**
Cedar (NY)	**92.6%**	**55.5%**	**144.2%**	**157.6%**
Bek, Talbot & Ramsey	**104.8%**	**103.9%**	**101.9%**	**103.4%**

5.12 With regards to the use of Prone restraint this will continue to be monitored within the Force reduction project and monthly within the Safe Staffing reports, however, it is worth highlighting that during the reporting period there were 164 episodes of Prone used.

6.0 9 Safe Nursing Indicators

6.1 As previously highlighted, there is currently no evidence based guidelines for mental health settings to support safe staffing levels however NICE Guidance for safe staffing for nursing in adult inpatient wards in acute hospitals has been published. The guideline identifies organisational and managerial factors that are required to support safe staffing for nurses, and indicators that should be used to provide information on whether safe nursing care is being provided. The 9 indicators include:

- Adequacy of meeting patients' nursing care needs
- Falls
- Pressure ulcers
- Medication administration errors
- Missed breaks
- Nursing overtime

- Planned, required and available nurses for each shift
- High levels and / or ongoing reliance on temporary nursing
- Compliance with any mandatory training

6.2 Appendix 6 contains the safe nursing indicators into a single dashboard. This section won't discuss all of these metrics but the ones that haven't been discussed to date within this report.

6.3 Falls that have resulted in significant harm for all inpatient services have been examined. Within the reporting period there have been a total of 505 incidents across 52 wards.

6.4 The top 6 wards that have resulted in significant harm are as follows:

Speciality	Ward / Team	Number of incidents
MHSOP	Springwood	61
MHSOP	Westerdale South	59
MHSOP	Rowan Ward	44
MHSOP	Roseberry Ward	40
MHSOP	Westerdale North	40
MHSOP	Rowan Lea	22
Forensic MH	Mallard	20

From the table the following is of relevance:

- It is not surprising that the majority of the falls incidents have occurred within the older people's service due to other health problems that they may encounter such as reduced vision, mobility and balance problems.
- In turning to the triangulation of data with the safe nursing indicators Mallard, Rowan Lea, Rowan and Springwood all had one metric that was categorised as being 'red' within the staffing fill rate 6 month average
- Roseberry, Westerdale North and South all had staffing that were classified as either 'green' or 'blue'
- Westerdale South had bank usage equating to 74% shown as 'red'
- Mallard Ward had bank usage equating to 34.1% shown as 'amber'
- Agency workers were utilised within Rowan, Springwood and Westerdale South
- Overtime occurred within all wards during the reporting period
- All wards are showing as 'red' for compliance with mandatory training.

6.5 Data in relation to pressure ulcers was obtained. There were 10 incidents reported across 6 wards as follows:

Speciality	Ward / Team	Number of incidents
MHSOP	Roseberry Wards	3
MHSOP	Rowan Lea	2
MHSOP	Rowan Ward	2
MHSOP	Picktree Ward	1
MHSOP	Springwood	1
AMH	Overdale	1

From the table the following is of relevance:

- As expected, the majority of the incidents of 'pressure ulcers' occurred within the older people's service.

- In turning to the triangulation of staffing data; Rowan Ward, Rowan Lea, Springwood and Overdale all had one metric within the staffing fill rate that was classified as 'red'.
- Picktree and Roseberry Wards had staffing fill rates that were classified as either 'green' or 'blue'
- Picktree Ward had bank usage equating to 46.2% shown as 'red'
- Overdale had bank usage equating to 25.3% shown as 'amber'
- Agency workers were utilised within Rowan Ward and Springwood
- Overtime was worked across all of the wards listed.
- All wards with the exception of Picktree Ward are showing as 'red' for compliance with mandatory training.

It is not possible to draw any meaningful conclusions from this data however the data does support the need to further review levels of clinical activity and safe nursing indicators across MHSOP.

6.6 There were 410 incidents of medication errors reported within the reporting period across 62 wards. The top 6 wards are shown as follows:

Ward / Team	Number of incidents
Baysdale	29
Maple	20
Newtondale	18
Fulmar Ward	17
Elm Ward	16
Westerdale South	14

From the table the following is of relevance:

- There is only Fulmar ward who are showing as 'red' for one of the fill rate indicators
- All wards with the exception of Fulmar ward are showing either as 'green' or 'blue' across all metrics within the fill rate indicators
- Westerdale South had bank usage equating to 74% shown as 'red'
- From the wards listed agency working was only undertaken within Westerdale South equating to 0.2% and is shown as 'green'
- Overtime working occurred within all of the wards listed.
- With the exception of Newtondale all wards listed within the table are showing as 'red' for mandatory training.

6.7 In terms of shifts worked without a break there were 7414 shifts worked within the reporting period where breaks were not given. The top 6 wards were as follows:

Ward / Team	Number of shifts	% of shifts without a break	Day Shifts	Night Shifts
Aysgarth	1260	87.14%	981	374
Newberry Centre	1205	52.01%	774	431
Bankfields Unit 2	771	41.38%	767	4
Abdale House	669	64.90%	342	357
Westwood Centre	278	10.52%	137	141
Wingfield	238	18.67%	58	180

From the table the following is of relevance:

- It is important to highlight that staff are not ordinarily allocated breaks within Aysgarth and Newberry Centre as a result of them eating with the service users as part of therapeutic engagement.
- The majority of the shifts where breaks were not given occurred on day shifts
- It is not possible to highlight the reasons as to why breaks are not given due to this not being reported within the HealthRoster system. It is therefore not possible to separate whether this is due to clinical need or customary practice.
- This exercise also highlighted examples whereby staff were receiving both time owing and overtime payments for breaks not taken in some areas.
- Newberry and Wingfield were the only wards highlighted whereby they had a 'red' fill rate indicator within the reporting period
- All other wards had either a 'green' or 'blue' fill rate indicators across all metrics within the staffing fill rates
- All wards were categorised as either 'amber' or 'green' for bank usage
- None of the wards listed had used agency workers within the reporting period
- Overtime was utilised across all of the wards listed within the table during the reporting period.
- All wards with the exception of Wingfield were all 'red' for mandatory training.

Appendix 2

Budgeted and Actual Staffing Establishments in WTE

Locality	WARD	Speciality	Bed Numbers	Shifts LD or SD	Establishment at 1/6/15				Establishment at 30/11/15				Comparison 1/6/15 to 30/11/15 Budget v actual WTE hours			
					Registered Staff		Unrestistered Staff		Registered Staff		Unregistered Staff		Registered Staff		Unregistered Staff	
					Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
Durham & Darlington	Cedar Ward	Adults	10	LD	8.50	11.00	14.30	13.80	8.50	10.00	14.30	12.60	-	-1.00	-	-1.20
	Birch Ward	Adults	15	LD	8.60	8.10	15.90	13.10	8.60	8.40	15.90	13.70	-	0.30	-	0.60
	Earlston House	Adults	15	LD	8.60	8.50	11.40	11.80	8.60	8.50	11.40	10.10	-	-	-	-1.70
	Primrose Lodge	Adults	15	LD	8.60	8.60	11.40	10.10	8.60	7.60	11.40	10.00	-	-1.00	-	-0.10
	Willow Ward	Adults	15	LD	8.60	9.90	11.40	11.10	8.60	9.10	11.40	11.10	-	-0.80	-	-
	Maple Ward	Adults	17	LD	8.40	8.40	11.40	9.60	8.60	8.90	11.40	10.60	0.20	0.50	-	1.00
	Elm Ward	Adults	20	LD	8.60	8.70	11.40	10.90	8.60	8.10	11.40	12.10	-	-0.60	-	1.20
	Farnham Ward	Adults	20	LD	8.60	8.60	11.40	11.70	8.60	8.60	11.40	11.70	-	-	-	0.00
	Tunstall Ward	Adults	20	LD	8.60	8.00	11.40	12.80	8.60	9.00	11.40	12.70	-	1.00	-	-0.10
	Holly Unit	CYPS	4	LD & SD	4.80	4.60	5.20	5.60	4.80	4.60	5.20	5.10	-	-	-	-0.50
	Bek, Ramsey, Talbot Wards	LD	16	LD	11.20	9.40	44.10	38.50	11.20	10.40	44.10	33.10	-	1.00	-	-5.40
	Ceddesfeld Ward	MHSOP	10	LD	8.60	9.00	5.40	11.70	8.60	9.00	5.40	11.70	-	-	-	-
	Hamsterley Ward	MHSOP	10	LD	8.60	9.00	7.00	9.70	8.60	9.00	7.00	9.70	-	-	-	-
	Picktree Ward.	MHSOP	10	LD	8.60	7.70	8.30	8.40	8.60	8.40	8.30	8.40	-	0.70	-	-
	Oak Ward	MHSOP	12	LD	8.60	9.80	11.40	11.20	8.60	8.80	11.40	11.10	-	-1.00	-	-0.10
	Roseberry Wards	MHSOP	15	LD	8.60	8.30	11.40	12.40	8.60	7.40	11.40	13.00	-	-0.90	-	0.60
Forensics	Clover/Ivy	Forensics LD	12	LD	8.10	9.00	24.10	19.90	8.10	9.00	20.30	20.40	-	-	-3.80	0.50
	Thistle Ward	Forensics LD	5	LD	8.10	7.00	13.40	13.00	10.70	7.00	14.80	11.60	2.60	-	1.40	-1.40
	Northdale Centre	Forensics LD	6	LD	8.10	9.90	29.50	21.50	8.10	8.00	26.90	20.90	-	-1.90	-2.60	-0.60
	Oakwood	Forensics LD	8	LD	8.10	6.80	8.30	9.00	8.10	7.80	6.60	8.00	-	1.00	-1.70	-1.00

	Eagle/Osprey	Forensics LD	10	LD	8.10	8.00	21.50	14.30	8.10	9.70	17.50	19.60	-	1.70	-4.00	5.30
	Harrier/Hawk	Forensics LD	10	LD	8.10	6.90	24.10	19.40	8.10	7.20	20.20	19.60	-	0.30	-3.90	0.20
	Langley Ward	Forensics LD	10	LD	8.10	8.00	10.70	10.00	8.10	6.80	9.30	10.00	-	-1.20	-1.40	-
	Kingfisher/Heron/Robin	Forensics LD	14	LD	8.10	9.70	26.80	20.80	13.50	4.00	17.60	15.70	5.40	-5.70	-9.20	-5.10
	Kestrel/Kite	Forensics LD	16	LD	8.10	9.80	24.10	18.70	8.10	7.80	22.00	19.90	-	-2.00	-2.10	1.20
	Brambling Ward	Forensics MH	13	LD	8.10	8.00	13.20	11.80	8.10	5.60	13.20	8.30	-	-2.40	-	-3.50
	Jay Ward	Forensics MH	5	LD	8.10	6.80	13.40	13.00	8.10	5.70	13.40	13.10	-	-1.10	-	0.10
	Sandpiper Ward	Forensics MH	8	LD	10.70	9.50	17.10	16.50	10.70	11.00	17.10	14.50	-	1.50	-	-2.00
	Merlin	Forensics MH	10	LD	10.70	10.50	15.30	14.70	10.70	8.50	15.30	13.70	-	-2.00	-	-1.00
	Swift Ward	Forensics MH	10	LD	8.10	6.40	15.30	14.70	8.10	7.40	15.30	17.90	-	1.00	-	3.20
	Fulmar Ward.	Forensics MH	12	LD	8.10	7.60	15.30	15.20	8.10	8.80	15.30	14.80	-	1.20	-	-0.40
	Lark	Forensics MH	15	LD	8.10	7.00	13.20	14.00	8.10	8.00	13.20	14.00	-	1.00	-	-
	Kirkdale Ward	Forensics MH	16	LD	8.10	8.00	15.30	15.10	8.10	6.90	15.30	13.60	-	-1.10	-	-1.50
	Mallard Ward	Forensics MH	16	LD	8.10	9.10	15.30	14.40	8.10	7.60	15.30	15.40	-	-1.50	-	1.00
	Mandarin	Forensics MH	16	LD	8.10	7.00	13.20	12.60	8.10	8.00	13.20	13.50	-	1.00	-	0.90
	Nightingale Ward	Forensics MH	16	LD	8.10	8.90	13.20	12.70	8.10	8.00	13.20	12.70	-	-0.90	-	-
	Linnet Ward	Forensics MH	17	LD	8.10	8.50	13.20	13.20	8.10	6.90	13.20	13.80	-	-1.60	-	0.60
	Newtondale Ward	Forensics MH	20	LD	10.70	9.90	17.90	17.50	10.70	10.90	17.90	16.20	-	1.00	-	-1.30
North Yorkshire	Abdale House (The Orchards)	Adults	9	LD	10.70	9.40	5.60	5.00	10.70	9.20	5.60	5.50	-	-0.20	-	0.50
	Ayckbourn Unit Danby Ward	Adults	13	SD	9.10	7.00	10.70	10.00	9.10	9.00	10.70	9.00	-	2.00	-	-1.00
	Ayckbourn Unit Esk Ward	Adults	13	LD	9.10	7.40	10.70	11.60	9.10	9.00	10.70	10.60	-	1.60	-	-1.00
	Ward 15 Friarage	Adults	14	LD	9.10	8.50	10.70	12.20	9.10	7.00	10.70	11.30	-	-1.50	-	-0.90
	Cedar Ward (NY)	Adults	18	LD	9.10	10.20	15.20	13.60	9.10	8.60	15.20	18.20	-	-1.60	-	4.60
	Newberry Centre	CYPS	14	SD	11.70	15.20	15.20	16.80	11.70	11.70	15.20	17.30	-	-3.50	-	0.50
	The Evergreen Centre	CYPS	12	LD	10.00	10.80	16.00	15.50	13.50	12.40	18.30	18.70	3.50	1.60	2.30	3.20
	Westwood Centre	CYPS	12	LD	14.70	11.00	18.20	21.50	14.70	12.60	18.20	19.50	-	1.60	-	-2.00
	Ward 14	MHSOP	9	LD & SD	9.10	8.40	10.00	11.20	9.10	9.40	10.00	10.40	-	1.00	-	-0.80
	Rowan Ward	MHSOP	12	LD	9.10	10.30	10.70	9.30	9.10	9.30	10.70	9.30	-	-1.00	-	-

	Springwood Community Unit	MHSOP	14	LD	9.10	8.60	12.50	12.40	9.10	8.70	12.50	11.40	-	0.10	-	-1.00
	Rowan Lea	MHSOP	20	SD&LD	9.10	8.40	17.90	17.00	9.10	8.20	17.90	16.00	-	-0.20	-	-1.00
Teesside	Bedale Ward	Adults	10	LD	8.20	8.00	13.70	12.60	8.20	7.00	13.70	13.60	-	-1.00	-	1.00
	Bilsdale Ward	Adults	14	LD	8.20	6.80	11.00	12.00	8.20	8.80	11.00	10.20	-	2.00	-	-1.80
	Bransdale Ward	Adults	14	LD	8.20	6.80	11.00	11.60	8.20	7.10	11.00	9.80	-	0.30	-	-1.80
	Park House	Adults	14	LD	7.80	7.60	11.00	10.00	7.80	6.90	11.00	10.00	-	-0.70	-	-
	Overdale Ward	Adults	18	LD	8.20	6.60	11.00	11.80	8.20	6.60	11.00	12.00	-	-	-	0.20
	Stockdale Ward	Adults	18	LD	8.20	7.60	11.00	11.40	8.20	9.80	11.00	12.30	-	2.20	-	0.90
	Lincoln Ward	Adults	20	LD & SD	9.40	10.40	11.90	12.90	9.40	11.00	11.90	13.30	-	0.60	-	0.40
	Lustrum Vale	Adults	20	LD & SD	10.30	9.20	11.00	10.20	10.30	8.10	11.00	10.20	-	-1.10	-	-
	Baysdale	CYPS	6	SD	6.70	7.10	12.70	11.70	6.70	7.10	12.70	11.10	-	-	-	-0.60
	Aysgarth	LD	6	SD	6.00	5.40	11.50	9.30	6.00	5.40	11.50	10.10	-	-	-	0.80
	Bankfields Court Unit 2	LD	5	SD	6.80	8.00	9.50	8.00	6.80	6.00	9.50	7.00	-	-2.00	-	-1.00
	Bankfields Court	LD	12	SD&LD	14.30	19.60	57.30	49.00	14.30	17.50	57.30	48.00	-	-2.10	-	-1.00
	Wingfield Ward	MHSOP	9	LD & SD	8.10	6.80	10.00	9.50	8.10	7.80	10.00	9.50	-	1.00	-	-
	Westerdale South	MHSOP	14	SD&LD	8.20	10.00	11.00	9.90	8.20	10.00	11.00	12.90	-	-	-	3.00
	Westerdale North	MHSOP	18	SD&LD	8.20	8.20	11.00	11.40	8.20	8.20	11.00	11.60	-	-	-	0.20

Appendix 3

Absence Factors and Additional Staffing Usage

Ward Name	Locality	Speciality	Maternity		Sickness		Vacancies		Total Bank Usage Vs Actual Hours		Total Agency Usage Vs Actual Hours		Overtime Vs Actual Hours	
			Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours
Cedar	Durham & Darlington	AMH	385.50	1.48%	1144.00	4.40%	363.75	1.40%	14029.96	54.00%	0.00	0.00%	1343.36	5.17%
Elm Ward	Durham & Darlington	AMH	0.00	0.00%	910.50	4.86%	547.50	2.92%	5112.14	27.31%	0.00	0.00%	1332.49	7.12%
Farnham Ward	Durham & Darlington	AMH	0.00	0.00%	721.50	4.26%	90.00	0.53%	1162.66	6.86%	0.00	0.00%	785.16	4.63%
Tunstall Ward	Durham & Darlington	AMH	0.00	0.00%	1867.50	11.09%	37.50	0.22%	1466.00	8.71%	0.00	0.00%	1262.21	7.50%
Maple	Durham & Darlington	AMH	0.00	0.00%	1506.00	8.20%	536.25	2.92%	7204.00	39.24%	0.00	0.00%	1231.95	6.71%
Willow Ward	Durham & Darlington	AMH	0.00	0.00%	432.00	2.44%	191.25	1.08%	2990.99	16.90%	0.00	0.00%	372.16	2.10%
Primrose Lodge	Durham & Darlington	AMH	0.00	0.00%	1559.00	9.79%	333.75	2.10%	871.16	5.47%	0.00	0.00%	1231.65	7.73%
Earlston House	Durham & Darlington	AMH	0.00	0.00%	816.50	5.02%	217.50	1.34%	1640.65	10.09%	0.00	0.00%	504.82	3.11%
Holly	Durham & Darlington	CYPS	600.00	6.72%	0.00	0.00%	45.00	0.50%	910.45	10.19%	0.00	0.00%	451.00	5.05%
Birch Ward	Durham & Darlington	ED	0.00	0.00%	591.00	2.55%	1155.00	4.98%	9820.76	42.36%	0.00	0.00%	1851.90	7.99%
Bek, Talbot and Ramsey	Durham & Darlington	LD	0.00	0.00%	1340.50	3.64%	4946.25	13.43%	3734.18	10.14%	0.00	0.00%	3088.38	8.39%
Ceddesfeld	Durham & Darlington	MHSOP	837.00	5.07%	446.00	2.70%	45.00	0.27%	1979.99	12.00%	0.00	0.00%	421.16	2.55%
Picktree	Durham & Darlington	MHSOP	0.00	0.00%	861.50	4.50%	296.25	1.55%	8852.38	46.21%	0.00	0.00%	827.94	4.32%
Roseberry Wards	Durham & Darlington	MHSOP	0.00	0.00%	707.25	4.42%	187.50	1.17%	1439.89	9.00%	0.00	0.00%	729.46	4.56%
Hamsterley	Durham & Darlington	MHSOP	0.00	0.00%	642.00	3.97%	225.00	1.39%	1140.33	7.06%	0.00	0.00%	928.66	5.75%
Oak Ward	Durham & Darlington	MHSOP	0.00	0.00%	2355.90	15.73%	37.50	0.25%	613.84	4.10%	0.00	0.00%	577.27	3.85%
Oakwood	Forensics	FLD	1072.50	8.77%	1181.00	9.66%	345.00	2.82%	1305.52	10.68%	0.00	0.00%	494.25	4.04%
Eagle / Osprey	Forensics	FLD	1177.50	5.61%	2010.00	9.57%	1248.75	5.95%	4713.33	22.45%	0.00	0.00%	549.92	2.62%
Kingfisher / Heron / Robin	Forensics	FLD	1005.00	5.18%	1473.92	7.59%	2553.75	13.16%	4705.18	24.24%	0.00	0.00%	650.15	3.35%
Kestrel / Kite	Forensics	FLD	607.50	2.61%	1334.25	5.73%	1751.25	7.52%	5766.66	24.75%	0.00	0.00%	290.01	1.24%

Clover / Ivy	Forensics	FLD	161.25	0.60%	1800.50	6.65%	1830.00	6.76%	8361.63	30.87%	0.00	0.00%	1176.77	4.35%
Langley	Forensics	FLD	0.00	0.00%	1852.25	13.68%	303.75	2.24%	1966.59	14.53%	0.00	0.00%	269.59	1.99%
Northdale Centre	Forensics	FLD	0.00	0.00%	1260.08	4.72%	2463.75	9.23%	7775.78	29.13%	0.00	0.00%	1240.84	4.65%
Harrier / Hawk	Forensics	FLD	0.00	0.00%	953.50	4.05%	1676.25	7.13%	4332.25	18.42%	0.00	0.00%	858.26	3.65%
Thistle Ward	Forensics	FLD	0.00	0.00%	150.00	0.90%	1297.50	7.81%	2697.59	16.24%	0.00	0.00%	1136.71	6.84%
Brambling	Forensics	FMH	1297.50	7.12%	1546.50	8.48%	2351.25	12.90%	8450.50	46.35%	0.00	0.00%	375.55	2.06%
Sandpiper Ward	Forensics	FMH	1305.00	5.62%	1083.00	4.67%	1346.25	5.80%	7136.60	30.76%	0.00	0.00%	779.42	3.36%
Linnet Ward	Forensics	FMH	933.75	5.35%	499.00	2.86%	2103.75	12.06%	4039.65	23.16%	0.00	0.00%	473.48	2.71%
Nightingale	Forensics	FMH	855.00	5.13%	1163.50	6.98%	2355.00	14.12%	3029.90	18.17%	0.00	0.00%	540.50	3.24%
Newtondale	Forensics	FMH	903.75	4.13%	1426.00	6.52%	1856.25	8.48%	3159.50	14.43%	0.00	0.00%	773.93	3.54%
Lark	Forensics	FMH	648.75	3.88%	1949.75	11.66%	1653.75	9.89%	3780.58	22.61%	0.00	0.00%	507.16	3.03%
Mandarin	Forensics	FMH	416.25	2.48%	1655.25	9.87%	2853.75	17.01%	3356.25	20.01%	0.00	0.00%	579.75	3.46%
Swift Ward	Forensics	FMH	423.75	2.08%	1493.75	7.33%	1556.25	7.63%	7406.00	36.32%	0.00	0.00%	242.33	1.19%
Mallard	Forensics	FMH	236.25	1.08%	885.00	4.06%	1211.25	5.56%	7423.75	34.08%	0.00	0.00%	847.09	3.89%
Merlin	Forensics	FMH	97.50	0.39%	1727.75	6.91%	2355.00	9.42%	13344.83	53.37%	0.00	0.00%	797.31	3.19%
Jay Ward	Forensics	FMH	0.00	0.00%	1328.83	7.72%	2505.00	14.56%	5615.75	32.64%	0.00	0.00%	356.50	2.07%
Fulmar Ward	Forensics	Locked Rehab	1503.75	8.08%	1098.35	5.90%	993.75	5.34%	4996.75	26.86%	0.00	0.00%	270.25	1.45%
Kirkdale	Forensics	Locked Rehab	626.25	3.29%	1080.75	5.67%	2310.00	12.12%	3352.58	17.59%	0.00	0.00%	438.57	2.30%
Ward 15	North Yorkshire	AMH	987.00	6.34%	530.00	3.41%	1256.25	8.08%	2637.30	16.95%	0.00	0.00%	178.00	1.14%
Abdale House	North Yorkshire	AMH	547.50	4.15%	540.00	4.09%	1515.00	11.48%	595.00	4.51%	0.00	0.00%	1859.18	14.09%
Cedar (NY)	North Yorkshire	AMH	432.00	1.85%	681.50	2.91%	3405.00	14.55%	3790.50	16.20%	2048.00	8.75%	957.17	4.09%
Ayckbourn Esk Ward	North Yorkshire	AMH	0.00	0.00%	880.50	5.37%	1398.75	8.53%	2266.50	13.82%	0.00	0.00%	145.26	0.89%
Ayckbourn Danby Ward	North Yorkshire	AMH	0.00	0.00%	343.53	2.22%	2381.25	15.38%	2573.05	16.62%	0.00	0.00%	443.69	2.87%
Newberry Centre	North Yorkshire	CYPS	1207.50	5.91%	907.50	4.44%	787.50	3.85%	3693.05	18.07%	0.00	0.00%	284.67	1.39%
Westwood Centre	North Yorkshire	CYPS	86.50	0.28%	1732.25	5.69%	1965.00	6.46%	8163.25	26.83%	0.00	0.00%	1641.21	5.39%
The Evergreen Centre	North Yorkshire	CYPS	15.00	0.07%	1363.00	6.08%	1151.25	5.14%	3822.02	17.05%	0.00	0.00%	615.19	2.74%
Rowan Ward	North Yorkshire	MHSOP	26.50	0.15%	1727.25	9.96%	1623.75	9.37%	2478.75	14.30%	1292.50	7.45%	743.43	4.29%
Rowan Lea	North Yorkshire	MHSOP	0.00	0.00%	1282.67	5.80%	1931.25	8.73%	1675.56	7.57%	0.00	0.00%	1777.38	8.03%

Springwood	North Yorkshire	MHSOP	0.00	0.00%	2530.87	12.49%	2058.75	10.16%	3723.84	18.38%	2674.50	13.20%	1043.42	5.15%
Ward 14	North Yorkshire	MHSOP	0.00	0.00%	697.00	4.74%	236.25	1.61%	259.25	1.76%	22.50	0.15%	868.23	5.91%
Stockdale	Teesside	AMH	1823.00	11.08%	706.50	4.29%	1308.75	7.95%	3295.50	20.03%	0.00	0.00%	649.25	3.95%
Bilsdale	Teesside	AMH	787.50	5.09%	2316.50	14.96%	2137.50	13.81%	3181.50	20.55%	0.00	0.00%	422.10	2.73%
Lincoln Ward	Teesside	AMH	596.50	3.28%	1483.13	8.16%	1863.75	10.25%	2694.30	14.82%	0.00	0.00%	348.50	1.92%
Lustrum Vale	Teesside	AMH	0.00	0.00%	2144.00	13.32%	1623.75	10.09%	3937.50	24.46%	0.00	0.00%	189.80	1.18%
Overdale	Teesside	AMH	0.00	0.00%	847.00	4.76%	1053.75	5.92%	4507.00	25.31%	0.00	0.00%	152.25	0.86%
Bransdale	Teesside	AMH	0.00	0.00%	2476.25	15.62%	1417.50	8.94%	5862.75	36.98%	0.00	0.00%	528.05	3.33%
Park House	Teesside	AMH	0.00	0.00%	839.50	5.52%	0.00	0.00%	3143.18	20.68%	0.00	0.00%	81.08	0.53%
Bedale Ward	Teesside	AMH	0.00	0.00%	2036.50	9.68%	1702.50	8.09%	9187.75	43.67%	0.00	0.00%	1371.50	6.52%
Baysdale	Teesside	CYPS	0.00	0.00%	355.58	2.42%	918.75	6.25%	406.58	2.77%	0.00	0.00%	1575.95	10.72%
Bankfields Court	Teesside	LD	4279.50	8.61%	2479.00	4.99%	3911.25	7.87%	7590.85	15.27%	0.00	0.00%	1198.43	2.41%
Aysgarth	Teesside	LD	457.50	3.26%	619.00	4.41%	558.75	3.98%	4048.09	28.84%	0.00	0.00%	661.50	4.71%
Bankfields Court Unit 2	Teesside	LD	0.00	0.00%	558.33	4.13%	585.00	4.33%	3376.86	25.01%	0.00	0.00%	1012.18	7.50%
Wingfield	Teesside	MHSOP	605.50	4.29%	420.00	2.98%	945.00	6.70%	581.00	4.12%	0.00	0.00%	418.00	2.96%
Westerdale North	Teesside	MHSOP	0.00	0.00%	412.50	2.45%	337.50	2.01%	545.75	3.24%	0.00	0.00%	608.75	3.62%
Westerdale South	Teesside	MHSOP	606.90	2.59%	1275.11	6.73%	1782.01	9.45%	3590.20	19.03%	214.38	1.06%	688.30	2.58%

	Green	Amber	Red
Maternity	0-1.9%	2-4.9%	5% and over
Sickness	0-1.9%	2-5.9%	5% and over
Vacancies	0-4.9%	5-9.9%	10% and over
Bank Usage	0-19.9%	20-39.9%	39.9% and over
Agency & Overtime	0-2.9%	3-3.9%	4% and over

Appendix 4

Average fill rate covering the period of 1st June 2015 to 30th November 2015

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE AVERAGE (JUNE TO NOVEMBER 2015)							
				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)
Abdale House	North Yorkshire	Adults	10	133.4%	90.2%	104.1%	147.3%
Ayckbourn Danby Ward	North Yorkshire	Adults	13	96.9%	104.3%	111.1%	93.7%
Ayckbourn Esk Ward	North Yorkshire	Adults	13	91.4%	112.7%	100.8%	99.3%
Aysgarth	Teesside	LD	6	108.8%	141.9%	101.3%	103.2%
Bankfields Court Unit 2	Teesside	LD	5	116.5%	101.7%	100.3%	110.6%
Bankfields Court	Teesside	LD	19	81.9%	114.7%	95.4%	101.1%
Baysdale	Teesside	CYPS	6	126.4%	92.8%	99.9%	100.0%
Bedale Ward	Teesside	Adults	10	74.7%	176.0%	103.7%	122.4%
Bek, Talbot and Ramsey	Durham & Darlington	LD	11	104.8%	101.9%	103.9%	103.4%
Bilsdale	Teesside	Adults	14	70.3%	137.8%	94.1%	101.8%
Birch Ward	Durham & Darlington	Adults	15	113.8%	125.4%	100.0%	169.7%
Brambling	Forensics	Forensic MH	13	78.0%	125.7%	104.3%	118.1%
Bransdale	Teesside	Adults	14	67.0%	140.6%	93.8%	110.0%
Cedar	Durham & Darlington	Adults	10	113.6%	191.5%	100.0%	158.0%
Cedar (NY)	North Yorkshire	Adults	18	92.6%	144.2%	55.5%	157.6%
Ceddesfeld	Durham & Darlington	MHSOP	10	92.5%	155.9%	100.3%	100.3%
Clover / Ivy	Forensics	Forensic LD	12	95.9%	111.7%	100.0%	114.2%
Eagle / Osprey	Forensics	Forensic LD	10	85.9%	93.1%	99.1%	95.4%

Earlston House	Durham & Darlington	Adults	15	104.9%	107.0%	100.5%	101.0%
Elm Ward	Durham & Darlington	Adults	20	99.1%	132.9%	100.8%	128.9%
Farnham Ward	Durham & Darlington	Adults	20	108.0%	113.3%	103.3%	102.8%
Fulmar Ward	Forensics	Forensic MH	12	85.5%	104.1%	94.0%	104.3%
Hamsterley	Durham & Darlington	MHSOP	10	87.3%	144.5%	102.1%	105.8%
Harrier / Hawk	Forensics	Forensic LD	6	76.8%	97.5%	101.0%	98.8%
Holly	Durham & Darlington	CYPS	4	115.6%	124.2%	101.1%	111.6%
Jay Ward	Forensics	Forensic MH	5	72.2%	109.1%	104.9%	108.1%
Kestrel / Kite	Forensics	Forensic LD	16	82.0%	92.7%	95.0%	98.8%
Kingfisher / Heron / Robin	Forensics	Forensic LD	14	81.2%	90.2%	87.6%	99.7%
Kirkdale	Forensics	Forensic MH	16	90.9%	103.0%	101.5%	112.4%
Langley	Forensics	Forensic LD	10	80.0%	90.3%	103.2%	101.3%
Lark	Forensics	Forensic MH	15	80.4%	110.5%	98.4%	99.5%
Lincoln Ward	Teesside	Adults	20	97.5%	101.2%	99.1%	112.2%
Linnet Ward	Forensics	Forensic MH	17	88.4%	112.3%	98.8%	102.4%
Lustrum Vale	Teesside	Adults	16	92.7%	115.1%	105.7%	100.8%
Mallard	Forensics	Forensic MH	16	89.6%	122.6%	102.2%	139.9%
Mandarin	Forensics	Forensic MH	16	89.6%	102.1%	102.4%	96.6%
Maple	Durham & Darlington	Adults	17	100.3%	119.2%	102.2%	132.0%
Merlin	Forensics	Forensic MH	10	102.7%	137.9%	83.9%	165.9%
Newberry Centre	North Yorkshire	CYPS	14	70.1%	117.2%	91.5%	92.7%
Newtondale	Forensics	Forensic MH	20	94.2%	97.1%	90.6%	102.2%
Nightingale	Forensics	Forensic MH	16	90.0%	100.6%	99.8%	99.4%
Northdale Centre	Forensics	Forensic LD	12	84.1%	90.4%	104.0%	91.4%
Oak Ward	Durham & Darlington	MHSOP	12	71.3%	101.4%	98.9%	103.2%
Oakwood	Forensics	Forensic LD	8	94.5%	96.2%	97.8%	100.0%
Overdale	Teesside	Adults	18	67.1%	151.7%	97.6%	111.4%
Park House	Teesside	Adults	14	102.0%	105.7%	99.1%	106.8%

Picktree	Durham & Darlington	MHSOP	10	98.8%	165.9%	100.6%	127.5%
Primrose Lodge	Durham & Darlington	Adults	15	87.4%	107.1%	107.7%	103.9%
Roseberry Wards	Durham & Darlington	MHSOP	15	92.9%	96.1%	100.5%	100.3%
Rowan Lea	North Yorkshire	MHSOP	20	82.8%	106.3%	109.8%	101.4%
Rowan Ward	North Yorkshire	MHSOP	12	106.9%	79.7%	122.3%	101.8%
Sandpiper Ward	Forensics	Forensic MH	8	91.2%	104.3%	87.6%	120.5%
Springwood	North Yorkshire	MHSOP	14	77.4%	141.5%	106.1%	133.8%
Stockdale	Teesside	Adults	18	87.7%	120.4%	102.4%	101.5%
Swift Ward	Forensics	Forensic MH	10	78.3%	120.1%	101.1%	123.9%
The Evergreen Centre	North Yorkshire	CYPS	16	96.6%	112.0%	102.3%	108.4%
Thistle Ward	Forensics	Forensic LD	5	76.8%	108.8%	101.1%	100.8%
Tunstall Ward	Durham & Darlington	Adults	20	96.4%	116.4%	97.8%	109.5%
Ward 14	North Yorkshire	MHSOP	9	76.0%	121.4%	102.1%	103.2%
Ward 15	North Yorkshire	Adults	14	75.9%	120.9%	99.6%	104.6%
Westerdale North	Teesside	MHSOP	18	100.1%	125.1%	101.7%	103.6%
Westerdale South	Teesside	MHSOP	14	99.6%	270.3%	100.3%	215.8%
Westwood Centre	North Yorkshire	CYPS	12	103.9%	124.3%	101.8%	190.4%
Willow Ward	Durham & Darlington	Adults	15	86.9%	144.9%	102.2%	107.9%
Wingfield	Teesside	MHSOP	9	85.8%	107.7%	99.0%	100.4%

Appendix 5

Quality Indicators

Ward Name	Locality	Speciality	Bed Numbers	Bank Usage vs Actual Hours		Quality Indicators					Incidents of Restraints				Registered Average %		Unregistered Average %	
				Hours	% against Actual Hours	Number of SUIs	Level 4 Incidents	Level 3 Self-Harm Incidents	Number of Complaints	Number of PALS	Number of Incidents	Number of PRO Restraints Used	Number of Other Restraints Used	Total Number of Restraints Used	Day	Night	Day	Night
Cedar	Durham & Darlington	AMH	10	14030.0	54.0%	1		2		3	61	13	126	139	**113.6%**	**100.0%**	**191.5%**	**158.0%**
Earlston House	Durham & Darlington	AMH	15	1640.7	10.1%						2	1	6	7	**104.9%**	**100.5%**	**107.0%**	**101.0%**
Elm Ward	Durham & Darlington	AMH	20	5112.1	27.3%					4	8	2	11	13	**99.1%**	**100.8%**	**132.9%**	**128.9%**
Farnham Ward	Durham & Darlington	AMH	20	1162.7	6.9%	1			2	2	2	1	3	4	**108.0%**	**103.3%**	**113.3%**	**102.8%**
Maple	Durham & Darlington	AMH	17	7204.0	39.2%		1	2	2	6	20	1	26	27	**100.3%**	**102.2%**	**119.2%**	**132.0%**
Primrose Lodge	Durham & Darlington	AMH	15	871.2	5.5%			2							**87.4%**	**107.7%**	**107.1%**	**103.9%**
Tunstall Ward	Durham & Darlington	AMH	20	1466.0	8.7%			2	1	2	10	2	16	18	**96.4%**	**97.8%**	**116.4%**	**109.5%**
Willow Ward	Durham & Darlington	AMH	15	2991.0	16.9%					1	1	1	1	2	**86.9%**	**102.2%**	**144.9%**	**107.9%**
Holly	Durham & Darlington	CYPS	4	910.5	10.2%										**115.6%**	**101.1%**	**124.2%**	**111.6%**
Birch Ward	Durham & Darlington	ED	15	9820.8	42.4%				1	2	3		7	7	**113.8%**	**100.0%**	**125.4%**	**169.7%**
Bek, Talbot and Ramsey	Durham & Darlington	LD	11	3734.2	10.1%						81	11	103	114	**104.8%**	**103.9%**	**101.9%**	**103.4%**
Ceddesfeld	Durham & Darlington	MHSOP	10	1980.0	12.0%					1	22		30	30	**92.5%**	**100.3%**	**155.9%**	**100.3%**
Hamsterley	Durham & Darlington	MHSOP	10	1140.3	7.1%	1					69		74	74	**87.3%**	**102.1%**	**144.5%**	**105.8%**
Oak Ward	Durham & Darlington	MHSOP	12	613.8	4.1%	1									**71.3%**	**98.9%**	**101.4%**	**103.2%**

Picktree	Durham & Darlington	MHSOP	10	8852.4	46.2%	1	1				16		31	31	98.8%	100.6%	165.9%	127.5%
Roseberry Wards	Durham & Darlington	MHSOP	15	1439.9	9.0%				1	1	6		7	7	92.9%	100.5%	96.1%	100.3%
Clover / Ivy	Forensics	Forensic LD	12	8361.6	30.9%			2		3	13		22	22	95.9%	100.0%	111.7%	114.2%
Eagle / Osprey	Forensics	Forensic LD	10	4713.3	22.4%										85.9%	99.1%	93.1%	95.4%
Harrier / Hawk	Forensics	Forensic LD	6	4332.3	18.4%	1			1	5	6	1	11	12	76.8%	101.0%	97.5%	98.8%
Kestrel / Kite	Forensics	Forensic LD	16	5766.7	24.7%				1	17	1		1	1	82.0%	95.0%	92.7%	98.8%
Kingfisher / Heron / Robin	Forensics	Forensic LD	14	4705.2	24.2%				2	7					81.2%	87.6%	90.2%	99.7%
Langley	Forensics	Forensic LD	10	1966.6	14.5%						1		1	1	80.0%	103.2%	90.3%	101.3%
Northdale Centre	Forensics	Forensic LD	12	7775.8	29.1%				1	14	29	2	49	51	84.1%	104.0%	90.4%	91.4%
Oakwood	Forensics	Forensic LD	8	1305.5	10.7%										94.5%	97.8%	96.2%	100.0%
Thistle Ward	Forensics	Forensic LD	5	2697.6	16.2%					5	36		71	71	76.8%	101.1%	108.8%	100.8%
Brambling	Forensics	Forensic MH	13	8450.5	46.4%			4	1	5	91	4	140	144	78.0%	104.3%	125.7%	118.1%
Jay Ward	Forensics	Forensic MH	5	5615.8	32.6%			1	1	3	9	2	18	20	72.2%	104.9%	109.1%	108.1%
Lark	Forensics	Forensic MH	15	3780.6	22.6%					1					80.4%	98.4%	110.5%	99.5%
Linnet Ward	Forensics	Forensic MH	17	4039.7	23.2%					4	4		7	7	88.4%	98.8%	112.3%	102.4%
Mallard	Forensics	Forensic MH	16	7423.8	34.1%	1	4			1	24		25	25	89.6%	102.2%	122.6%	139.9%
Mandarin	Forensics	Forensic MH	16	3356.3	20.0%					21	6		8	8	89.6%	102.4%	102.1%	96.6%
Merlin	Forensics	Forensic MH	10	13344.8	53.4%				1	7	23	4	36	40	102.7%	83.9%	137.9%	165.9%
Newtondale	Forensics	Forensic MH	20	3159.5	14.4%					1	2		3	3	94.2%	90.6%	97.1%	102.2%
Nightingale	Forensics	Forensic MH	16	3029.9	18.2%					4	1		2	2	90.0%	99.8%	100.6%	99.4%
Sandpiper Ward	Forensics	Forensic MH	8	7136.6	30.8%		1	2			54	13	120	133	91.2%	87.6%	104.3%	120.5%
Swift Ward	Forensics	Forensic MH	10	7406.0	36.3%			5		3	110	3	177	180	78.3%	101.1%	120.1%	123.9%
Fulmar Ward	Forensics	Locked Rehab	12	4996.8	26.9%					4	28	1	45	46	85.5%	94.0%	104.1%	104.3%
Kirkdale	Forensics	Locked Rehab	16	3352.6	17.6%		1	2		6	4		7	7	90.9%	101.5%	103.0%	112.4%
Abdale House	North Yorkshire	AMH	10	595.0	4.5%										133.4%	104.1%	90.2%	147.3%

Ayckbourn Danby Ward	North Yorkshire	AMH	13	2573.1	16.6%	1									96.9%	111.1%	104.3%	93.7%
Ayckbourn Esk Ward	North Yorkshire	AMH	13	2266.5	13.8%		1	2	2	18	34	7	47	54	91.4%	100.8%	112.7%	99.3%
Cedar (NY)	North Yorkshire	AMH	18	3790.5	16.2%	2		5	1	4	69	10	122	132	92.6%	55.5%	144.2%	157.6%
Ward 15	North Yorkshire	AMH	14	2637.3	17.0%	1		2	1	1	16		22	22	75.9%	99.6%	120.9%	104.6%
Newberry Centre	North Yorkshire	CYPS	14	3693.1	18.1%			1	1	2	127	8	202	210	70.1%	91.5%	117.2%	92.7%
The Evergreen Centre	North Yorkshire	CYPS	16	3822.0	17.0%					4	106	6	182	188	96.6%	102.3%	112.0%	108.4%
Westwood Centre	North Yorkshire	CYPS	12	8163.3	26.8%	1		5			428	57	864	921	103.9%	101.8%	124.3%	190.4%
Rowan Lea	North Yorkshire	MHSOP	20	1675.6	7.6%	1	3	1	2	2	57		83	83	82.8%	109.8%	106.3%	101.4%
Rowan Ward	North Yorkshire	MHSOP	12	2478.8	14.3%	2	1	1	1	3	52		79	79	106.9%	122.3%	79.7%	101.8%
Springwood	North Yorkshire	MHSOP	14	3723.8	18.4%	1					44		49	49	77.4%	106.1%	141.5%	133.8%
Ward 14	North Yorkshire	MHSOP	9	259.3	1.8%					1	17	1	25	26	76.0%	102.1%	121.4%	103.2%
Bedale Ward	Teesside	AMH	10	9187.8	43.7%				1	3	58	8	77	85	74.7%	103.7%	176.0%	122.4%
Bilsdale	Teesside	AMH	14	3181.5	20.5%			1		3	5		8	8	70.3%	94.1%	137.8%	101.8%
Bransdale	Teesside	AMH	14	5862.8	37.0%			4	2	2	12	1	17	18	67.0%	93.8%	140.6%	110.0%
Lincoln Ward	Teesside	AMH	20	2694.3	14.8%			4		2	8		11	11	97.5%	99.1%	101.2%	112.2%
Overdale	Teesside	AMH	18	4507.0	25.3%			3		8	19		29	29	67.1%	97.6%	151.7%	111.4%
Park House	Teesside	AMH	14	3143.2	20.7%					1	3		7	7	102.0%	99.1%	105.7%	106.8%
Stockdale	Teesside	AMH	18	3295.5	20.0%			4	1	10	15	1	20	21	87.7%	102.4%	120.4%	101.5%
Baysdale	Teesside	CYPS	6	406.6	2.8%						1		2	2	126.4%	99.9%	92.8%	100.0%
Aysgarth	Teesside	LD	6	4048.1	28.8%						1		1	1	108.8%	101.3%	141.9%	103.2%
Bankfields Court	Teesside	LD	19	7590.9	15.3%			2	1	1	121	3	187	190	81.9%	95.4%	114.7%	101.1%
Bankfields Court Unit 2	Teesside	LD	5	3376.9	25.0%						3		3	3	116.5%	100.3%	101.7%	110.6%
Lustrum Vale	Teesside	MHSOP	16	3937.5	24.5%				1	2	2		2	2	92.7%	105.7%	115.1%	100.8%
Westerdale North	Teesside	MHSOP	18	545.8	3.2%	1	1	1		4	5		5	5	100.1%	101.7%	125.1%	103.6%
Westerdale South	Teesside	MHSOP	14	19701.9	74.0%				2	2	19		27	27	99.6%	100.3%	270.3%	215.8%
Wingfield	Teesside	MHSOP	9	581.0	4.1%					1	7		11	11	85.8%	99.0%	107.7%	100.4%
Total			852	287425.14	23.0%	17	14	60	31	207	1972	164	3266	3430				

Safe Nursing Indicators

Appendix 6

Locality	Ward Name	Safe Nursing Indicators											
		Falls resulting in significant harm	Pressure Ulcers	Medication Errors	Missed Breaks (No. of Shifts)	Staffing Fill Rate - Day - Registered Nurses	Staffing Fill Rate - Night - Registered Nurses	Staffing Fill Rate - Day - Unregistered Nurses	Staffing Fill Rate - Night - Unregistered Nurses	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours	Mandatory Training (Nov'15)
Durham & Darlington	Cedar	5		9		113.6%	100.0%	191.5%	158.0%	54.0%		5.20%	83.93%
Durham & Darlington	Earlston House	2		6	2	104.9%	100.5%	107.0%	101.0%	10.1%		3.10%	89.44%
Durham & Darlington	Elm Ward			16	11	99.1%	100.8%	132.9%	128.9%	27.3%		7.10%	81.87%
Durham & Darlington	Farnham Ward			5	96	108.0%	103.3%	113.3%	102.8%	6.9%		4.60%	92.86%
Durham & Darlington	Maple	3		20	64	100.3%	102.2%	119.2%	132.0%	39.2%		6.70%	80.52%
Durham & Darlington	Primrose Lodge	1		3		87.4%	107.7%	107.1%	103.9%	5.5%		7.70%	78.26%
Durham & Darlington	Tunstall Ward	1		4	1	96.4%	97.8%	116.4%	109.5%	8.7%		7.50%	86.90%
Durham & Darlington	Willow Ward	2		2	1	86.9%	102.2%	144.9%	107.9%	16.9%		2.10%	88.82%
Durham & Darlington	Holly			2	13	115.6%	101.1%	124.2%	111.6%	10.2%		5.00%	76.92%
Durham & Darlington	Birch Ward			3	7	113.8%	100.0%	125.4%	169.7%	42.4%		8.00%	81.22%
Durham & Darlington	Bek, Talbot and Ramsey	4		2	4	104.8%	103.9%	101.9%	103.4%	10.1%		8.40%	91.88%
Durham & Darlington	Ceddesfeld	14		1	5	92.5%	100.3%	155.9%	100.3%	12.0%		2.60%	88.69%
Durham & Darlington	Hamsterley	9		5	6	87.3%	102.1%	144.5%	105.8%	7.1%		5.70%	88.31%
Durham & Darlington	Oak Ward	10		7	1	71.3%	98.9%	101.4%	103.2%	4.1%		3.90%	80.75%
Durham & Darlington	Picktree	13	1	2	43	98.8%	100.6%	165.9%	127.5%	46.2%		4.30%	95.03%
Durham & Darlington	Roseberry Wards	40	3	5	42	92.9%	100.5%	96.1%	100.3%	9.0%		4.60%	92.59%
Forensics	Clover / Ivy	12		1	49	95.9%	100.0%	111.7%	114.2%	30.9%		4.30%	96.55%
Forensics	Eagle / Osprey	1		5	20	85.9%	99.1%	93.1%	95.4%	22.4%		2.60%	93.10%
Forensics	Harrier / Hawk	3		3	32	76.8%	101.0%	97.5%	98.8%	18.4%		3.60%	88.67%
Forensics	Kestrel / Kite	1		3	4	82.0%	95.0%	92.7%	98.8%	24.7%		1.20%	91.01%
Forensics	Kingfisher / Heron / Robin	10		7	9	81.2%	87.6%	90.2%	99.7%	24.2%		3.30%	85.71%

Forensics	Langley	5		12	61	80.0%	103.2%	90.3%	101.3%	14.5%		2.00%	94.12%
Forensics	Northdale Centre	2		10	56	84.1%	104.0%	90.4%	91.4%	29.1%		4.60%	90.78%
Forensics	Oakwood	2		1	7	94.5%	97.8%	96.2%	100.0%	10.7%		4.00%	82.32%
Forensics	Thistle Ward	3		1	2	76.8%	101.1%	108.8%	100.8%	16.2%		6.80%	
Forensics	Brambling	8		10	87	78.0%	104.3%	125.7%	118.1%	46.4%		2.10%	88.72%
Forensics	Jay Ward			6	61	72.2%	104.9%	109.1%	108.1%	32.6%		2.10%	93.57%
Forensics	Lark			2	58	80.4%	98.4%	110.5%	99.5%	22.6%		3.00%	85.00%
Forensics	Linnet Ward	1		3	79	88.4%	98.8%	112.3%	102.4%	23.2%		2.70%	97.93%
Forensics	Mallard	20		7	98	89.6%	102.2%	122.6%	139.9%	34.1%		3.90%	83.23%
Forensics	Mandarin	1		4	42	89.6%	102.4%	102.1%	96.6%	20.0%		3.50%	93.79%
Forensics	Merlin			9	93	102.7%	83.9%	137.9%	165.9%	53.4%		3.20%	96.43%
Forensics	Newtondale	1		18	95	94.2%	90.6%	97.1%	102.2%	14.4%		3.50%	95.71%
Forensics	Nightingale	1		7	59	90.0%	99.8%	100.6%	99.4%	18.2%		3.20%	97.04%
Forensics	Sandpiper Ward	1		7	82	91.2%	87.6%	104.3%	120.5%	30.8%		3.40%	92.61%
Forensics	Swift Ward	4		11	133	78.3%	101.1%	120.1%	123.9%	36.3%		1.20%	83.04%
Forensics	Fulmar Ward	1		17	96	85.5%	94.0%	104.1%	104.3%	26.9%		1.50%	92.57%
Forensics	Kirkdale	1		2	110	90.9%	101.5%	103.0%	112.4%	17.6%		2.30%	85.71%
North Yorkshire	Abdale House				699	133.4%	104.1%	90.2%	147.3%	4.5%		14.10%	
North Yorkshire	Ayckbourn Danby Ward	3		9	3	96.9%	111.1%	104.3%	93.7%	16.6%		2.90%	91.11%
North Yorkshire	Ayckbourn Esk Ward				4	91.4%	100.8%	112.7%	99.3%	13.8%		0.90%	
North Yorkshire	Cedar (NY)				167	92.6%	55.5%	144.2%	157.6%	16.2%	8.8%	4.10%	78.35%
North Yorkshire	Ward 15	4		5	45	75.9%	99.6%	120.9%	104.6%	17.0%		1.10%	83.12%
North Yorkshire	Newberry Centre			3	1205	70.1%	91.5%	117.2%	92.7%	18.1%		1.40%	76.92%
North Yorkshire	The Evergreen Centre			4	51	96.6%	102.3%	112.0%	108.4%	17.0%		2.70%	82.74%
North Yorkshire	Westwood Centre			5	278	103.9%	101.8%	124.3%	190.4%	26.8%		5.40%	93.73%
North Yorkshire	Rowan Lea	22	2	13	52	82.8%	109.8%	106.3%	101.4%	7.6%		8%	93.49%
North Yorkshire	Rowan Ward	44	2	5	21	106.9%	122.3%	79.7%	101.8%	14.3%	7.5%	4.30%	74.87%
North Yorkshire	Springwood	61	1	6	9	77.4%	106.1%	141.5%	133.8%	18.4%	13.2%	5.20%	79.89%
North Yorkshire	Ward 14	15		5	16	76.0%	102.1%	121.4%	103.2%	1.8%	0.2%	5.90%	88.00%

Teesside	Bedale Ward	2		9	58	**74.7%**	**103.7%**	**176.0%**	**122.4%**	43.7%		6.50%	90.91%
Teesside	Bilsdale	1		5	32	**70.3%**	**94.1%**	**137.8%**	**101.8%**	20.5%		2.70%	83.12
Teesside	Bransdale	10		4	31	**67.0%**	**93.8%**	**140.6%**	**110.0%**	37.0%		3.30%	87.07%
Teesside	Lincoln Ward	4		6	171	**97.5%**	**99.1%**	**101.2%**	**112.2%**	14.8%		1.90%	99.07%
Teesside	Overdale	7	1	3	25	**67.1%**	**97.6%**	**151.7%**	**111.4%**	25.3%		0.90%	77.86%
Teesside	Park House	2		7	15	**102.0%**	**99.1%**	**105.7%**	**106.8%**	20.7%		0.50%	98.14%
Teesside	Stockdale	2		3	53	**87.7%**	**102.4%**	**120.4%**	**101.5%**	20.0%		3.90%	90.98%
Teesside	Baysdale	6		29	232	**126.4%**	**99.9%**	**92.8%**	**100.0%**	2.8%		10.70%	80.00%
Teesside	Aysgarth	3		8	1260	**108.8%**	**101.3%**	**141.9%**	**103.2%**	28.8%		4.70%	86.43%
Teesside	Bankfields Court	7		2	69	**81.9%**	**95.4%**	**114.7%**	**101.1%**	15.3%		2.40%	90.76%
Teesside	Bankfields Court Unit 2	8		3	771	**116.5%**	**100.3%**	**101.7%**	**110.6%**	25.0%		7.50%	94.81%
Teesside	Lustrum Vale	8		5	121	**92.7%**	**105.7%**	**115.1%**	**100.8%**	24.5%		1.20%	93.12%
Teesside	Westerdale North	40		13	62	**100.1%**	**101.7%**	**125.1%**	**103.6%**	3.2%		3.60%	88.10%
Teesside	Westerdale South	59		14	97	**99.6%**	**100.3%**	**270.3%**	**215.8%**	74.0%	0.2%	2.60%	74.18%
Teesside	Wingfield	15		6	238	**85.8%**	**99.0%**	**107.7%**	**100.4%**	4.1%		3.00%	96.43%
	Total	505	10	410	7414								

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26 January 2016**
TITLE:	**Finance Report for Period 1 April 2015 to 31 December 2015**
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 31 December 2015 is a surplus of £5,820k, which is equivalent to 2.6% of turnover and is marginally ahead of plan.

Identified Cash Releasing Efficiency Savings at 31 December 2015 are in line with plan.

The Trust continues to identify schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for 2017/18.

The Financial Sustainability Risk Rating for the Trust is 4 for the period ending 31 December 2015.

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:	**26 January 2016**
TITLE:	**Finance Report for Period 1 April 2015 to 31 December 2015**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2015 to 31 December 2015.

2. BACKGROUND INFORMATION

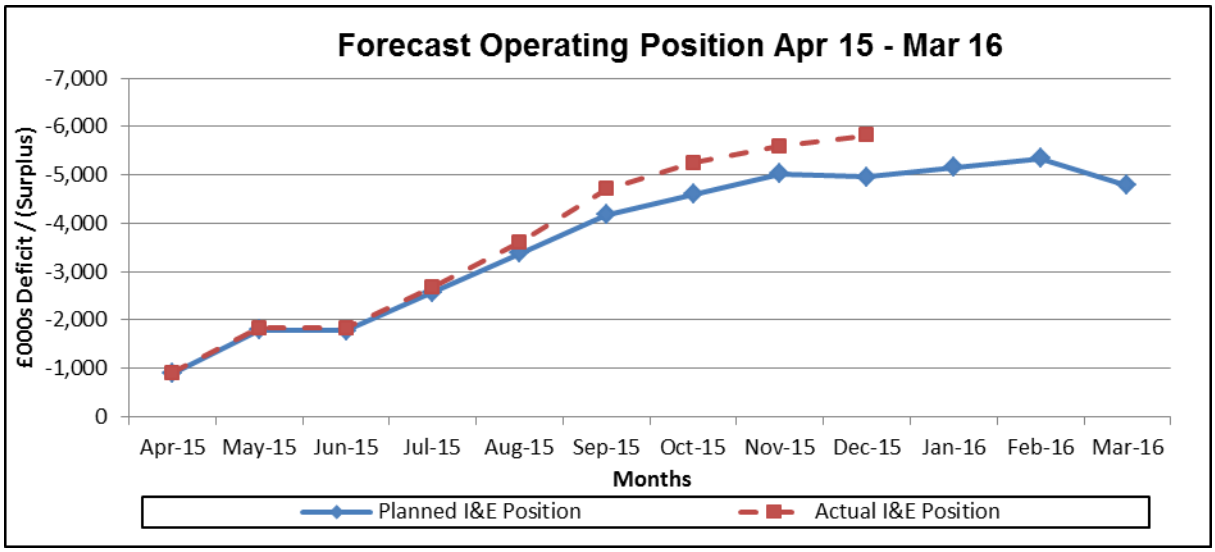
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

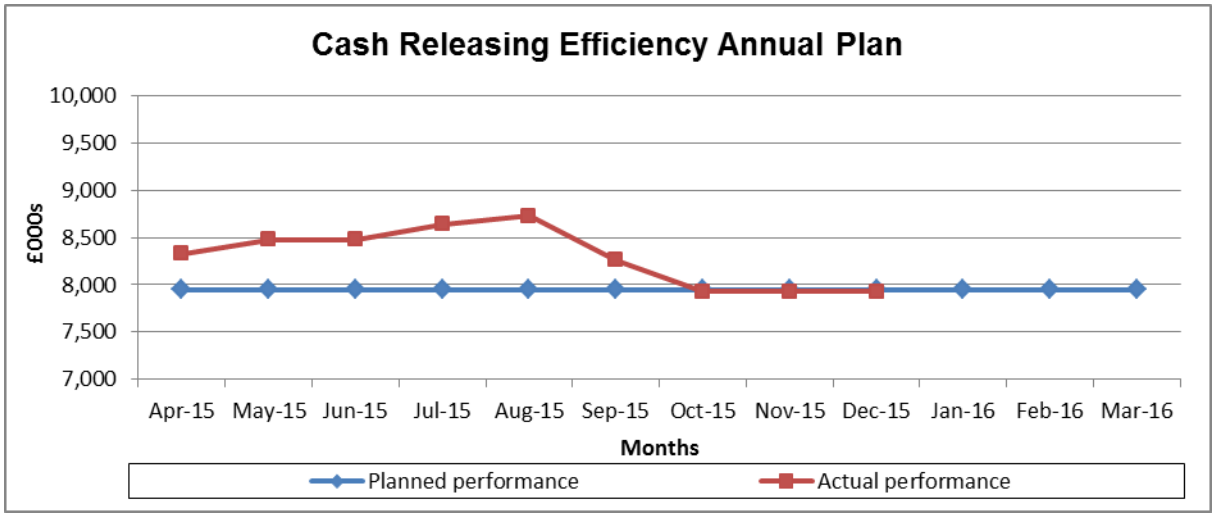
The financial position shows a surplus of £5,820k for the period 1 April 2015 to 31 December 2015, representing 2.6% of the Trust's turnover and is ahead of plan.

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

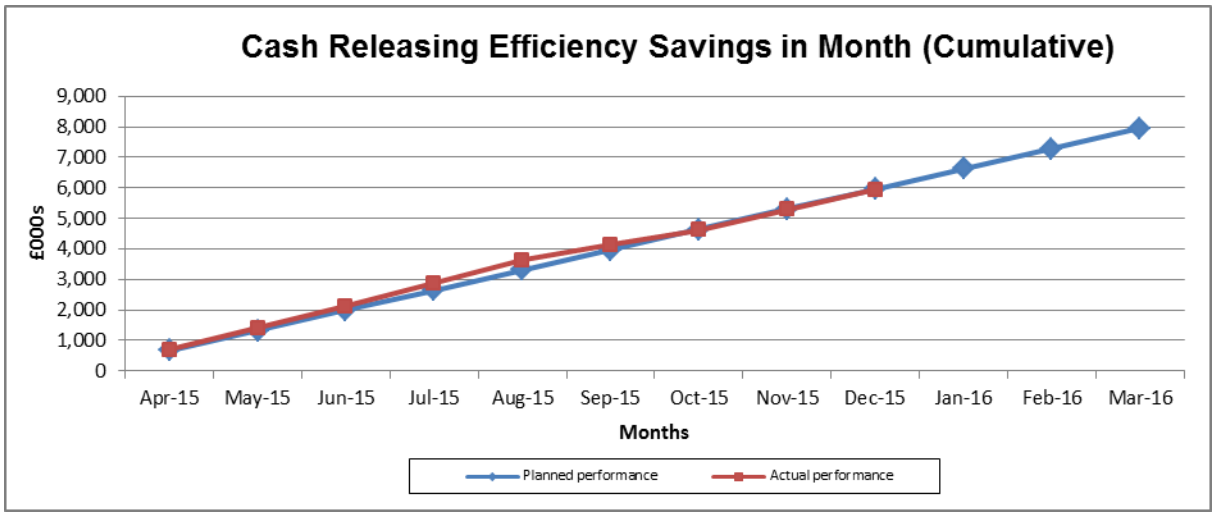


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 December 2015 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.

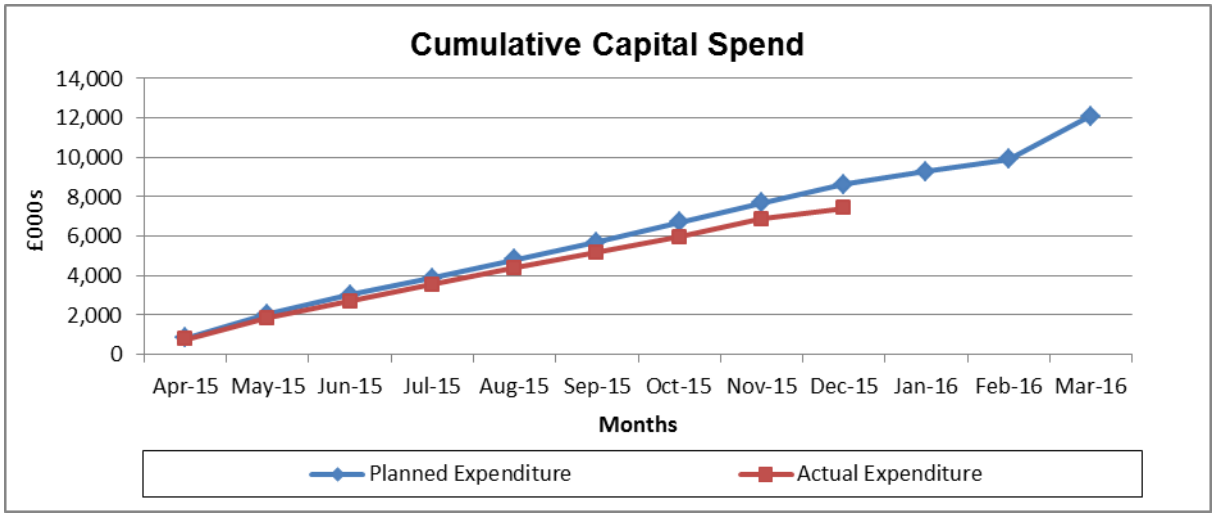


The monthly profile for CRES identified by Localities is shown below.



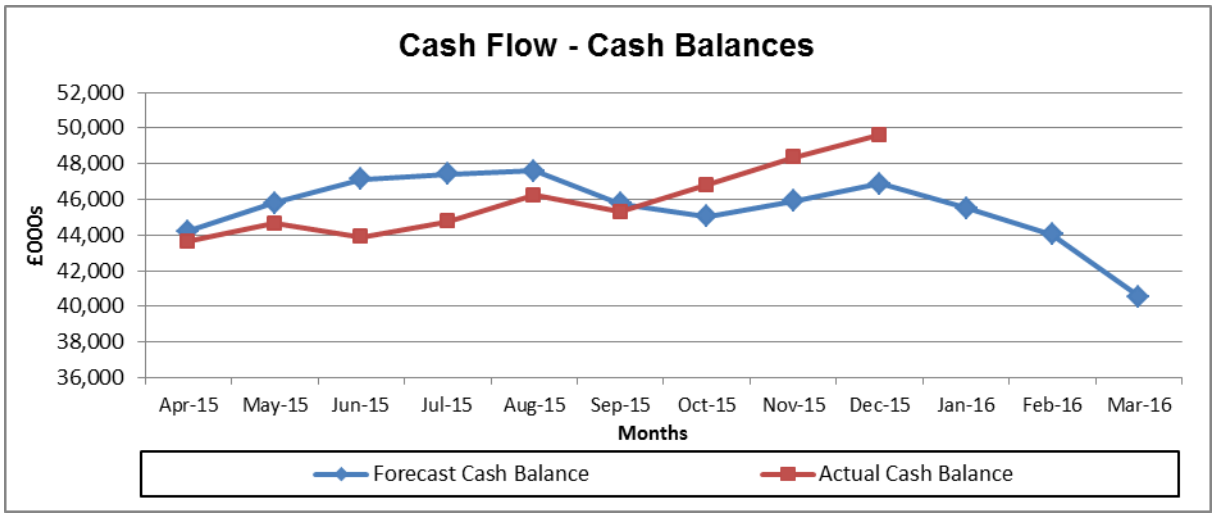
3.3 Capital Programme

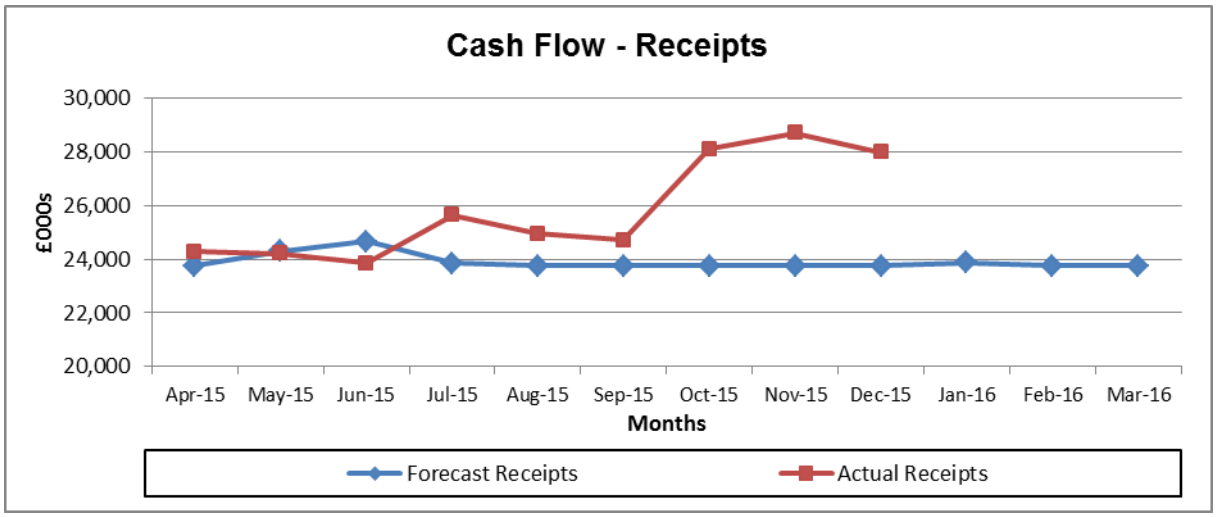
Capital expenditure to 31 December 2015 is £7,442k, and is slightly behind plan.

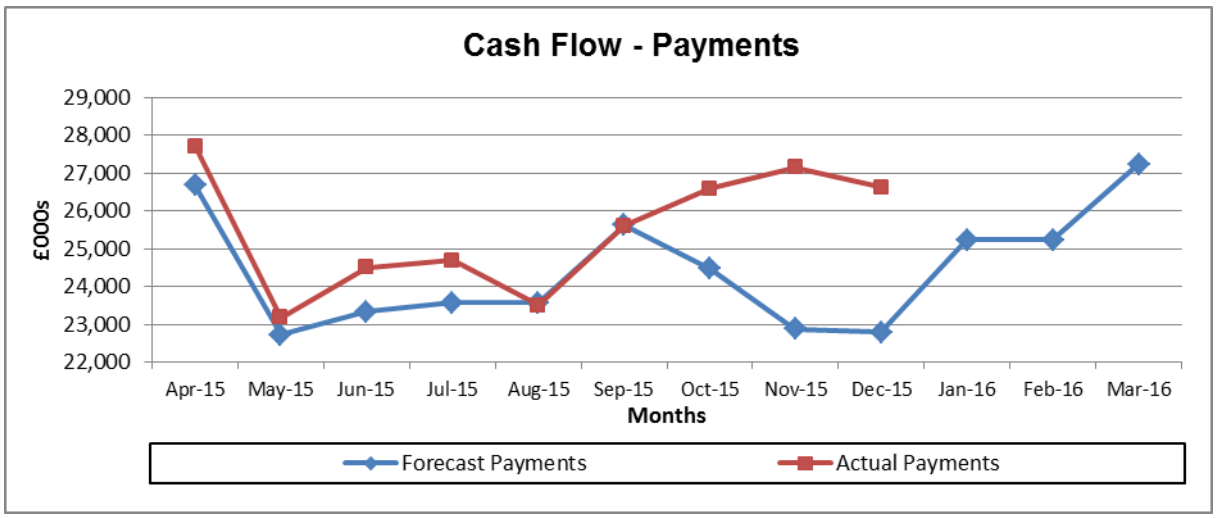


3.4 Cash Flow

Total cash at 31 December 2015 is £49,609k and is ahead of plan due to slippage against 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.





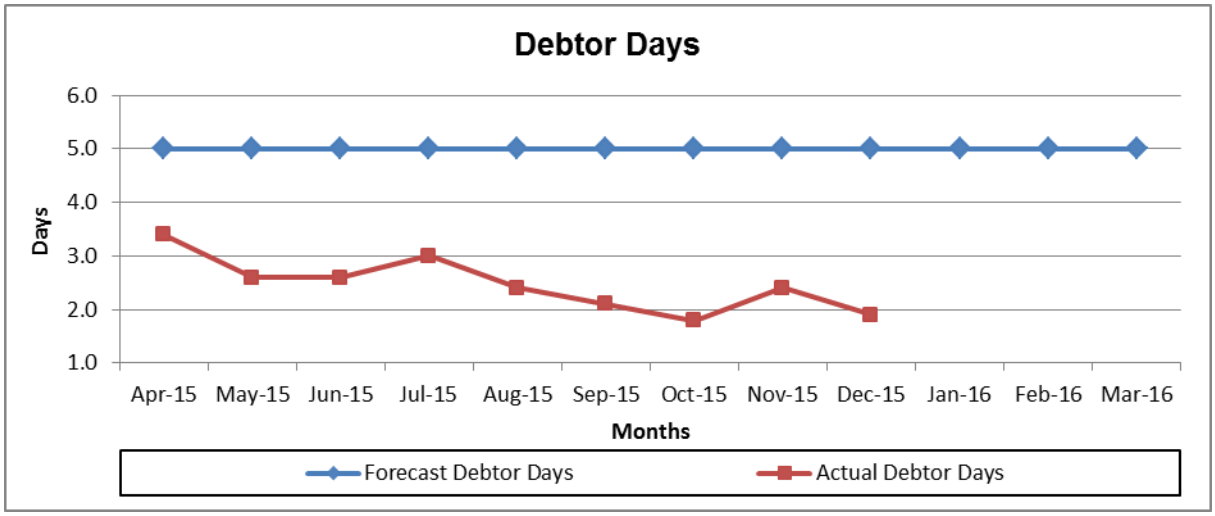


The increase within receipts and payments from October 2015 is due to additional revenue streams related to the York and Selby locality.

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

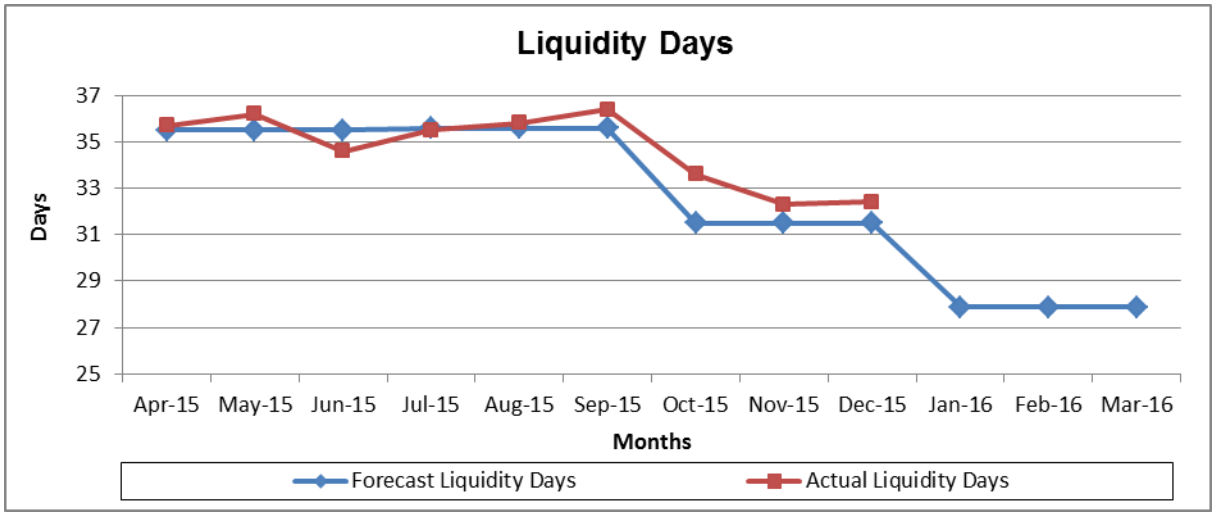
Working Capital ratios for period to 31 December 2015 were:

- Debtor Days of 1.9 days
- Liquidity of 32.4 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 74.67%
  Non NHS 30 Days – 98.78%



The Trust had a debtors' target of 5.0 days and actual performance of 1.9 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.



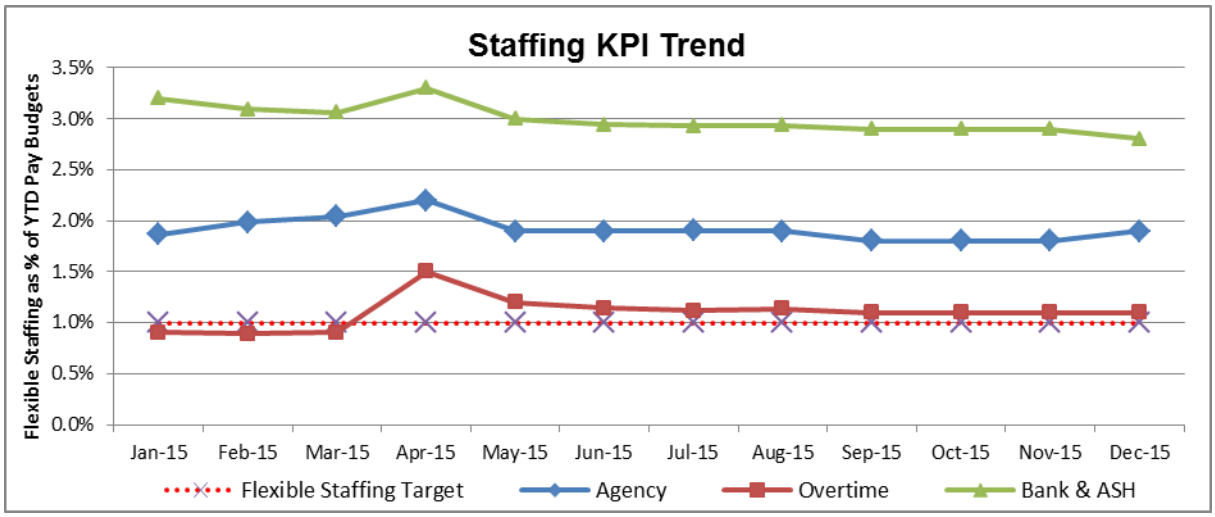
3.5 Financial Drivers

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

Tolerance	Aug	Sep	Oct	Nov	Dec
Agency (1%)	1.9%	1.8%	1.8%	1.8%	1.9%
Overtime (1%)	1.1%	1.1%	1.1%	1.1%	1.1%
Bank & ASH (flexed against establishment)	2.9%	2.9%	2.9%	2.9%	2.8%
Establishment (90%-95%)	94.3%	94.0%	94.0%	93.7%	93.0%
Total	**100.3%**	**99.8%**	**99.8%**	**99.5%**	**98.8%**

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 December 2015 the tolerance for Bank and ASH is 5.0% of pay budgets.

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



Additional staffing expenditure is 5.8% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (44%), 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 31 December 2015, 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 1.43x (can cover debt payments due 1.43 times), which is in line with plan.

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 32.4 days which 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 3.1% 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 0.3% 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 £2,123k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £24,725k is required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £4,745k is required.
- Variance from plan – to reduce to a 3 an operating surplus decrease of £708k is required.

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	1.43x	2	1.38x	2	0
Liquidity	32.4 days	4	31.5 days	4	0
I&E Margin	3.1%	4	3.0%	4	0
Variance from plan	0.3%	4	0%	4	0

Overall Financial Sustainability Risk Rating	**4.00**

3.6.7 6.9% of total receivables (£239k) 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 4.9% of total payables invoices (£523k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance set by Monitor.

3.6.9 The cash balance at 31 December 2015 is £49,609k and represents 66.0 days of annualised operating expenses.

3.6.10 Actual capital expenditure is 86% of planned expenditure to date.

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 31 December 2015 is a surplus of £5,820k, which is equivalent to 2.6% of turnover and is marginally ahead of plan.

6.2 Identified Cash Releasing Efficiency Savings at 31 December 2015 are in line with plan.

The Trust continues to identify schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for 2017/18.

6.3 The Financial Sustainability Risk Rating for the Trust is 4 for the period ending 31 December 2015.

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.

7.2 The Board of Directors are requested to approve the signing of the In Year Governance Statement confirming maintaining a financial sustainability risk rating of at least 3 in the next 12 months.

7.3 The Board of Directors are requested to approve the signing of the In Year Governance Statement confirming capital expenditure for the remainder of the financial year will not materially differ from plan.

Colin Martin
Director of Finance

Item 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th January 2016**
TITLE:	**Board Dashboard as at 31st December 2015**
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 31st December 2015 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) 13 of the 24 (54%) indicators are being reported as red in December 2015 which is a deterioration on the position in November. Of those, 5 are showing an improving trend over the last 3 months. In terms of the York and Selby Locality report 6 of the 11 (55%) indicators reported are showing as red.

The key risks identified are:

- Access – Waiting Times (KPIs 1 & 2)
- Psychological Therapies – Access (KPI 6) and Recovery (KPI 7)
- Out of Locality Admissions (KPI 12)
- Appraisal (KPI 19)
- Mandatory Training (KPI 20)

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:	**26th January 2016**
TITLE:	**Board Dashboard as at 31st December 2015**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st December 2015 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:

- Given that the Trust took over as the provider of mental health and learning disability services to the Vale of York CCG on 1st October this report now includes the following 4 Appendices:
  - The usual Dashboard report produced from the IIC in Appendix A. For most of the indicators this report does not include information relating to the York and Selby Locality as this is not available within the IIC. The exception is the 3 staffing indicators where the data relating to the staff in the York and Selby Locality are included. Whilst the figures and graphs include the York and Selby staff, the narrative provides the figures for the Trust geography pre the 1 October 2015 as well.
  - A separate dashboard for the locality of York and Selby is included within Appendix B where the information is available. It should be noted that until the services in York and Selby move over to the Trust's PARIS system in April 2016 (from the Leeds Partnership system) it will not be possible to report against all the indicators.
  - The Monitor Scorecard for Q3 is included within Appendix C. The position shown includes the York and Selby locality services.
  - The Data Quality Scorecard is included in Appendix D. This does not include an assessment of the data quality relating to the York and Selby locality. It is proposed that a data quality assessment for this is undertaken at the start of 2016/17 when the services transfer to the Trusts PARIS system.
- The Trust (including York and Selby services) achieved all of the Monitor targets for Q3.
- For the Trust (excluding the York and Selby Locality) 13 of the 24 (54%) indicators are being reported as red in December 2015 which is a deterioration on the position in November. Of those, 5 are showing an improving trend over the last 3 months. In terms of the York and Selby report 6 of the 11 (55%) indicators reported are showing as red.

The key risks are as follows:

- Access - Both waiting time targets (KPIs 1 & 2) continue to show an underperformance as at the end of December although they have not deteriorated from the November position despite there being less working days available due to the additional bank holidays in December. 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 and the services are developing a further action plan to improve the position where possible.
- Psychological Therapies - Access (KPI 6) The Trust is below target and there has been deterioration in performance. The York and Selby locality is also below target however it has improved its performance. Traditionally there is a reduction in people accessing the services over key holiday periods and this is reflected once again however the rate of the of reduction in December 2015 is less than that in previous years and performance has remained higher than that in December 2014 and 2013. Action plans to address performance issues (including recovery rates) in the different IAPT services continue to be implemented and an action plan has been developed for the York and Selby service.
- Psychological Therapies - Recovery Rate (KPI 7) Performance for the Trust continues to be below target with none of the localities delivering the target. There has, however, been an improvement from November in the Trust position excluding York and Selby. The York and Selby performance deteriorated in December when compared to November.
- Out of Locality Admissions (OoL) (KPI 12) Performance has improved in December however the Trust position (excluding York and Selby) remains one of underperformance. Only Durham and Darlington are achieving target with Teesside and North Yorkshire being over target at 22.5% and 35.94% respectively. Work is continuing in terms of identifying further actions that can be implemented to improve the position. It should be noted that the supporting indicators around number of readmissions, 3 or more admissions and median number of days between admissions have also under performed. The deep dive work, discussed previously, to further understand this performance is ongoing.
- Appraisal (KPI 19) – Performance is under target for the Trust (including York & Selby Locality) as a whole but has improved in December. The Trust figures excluding York & Selby Locality improves slightly to 83.77% from 83.75% (including York & Selby). Discussions are to be held in the Staff Domain group in terms of what more could be done to ensure that appraisals are accurately recorded in the Electronic Staff Record (ESR). Given the transfer date of staff in York and Selby onto the Trust ESR system was 1st November 2015 work is ongoing to validate the figures reported from ESR for these staff.
- Mandatory training (KPI 20) – Performance has improved significantly across the Trust (excluding York and Selby) during December from 82% to 90.8%.

2.2 **Appendix 5** provides further details of unexpected deaths. The breakdown by locality is now included.

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

	December 2015				April 2015 To December 2015			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%	84.40%			98.00%	82.64%		98.00%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	86.47%			98.00%	86.97%		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%	66.67%			50.00%	72.69%		50.00%
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	88.38%			75.00%	83.33%		75.00%
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	94.65%			95.00%	94.21%		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%	12.61%			15.00%	13.28%		15.00%
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	44.54%			50.00%	46.00%		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%	96.62%			95.00%	97.19%		95.00%
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.09%			95.00%	97.71%		95.00%
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.86%			98.00%	98.86%		98.00%
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	91.02%			85.00%	89.87%		85.00%

Trust Dashboard Summary for TRUST

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

	December 2015				April 2015 To December 2015			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%	22.54%			15.00%	17.12%		15.00%
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	23.38%			15.00%	24.70%		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)	17.00	28.00			157.00	200.00		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	115.50			146.00	114.50		146.00
16) Percentage of appointments cancelled by the Trust	0.67%	1.02%			0.67%	1.06%		0.67%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.74			9.00	12.14		12.00
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	71.11%			75.00%	74.12%		75.00%

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

	December 2015				April 2015 To December 2015			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%	83.75%			95.00%	83.75%		95.00%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.57%			95.00%	88.57%		95.00%
21) Percentage Sickness Absence Rate (month behind)	4.50%	4.77%			4.50%	4.53%		4.50%

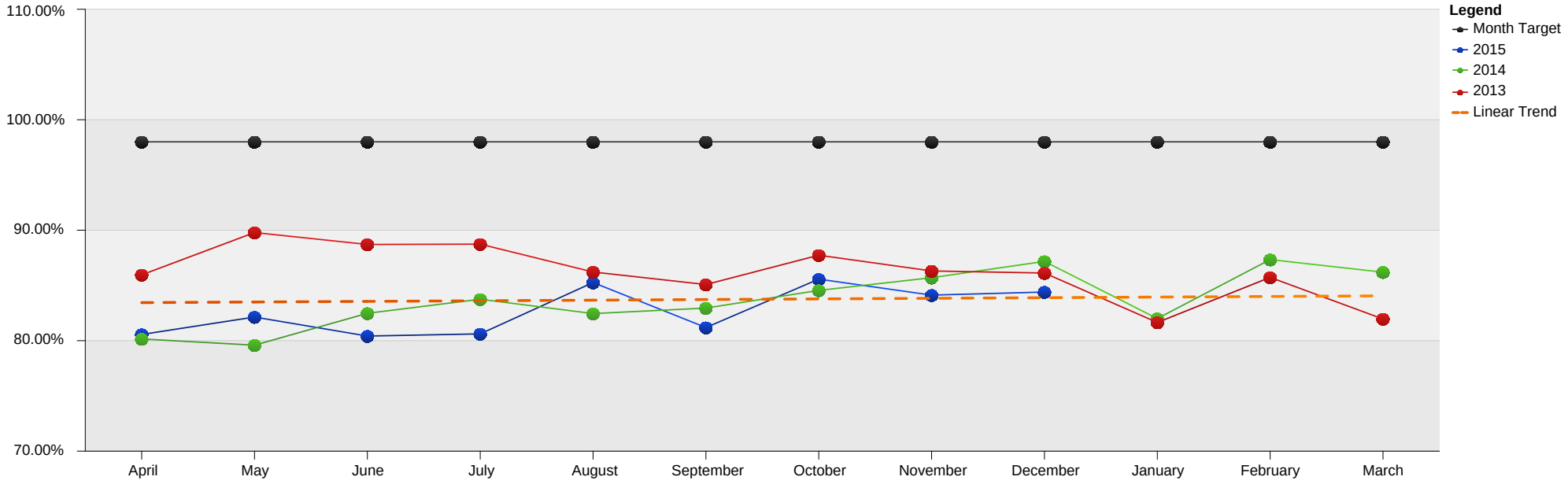
Trust Dashboard Summary for TRUST

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

	December 2015				April 2015 To December 2015			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	5,940.00	6,392.00			52,688.00	56,963.00		69,931.00
24) Delivery of our financial plan (I and E)	71,700.00	-223,000.00			-4,957,000.00	-5,820,000.00		-4,784,000.00

Trust Dashboard Graphs for TRUST

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



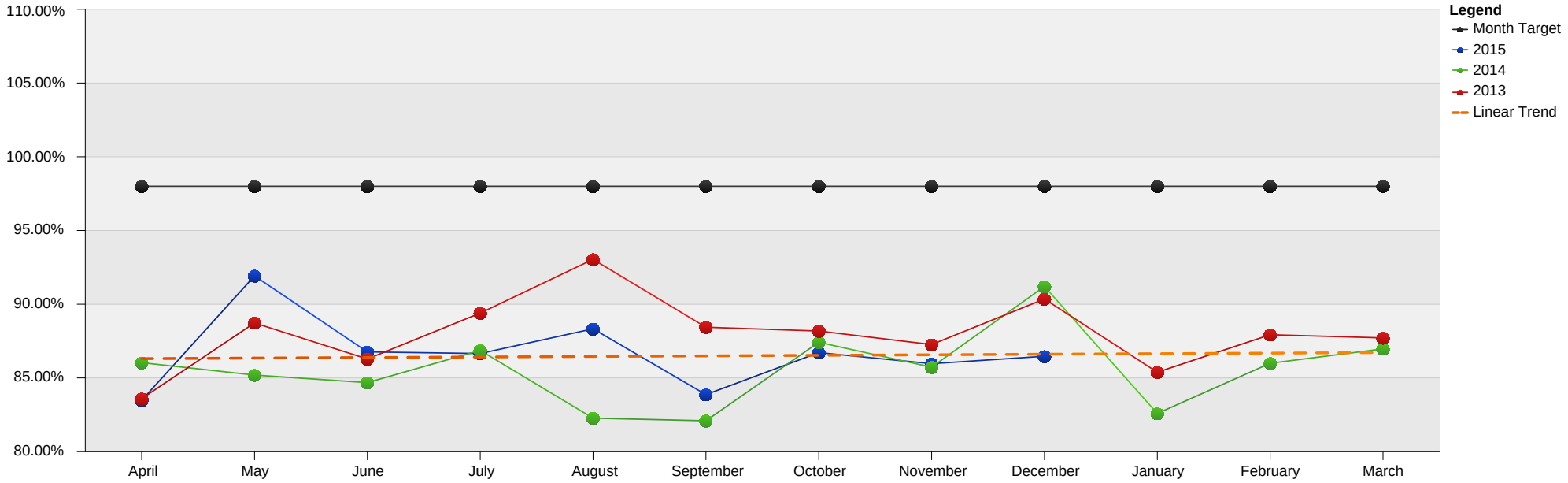
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	84.40%	82.64%	77.92%	78.14%	92.24%	89.65%	76.57%	75.00%	99.70%	99.86%		

Narrative

The Trust position December 2015 is 84.40%, which relates to 557 patients out of 3571 who had waited longer than 4 weeks for a first appointment. This is 13.60% below target, but an improvement on November 2015 performance. The Trust position for the financial year to date is 82.64%, which is 15.36% below target.The specific areas of concern are:• Durham & Darlington CYP at 29.59% (128 patients) and AMH at 78.71% (89 patients). Within CYP, staff vacancies and sickness are impacting on waiting times. In AMH there continues to be capacity issues within access teams; vacancies in this area have been filled with the exception of one.• Teesside CYP at 72.96% (63 patients). Improvements are expected by early 2016, with the Head of Service and Team Manager in Stockton to review the staff skill mix to identify what can be done to improve waiting times in that area.• North Yorkshire MHSOP at 72.20% (72 patients), CYP at 69.64% (34 patients) and LD at 71.43% (8 patients). The MHSOP action plan remains delayed due to sickness; however it is expected that staff will return in January 2016. Scarborough CYP and LD Services have also been impacted by sickness.Whilst there has been an increasing trend during this year to date, there remains a significant risk that we will not 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)



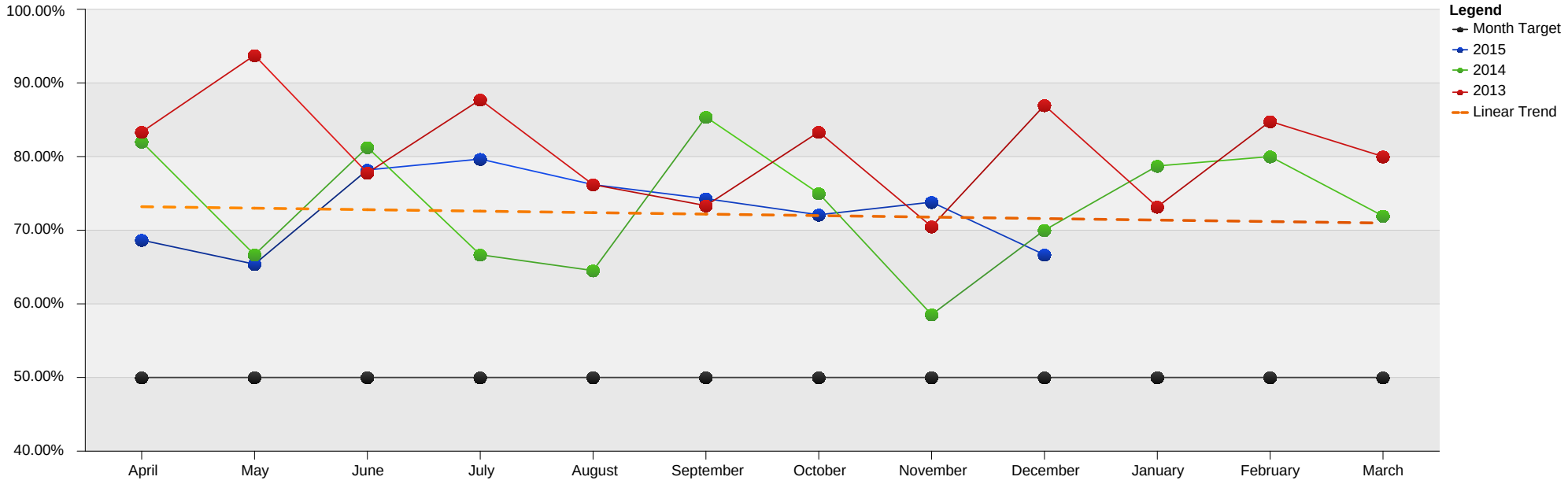
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	86.47%	86.97%	76.46%	81.53%	95.04%	92.53%	87.22%	89.73%	75.76%	53.76%		

Narrative

The Trust position for December 2015 is 86.47%, which relates to 292 patients out of 2158 that were not seen within 4 weeks of an internal referral. This is 11.53% below target but a very slight improvement on November performance. The Trust position for the financial year to date is 86.97%, which is 11.03% below target.The specific areas of concern are:• Durham & Darlington CYP at 59.38% (91 patients)• North Yorkshire LD at 66.67% (2 patients)• Forensic Learning Disability Services at 12.50% (7 patients), all of which are within autism services. High referral rates continue to impact on the capacity of the team to see patients within the 4 week target. The Directorate continues to investigate ways to improve the waiting times for this service and are discussing how to manage this most effectively with commissioners. Whilst there has been an increasing trend during this year to date, there remains a significant risk that we will not 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

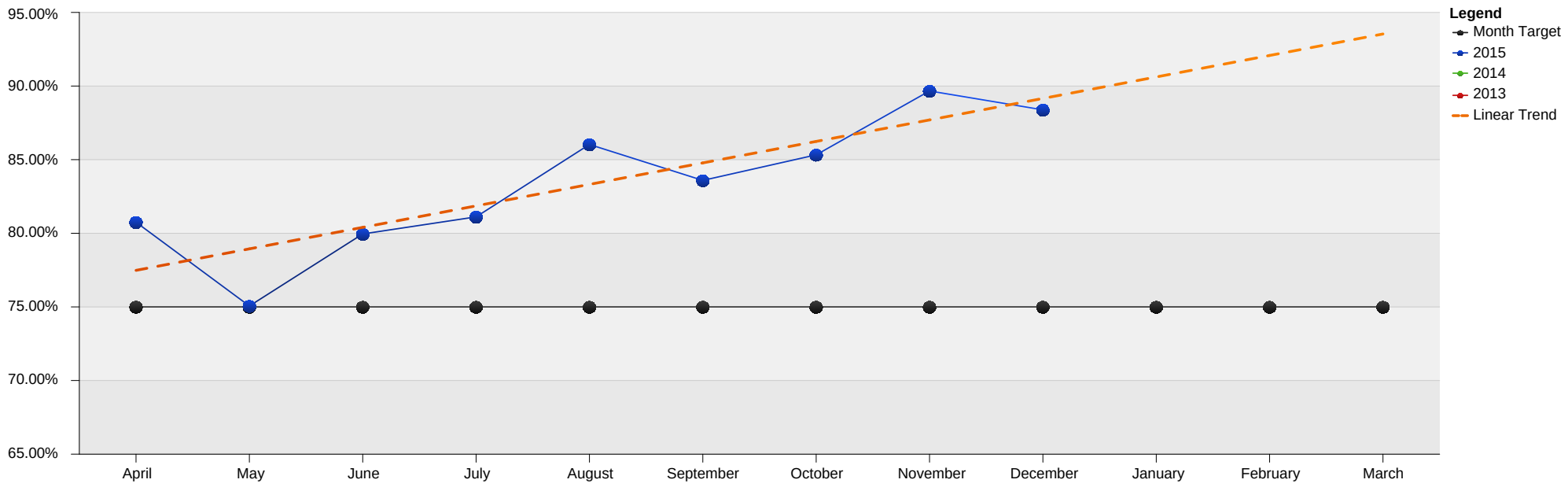


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	66.67%	72.69%	53.33%	62.50%	85.71%	81.44%	50.00%	72.84%	NA	NA		

Narrative
The Trust position for December 2015 is 66.67%, which relates to 16 patients out of 48 that were not treated within 2 weeks of referral. This is 16.67% above target but a slight deterioration on November 2015 performance. All localities are achieving target, however a decrease in performance has been seen in Durham & Darlington and North Yorkshire. In North Yorkshire assessment capacity has been impacted by vacancies and demand on the EIP teams as a result of the new EIP standards. Within Durham & Darlington, further investigations are currently underway to identify any issues. The Trust position for the financial year to date is 72.69%, which is 22.69% above target. It should be noted that the national definition for this indicator has not yet been published.Based on past performance and November'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.



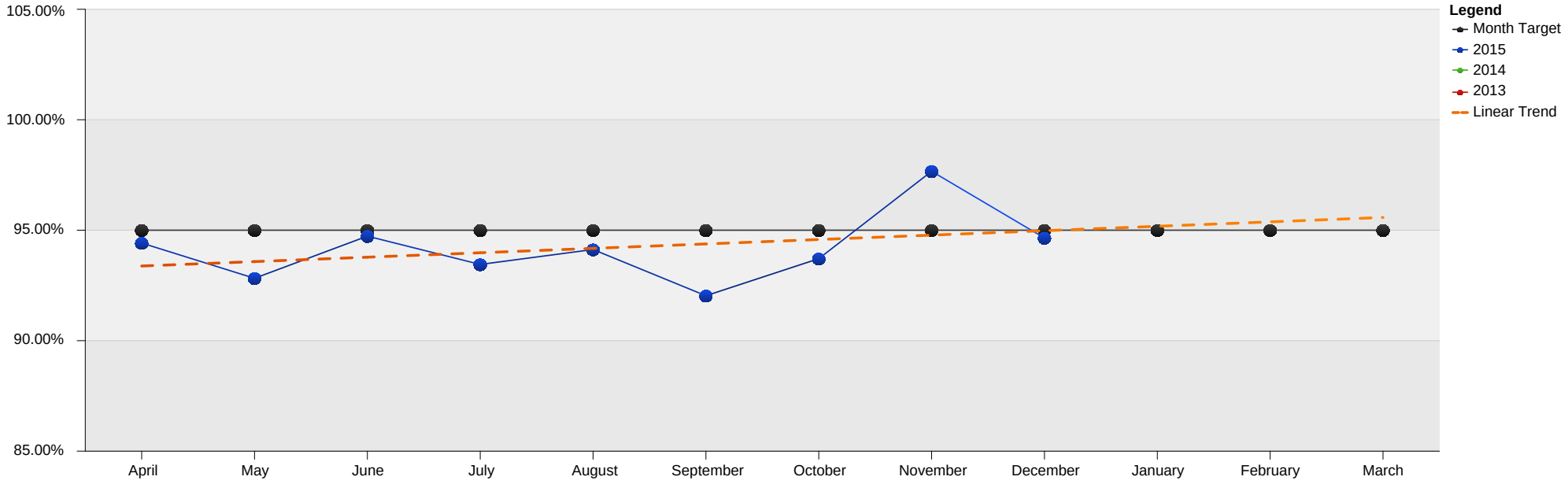
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	88.38%	83.33%	98.05%	98.42%	42.61%	56.91%	89.64%	73.19%	NA	NA		

Narrative

The Trust position for December 2015 is 88.38%, which relates to 102 patients out of 878 that were not treated within 6 weeks of referral. This is 13.38% above target but a slight deterioration on November 2015 performance. The Trust position for the financial year to date is 83.33%, which is 8.33% above target.Both Durham & Darlington (98.05%) and North Yorkshire (89.64%) report above target. Teesside reports significantly below target at 42.61% and a deterioration on November performance. All patients have now been assessed and staff are continuing to offer extra treatment slots and undertaking 5 treatment sessions per day to ensure patients are seen as soon as possible after assessment. Based on past performance, and the improving trend in performance since May 2015, 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.

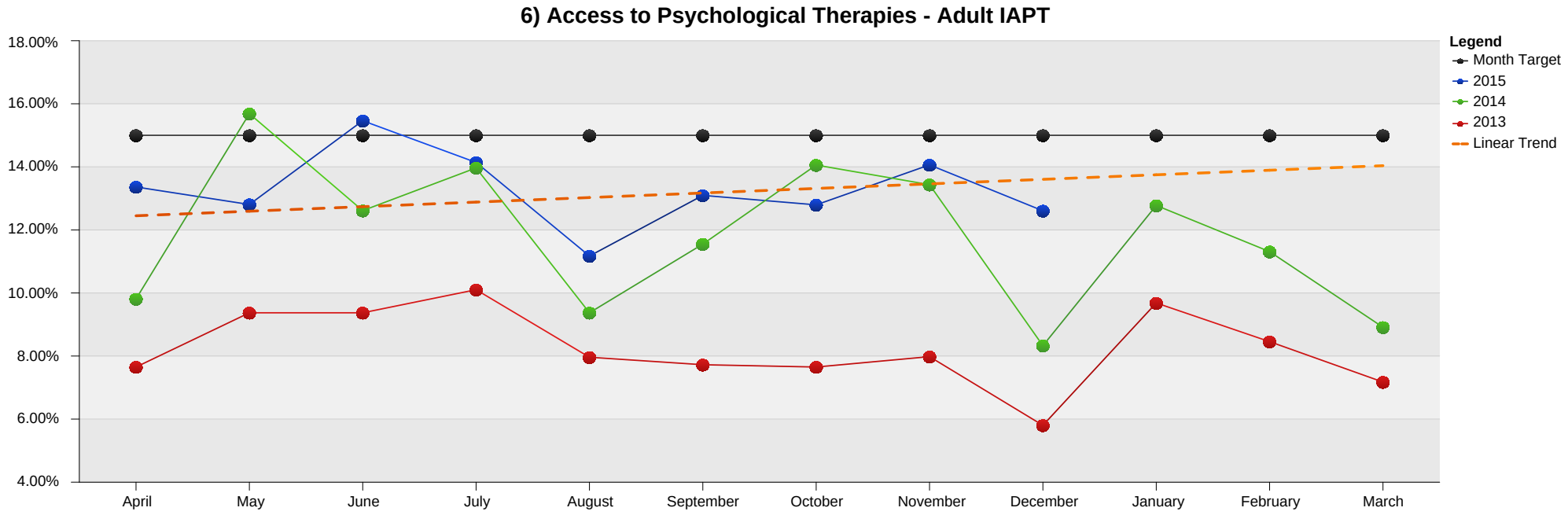


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	94.65%	94.21%	99.41%	99.80%	73.04%	79.76%	94.82%	92.96%	NA	NA		

Narrative

The Trust position for December 2015 is 94.65%, which relates to 47 patients out of 878 that were not treated within 18 weeks of referral. This is 0.35% below target and a deterioration on November 2015 performance. Only Durham & Darlington are achieving target, reporting 99.41%. The Trust position for the financial year to date is 94.21%, which is 0.79% below target.Teesside reports 73.04%. Referrals to the service ceased on 31st October. All patients have now been assessed and staff are continuing to offer extra treatment slots and undertaking 5 treatment sessions per day to ensure patients are seen as soon as possible after assessment. North Yorkshire reports 94.82% which is as a result of a deterioration in Harrogate and Rural CCG (92.75%), this is attributable to the team responding to higher levels of need if a small number of patients resulting in less capacity being available.Based on the slightly deteriorating trend during this year to date, there is a risk that we will not 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

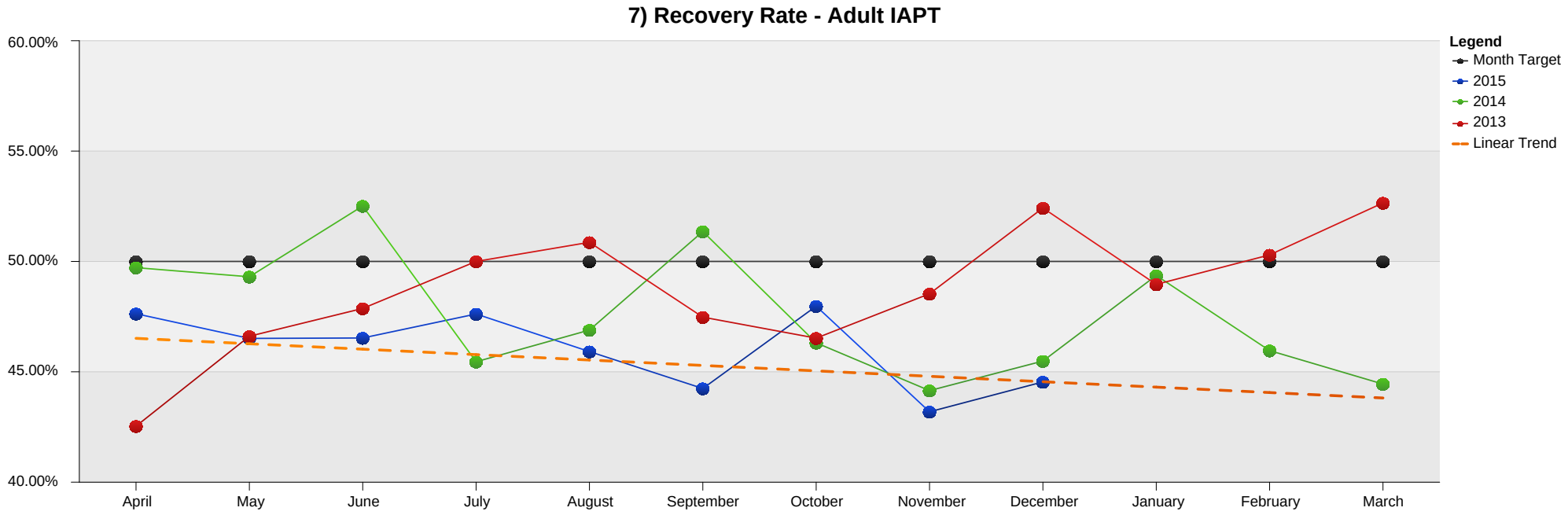


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	12.61%	13.28%	10.54%	12.54%	NA	NA	15.80%	14.42%	NA	NA		

Narrative

The Trust position for December 2015 is 12.61% which equates to 1134 people entering treatment from 8996 of the general population. This is 2.39% below the target of 15% and a deterioration on November 2015 performance. The Trust position for the financial year to date is 13.28%, which is 1.72% below target. North Durham CCG (10.80%), DDES CCG (10.21%) and Darlington CCG (10.86%) are below target. There remains a high number of referrals for step 2a treatment and Team Managers are in the process of developing a direct allocation model whilst managing waiting lists. Scarborough & Ryedale CCG (17.01%), Hambleton, Richmondshire & Whitby CCG (16.32%) and Harrogate & Rural CCG (15.63%) are above target. Vale of York CCG (6.31%) are below target. An action plan is being implemented and Improvements in referrals for Harrogate continue to be reported.A reduction in performance is always seen in December as a result of bank holidays and Christmas, however the reduction this year is less than in previous years with performance in December 2015 being higher than that in 2013 and 2014. 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%.1467

Trust Dashboard Graphs for TRUST



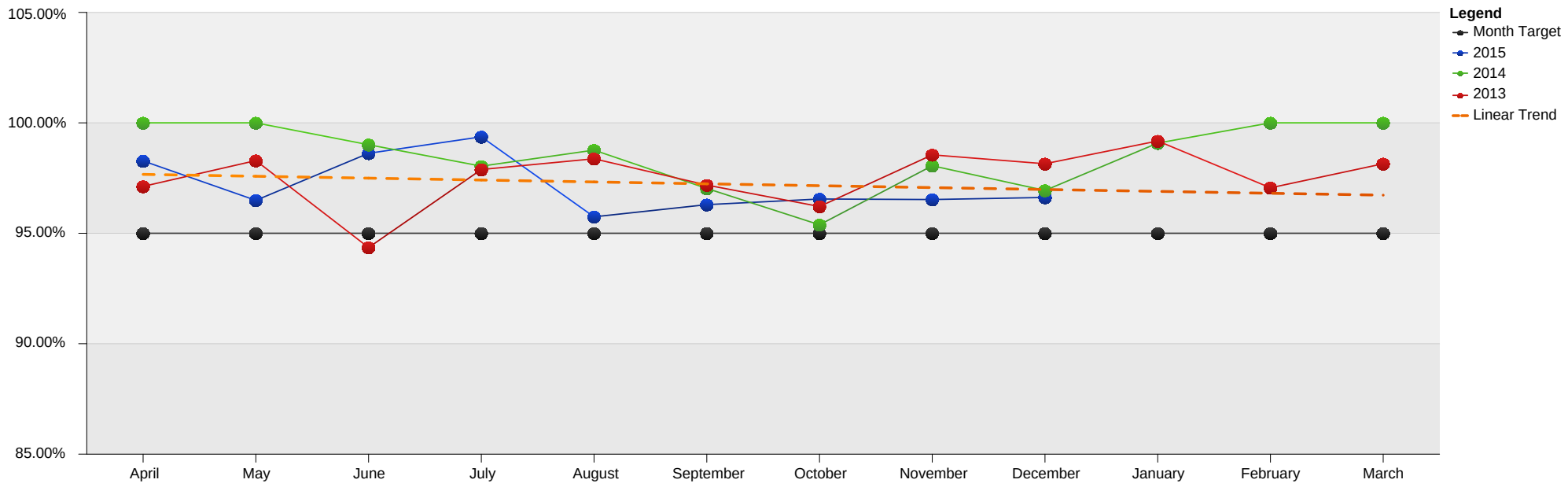
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	44.54%	46.00%	45.57%	45.07%	40.71%	45.04%	44.35%	48.10%	NA	NA		

Narrative

The Trust position for December 2015 is 44.54%, with 447 people out of 806 not achieving recovery. This is 5.46% below the target of 50% and a slight improvement on November performance. All localities are failing to achieve target. The Trust position for the financial year to date is 46%, which is 4% below target.North Durham CCG (47.69%) and DDES CCG (43.85%) have reported deteriorations in performance, whilst Darlington CCG (46%) has reported an improvement. An action plan has been developed and allocation processes reviewed to ensure patients move thorough the system effectively.Hartlepool and Stockton CCG (44.54%) has reported a deterioration whilst South Tees CCG (44.90%) report improvements in performance. The action plan concerning recovery, which is agreed with commissioners, is being implemented. Harrogate & Rural CCG (41.67%) have reported a deterioration, whilst Hambleton, Richmondshire & Whitby CCG (47.44%), and Scarborough & Ryedale CCG (41.67%) have improved. To improve recovery in North Yorkshire, the CCGs have agreed for the national IAPT Intensive Support Team to become involved in a review of recovery and waiting times, dates for this are to be confirmed. Although December has improved,, 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

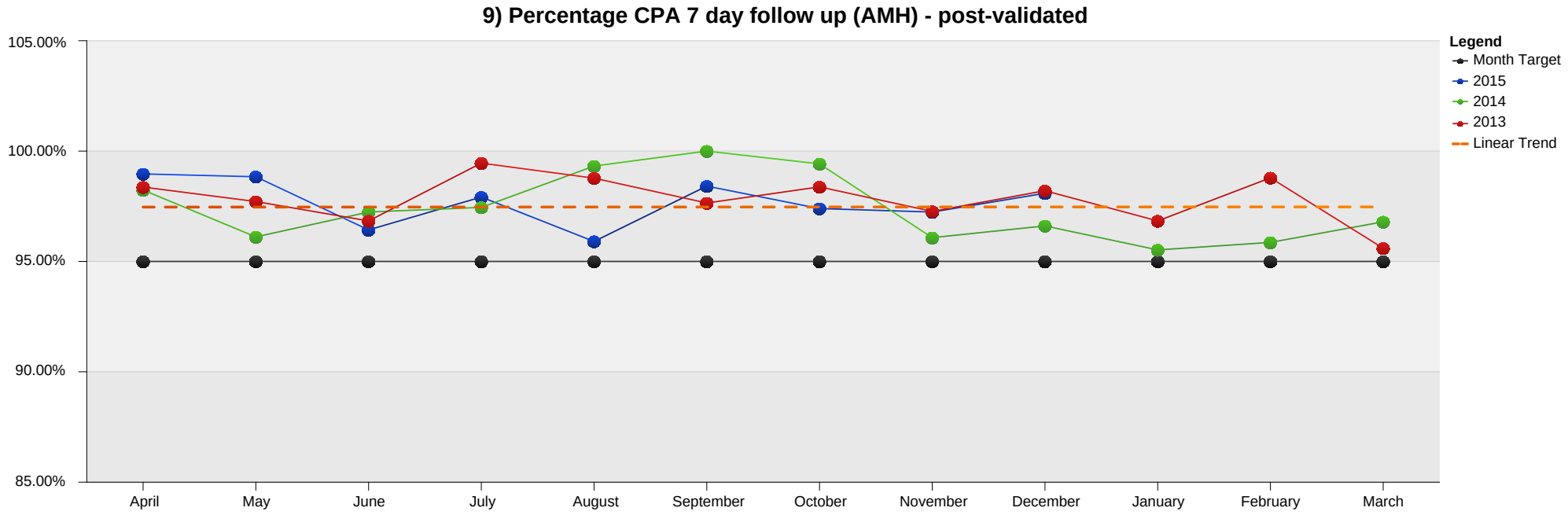
8) People seen by Crisis Services before admission - post-validated



	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	96.62%	97.19%	94.34%	96.31%	98.51%	97.36%	96.43%	97.99%	NA	NA		

Narrative
The Trust post validated position for December 2015 is 96.62%, which relates to 5 patients out of 148 that were not seen by a Crisis Home Treatment Team prior to admission. This is 1.62% above the target and a slight improvement on November's performance. The Trust post validated position for the financial year to date is 97.19%, which is 2.19% above target.Whilst performance during this financial year to date has reported a deteriorating trend, 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

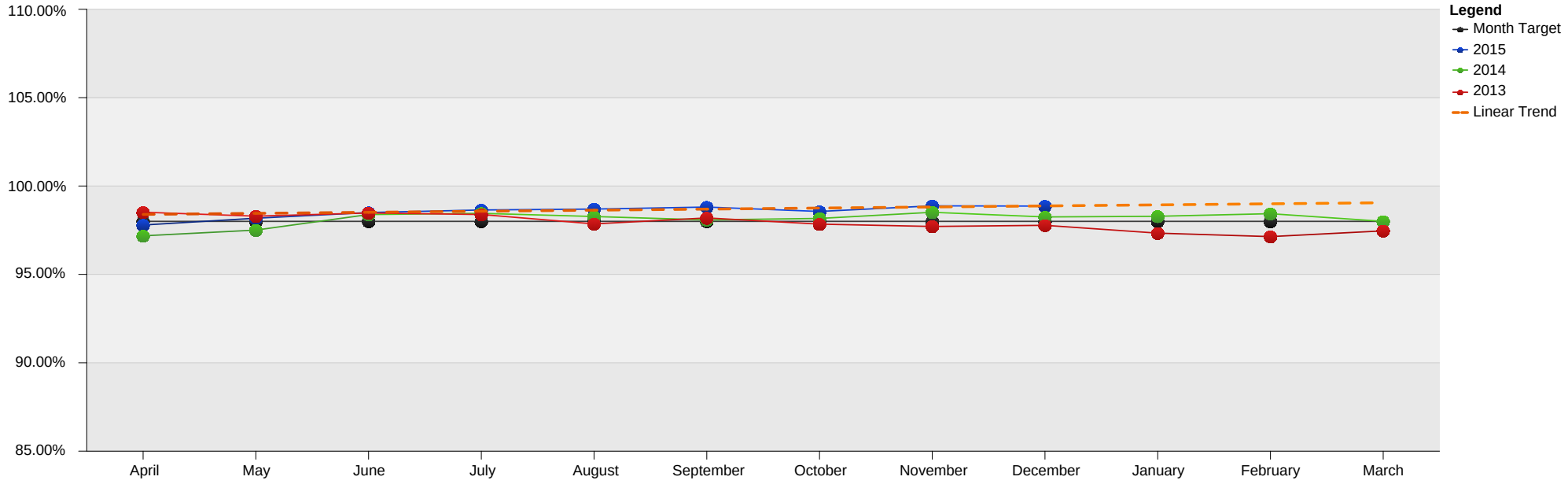


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) Percentage CPA 7 day follow up (AMH) - post-validated	98.09%	97.71%	98.46%	97.98%	98.44%	98.26%	96.43%	96.18%	NA	NA		

Narrative
The Trust post validated position for December 2015 is 98.09% which relates to 3 patients out of 157 that were not followed up within 7 days of discharge. This is 3.09% above the target and a slight improvement on November performance. The Trust post validated position for the financial year to date is 97.71%, which is 2.71% 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

10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)



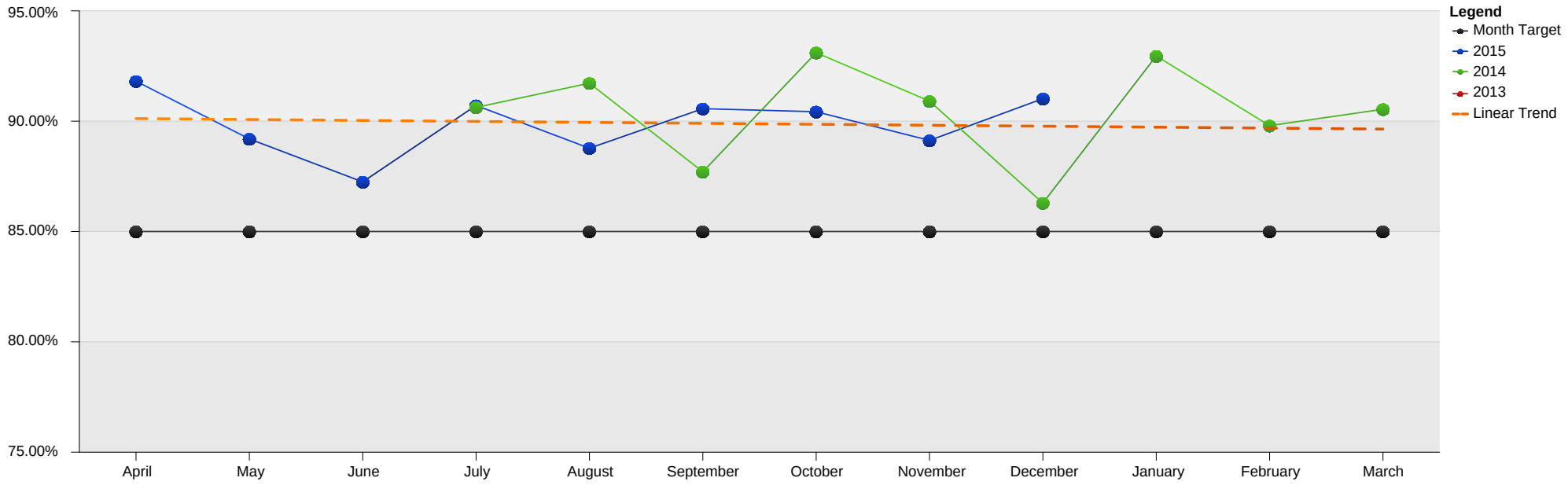
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.86%	98.86%	98.69%	98.69%	99.85%	99.85%	97.84%	97.84%	100.00%	100.00%		

Narrative

The Trust position for December 2015 is 98.86% which relates to 46 patients out of 4047 that had not had a formal review documented within 12 months. This is 3.86% above the Monitor target of 95%, 0.86% above the Trust target of 98% and the same as November's performance. All localities are achieving target with the exception of North Yorkshire who are 0.16% below target.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)



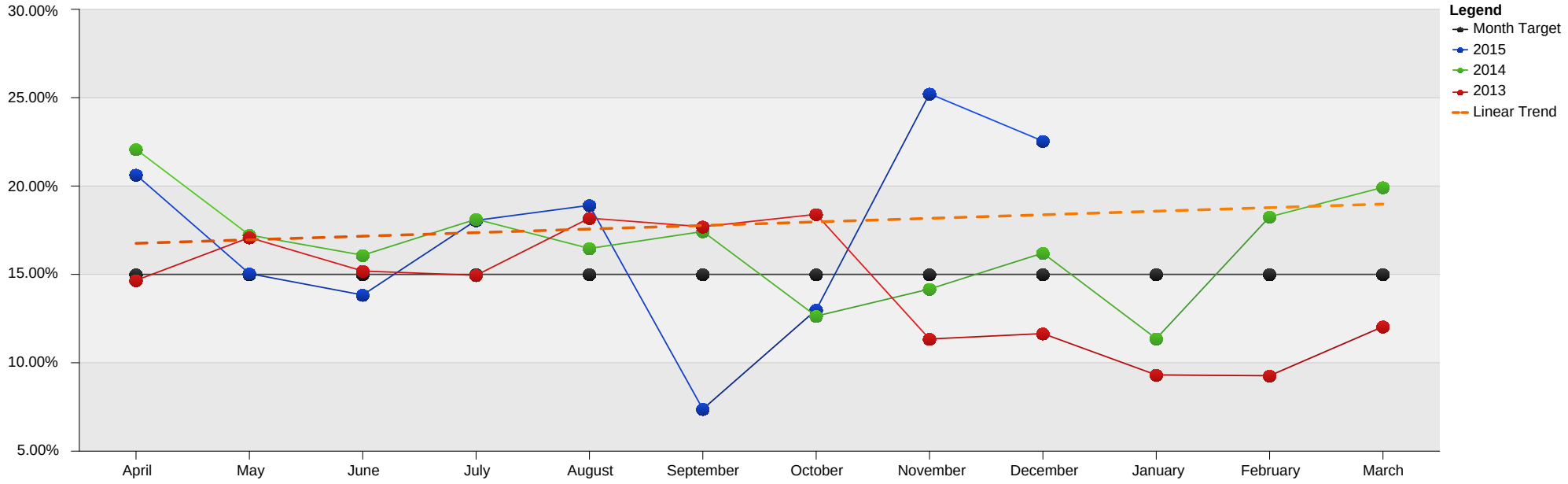
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	91.02%	89.87%	87.25%	89.38%	94.68%	90.95%	86.15%	87.74%	66.67%	89.47%		

Narrative

The position reported in December 2015 relates to November performance. The Trust position for November 2015 is 91.02%, which relates to 59 patients out of 657 that state they have not been involved in the development of their care plan. This is 6.02% above the target of 85% and a slight improvement on the performance reported for October. The Trust position for the financial year to date is 89.87%, which is 4.87% 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

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



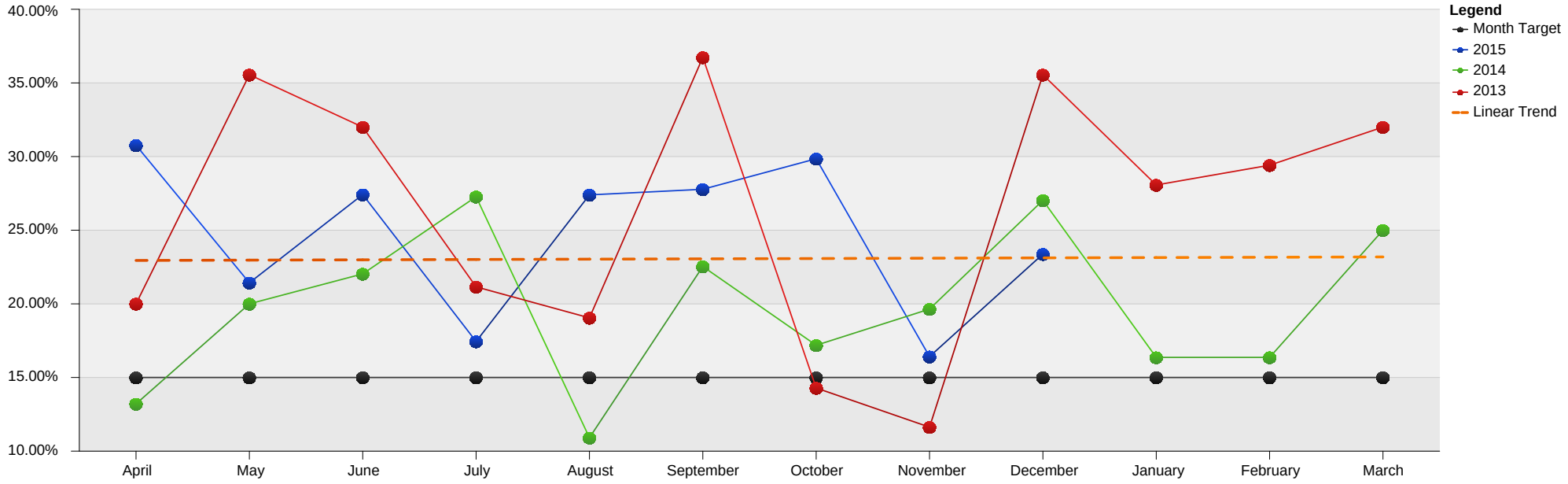
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	22.54%	17.12%	13.33%	17.04%	22.47%	10.65%	35.94%	26.55%	NA	NA		

Narrative

The Trust position for December 2015 is 22.38%, which relates to 55 admissions out of 244 that were admitted to assessment and treatment wards out of locality. This is 7.38% above the target of 15% but an improvement on the position reported in November. Only Durham and Darlington (13.33%) are below target. Tees are reporting 22.47% and North Yorkshire 35.94%. The Trust position for the financial year to date is 17.12%, which is 2.12% above target.Of the 55 patients admitted to an 'out of locality' bed, all were due to no beds being available at their local hospital (AMH 27, MHSOP 28). The localities continue to investigate ways in which they can reduce OOL admissions.Although there is an improvement on the November position and a reverse in the increasing trend since September, there is a significant 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)



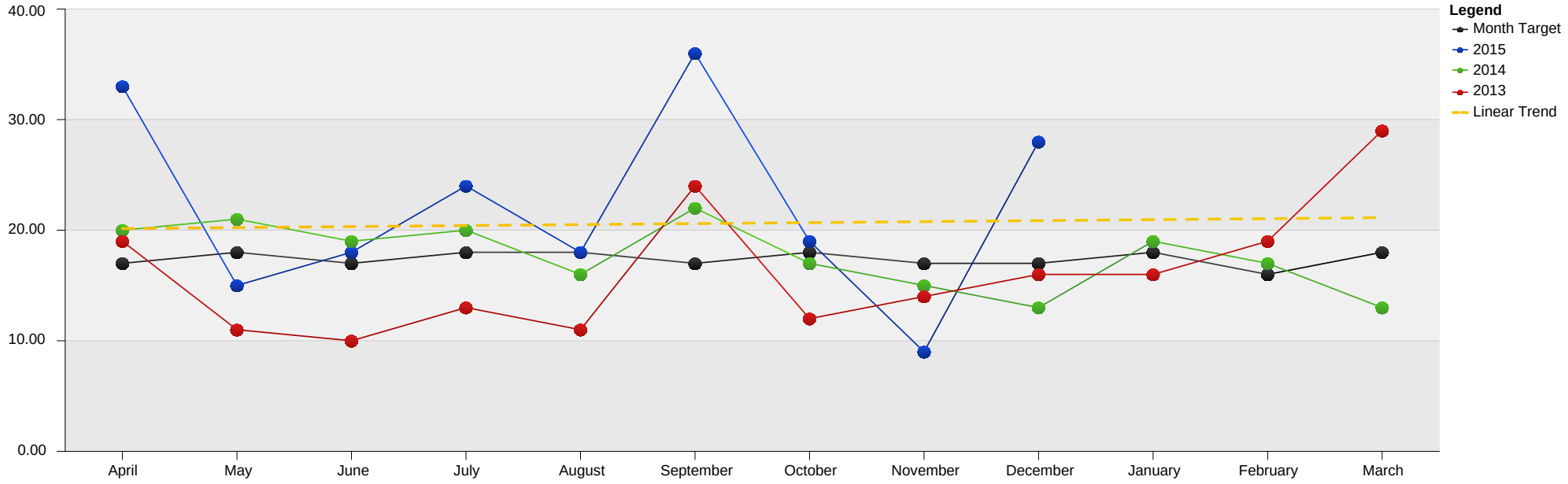
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	23.38%	24.70%	25.00%	22.87%	31.82%	22.42%	15.38%	28.99%	NA	NA		

Narrative

The Trust position for December 2015 is 23.38%, which relates to 18 patients out of 77 that were readmitted within 30 days. This is 10.38% above the target of 15% and a significant deterioration on the position reported in November. The Trust position for the financial year to date is 24.70%, which is 9.70% above target.All of the 18 readmissions were within AMH Services:• 7 (38.89%) were within Durham & Darlington • 7 (38.89%) were within Teesside.• 4 (22.22%) 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. No particular patterns or trends in terms of wards or community teams have been identified. The services are completing a more in depth review in this area. 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)



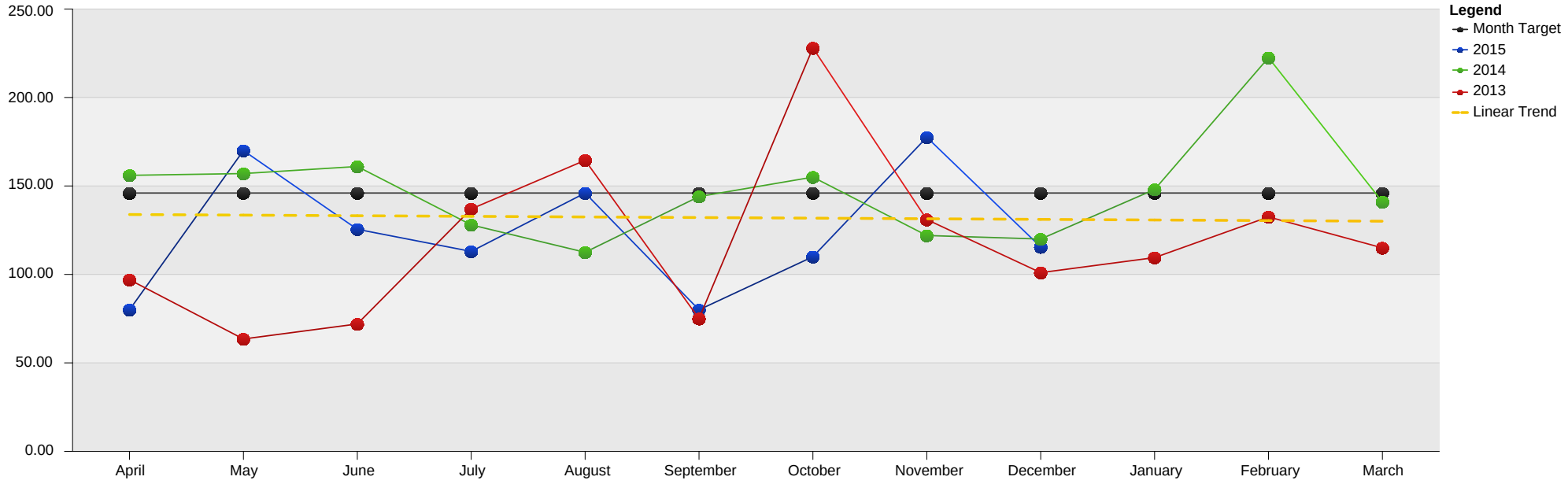
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	28.00	200.00	8.00	70.00	9.00	58.00	11.00	72.00	NA	NA		

Narrative

The Trust position for December 2015 is 28, which is 11 above the target of 17 and a significant deterioration on the position reported in November. All localities are below target. The Trust position for the financial year to date is 200, which is 43 above target.Of the 28 patients• 8 (28.57%) were within Durham & Darlington (AMH)• 9 (32.14%) were within Teesside (8 AMH, 1 MHSOP)• 11 (39.39%) were within North Yorkshire (7 AMH, 4 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. No particular patterns or trends in terms of wards or community teams have been identified. The services are completing a more in depth review in this area.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

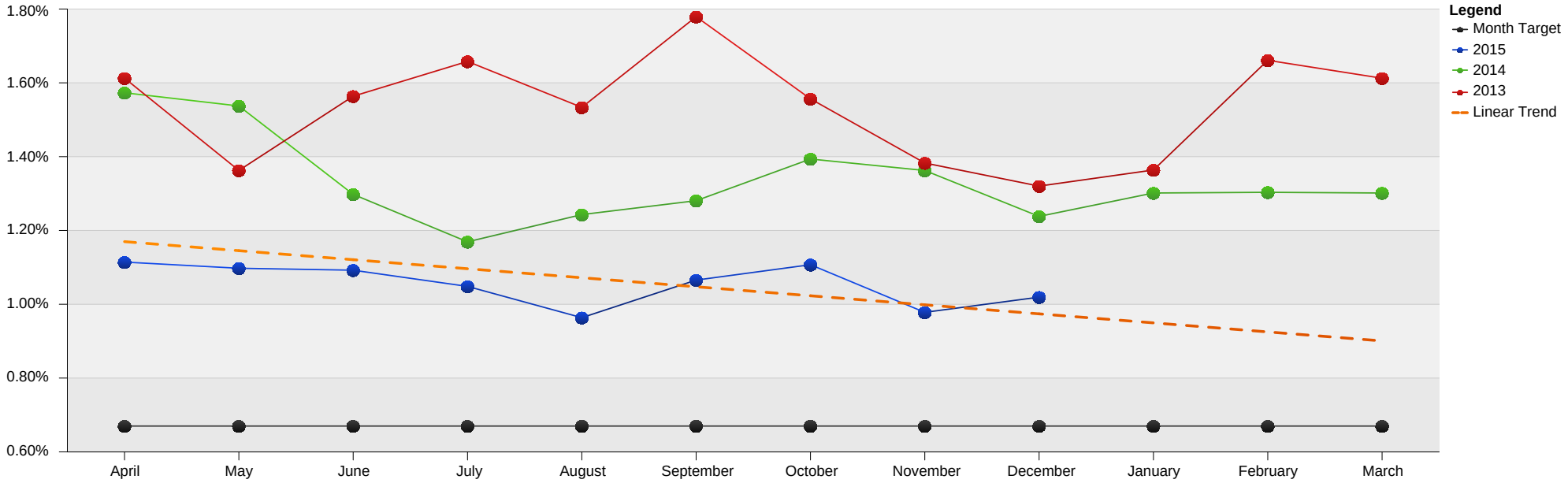


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	115.50	114.50	98.00	120.00	130.50	140.00	152.50	80.00	NA	NA		

Narrative
The Trust position for December 2015 is 115.50, which is 31 below the target of 146 and a significant deterioration on November performance. The Trust position for the financial year to date is 114.50, which is 31.50 below 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



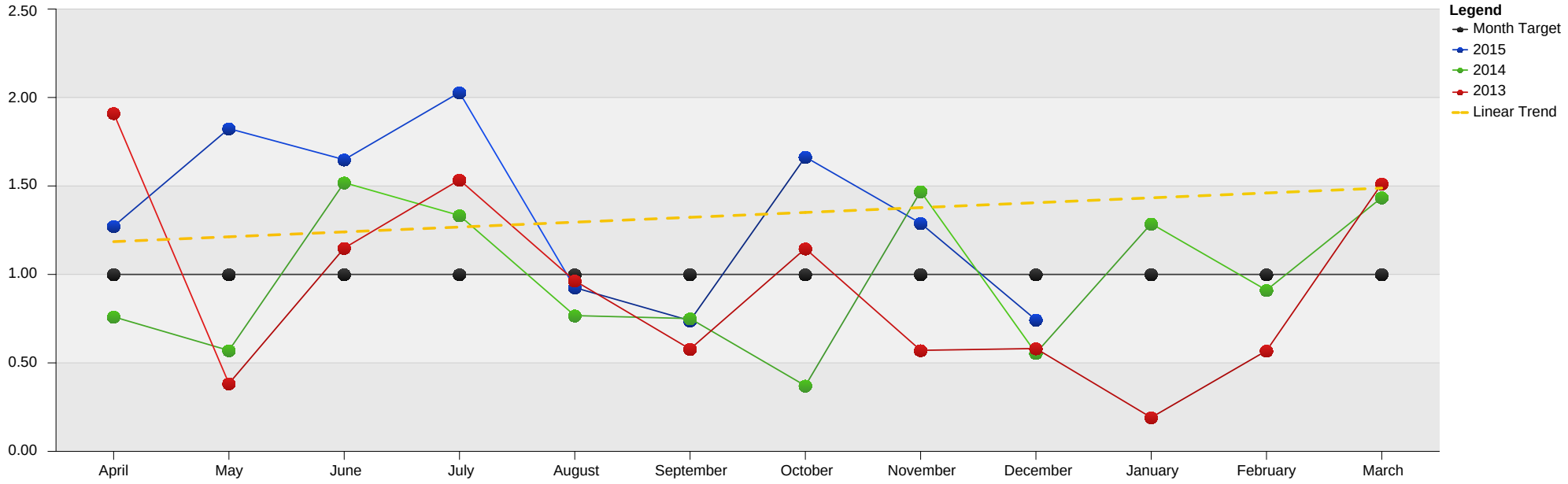
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of appointments cancelled by the Trust	1.02%	1.06%	0.97%	1.06%	0.88%	1.00%	1.43%	1.28%	0.07%	0.09%		

Narrative

The Trust position for December 2015 is 1.02%, which relates to 718 appointments out of 70,442 that have been cancelled. This is 0.35% above the target of 0.67% and a slight deterioration compared to November performance. The Trust position for the financial year to date is 1.06%, which is 0.39% above target. Only Forensic services are achieving target.The new outcome codes for PARIS have been developed and cascaded throughout the Trust to enable a greater understanding of the reasons for cancellations. It has been identified that some of these cancellations may be due to how some cancelled appointments are being incorrectly recorded; the Information Service Managers in all localities are continuing to work with services to resolve.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



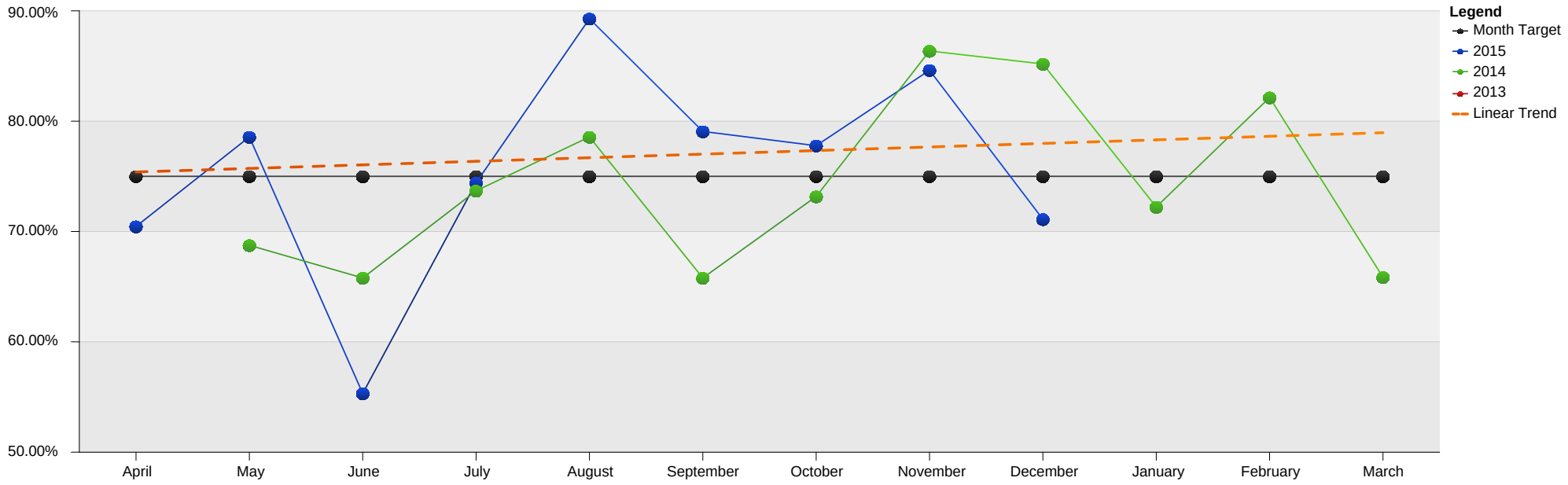
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.74	12.14	0.00	10.07	1.86	11.58	0.82	16.40	0.00	25.72		

Narrative

The Trust position for December 2015 is 0.74, which is 0.26 below the target of 1.00 but an improvement on November performance. This rate relates to 4 unexpected deaths, 3 in Teeside and I in North Yorkshire Services. The Trust position for the financial year to date is 12.14, which is 3.14 above target.Performance had improved; however the number of deaths classed as serious incidents has primarily been higher than the equivalent months in 2014/15 & 2013/14 and based on this there is a risk that we will not achieve 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)

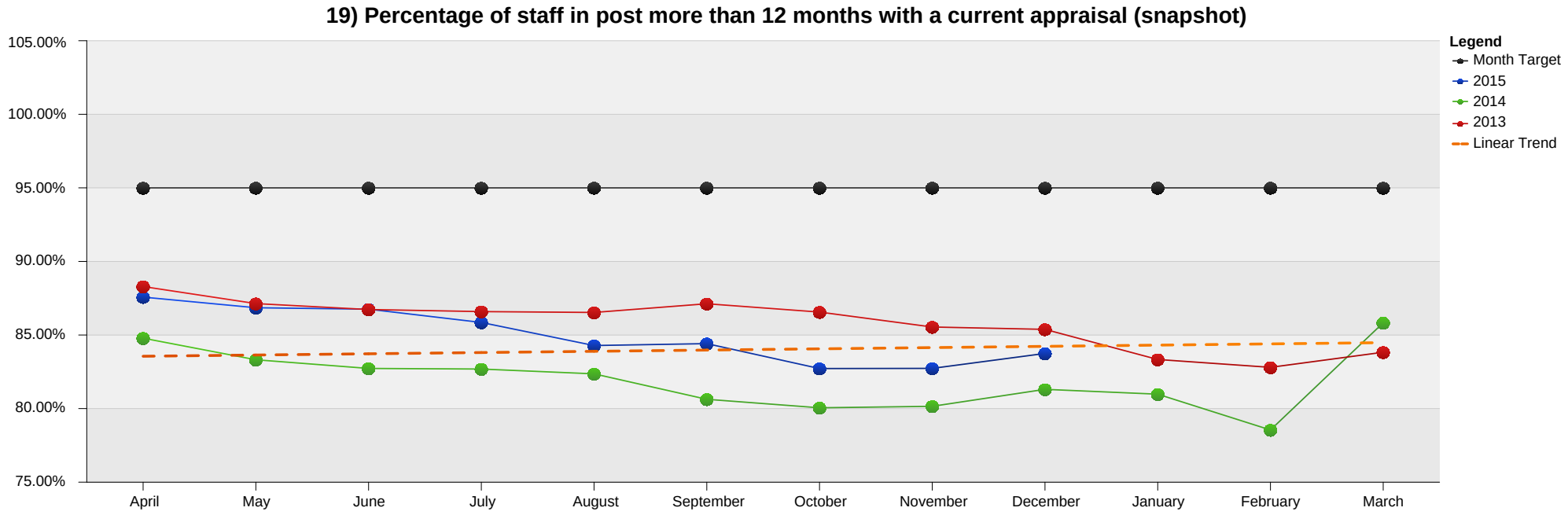


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	71.11%	74.12%	88.89%	87.00%	90.91%	87.64%	50.00%	68.75%	56.25%	41.33%		

Narrative

The Trust position reported in December relates to November performance. The Trust position for November 2015 is 71.11% with 11 wards out of 45 surveyed not scoring higher than 80%. This is 3.89% below the target of 75.00% and a deterioration on October's position. Durham & Darlington 88.89% and Teesside 90.91% are achieving target. The Trust position for financial year to date is 74.12%, which is 0.88% below target.North Yorkshire are reporting 50% (4 wards) and Forensics are reporting 56.25% (5 wards).All teams are monitoring surveys and work closely with Patient Experience to investigate any trends. The position within Forensics is largely attributable to the low numbers of surveys that patients are returning. Discussions continue within the service as to how this can be improved, as given the inherent nature of forensic patients being detained it is less likely that that they will be positive about their experiences. Performance at Trust level is reporting a slightly improving trend, should this continue there is a possibility that 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

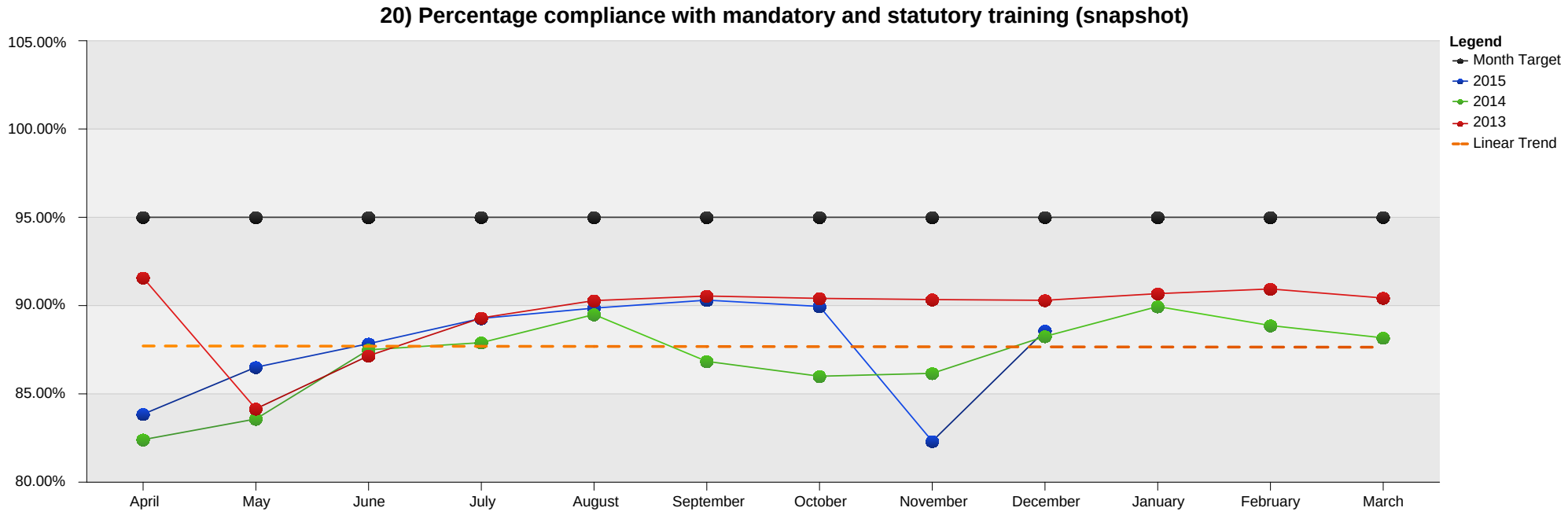


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	83.75%	83.75%	80.34%	80.34%	87.79%	87.79%	82.39%	82.39%	88.40%	88.40%	50.00%	50.00%

Narrative

The Trust position for December 2015 is 83.75% which relates to 839 members of staff out of 5162 that do not have a current appraisal. This is 11.25% below the target of 95%; this represents a slight improvement on the figure reported in November. 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. 7 staff had their pay progression withheld at the end of December due to non-compliance of mandatory training and/or appraisal; 15 staff are due to have their increment withheld at the end of January. Despite performance consistently reporting higher than that during 2014/15, based on the deteriorating trend and December'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%.

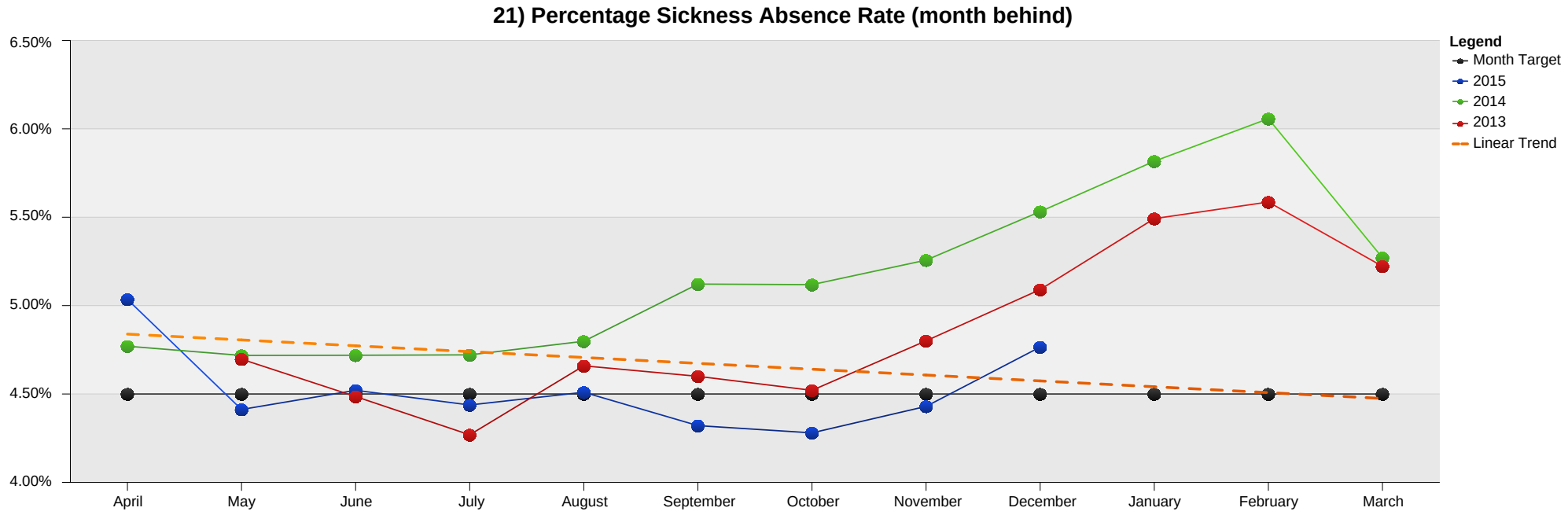
Trust Dashboard Graphs for TRUST



	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)	88.57%	88.57%	88.73%	88.73%	91.98%	91.98%	87.13%	87.13%	91.88%	91.88%	65.61%	65.61%

Narrative
The position for December 2015 is 88.57%. This is 6.43% below the target of 95% and an improvement on November 2015 performance. The reported figure includes York and Selby. Reports have been produced and are currently being validated by York and Selby operational services. The compliance figure is 90.84% when York and Selby figures are excluded. This is an improvement on the 82.43% achieved in November.Work is currently underway to identify how the IIC can be developed to further enhance the available HR related information. Potential developments include appraisal and mandatory & statutory training reports for Managers that highlight competencies that are due to expire, in addition to those that have already expired. 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



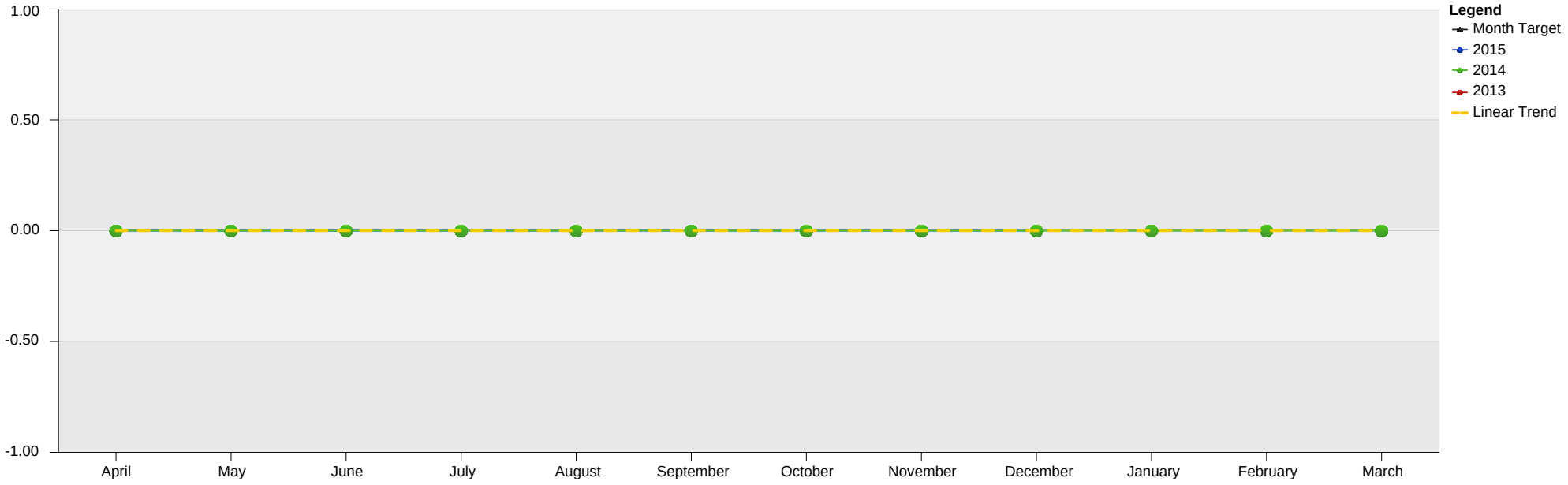
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Percentage Sickness Absence Rate (month behind)	4.77%	4.53%	4.44%	4.41%	5.74%	4.95%	5.26%	4.42%	4.65%	5.85%	6.46%	6.34%

Narrative

The Trust position reported in December relates to the November sickness level. The Trust position reported in December 2015 is 4.77%, which is 0.27% above the Trust target of 4.50% and a slight deterioration on November 2014. The Trust position for the financial year to date is 4.53%. The figure includes York and Selby sickness information. The figures reduce to 4.59% when York and Selby information is excluded. This is a deterioration on the 4.36% achieved in November. The figure reported is significantly below the sickness rate recorded for the same period last year which was 5.7%. Historically higher levels of sickness are reported between December and February. Should this occur, there is a risk that we will not achieve the annual target of 4.50%.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 5.12%.

Trust Dashboard Graphs for TRUST

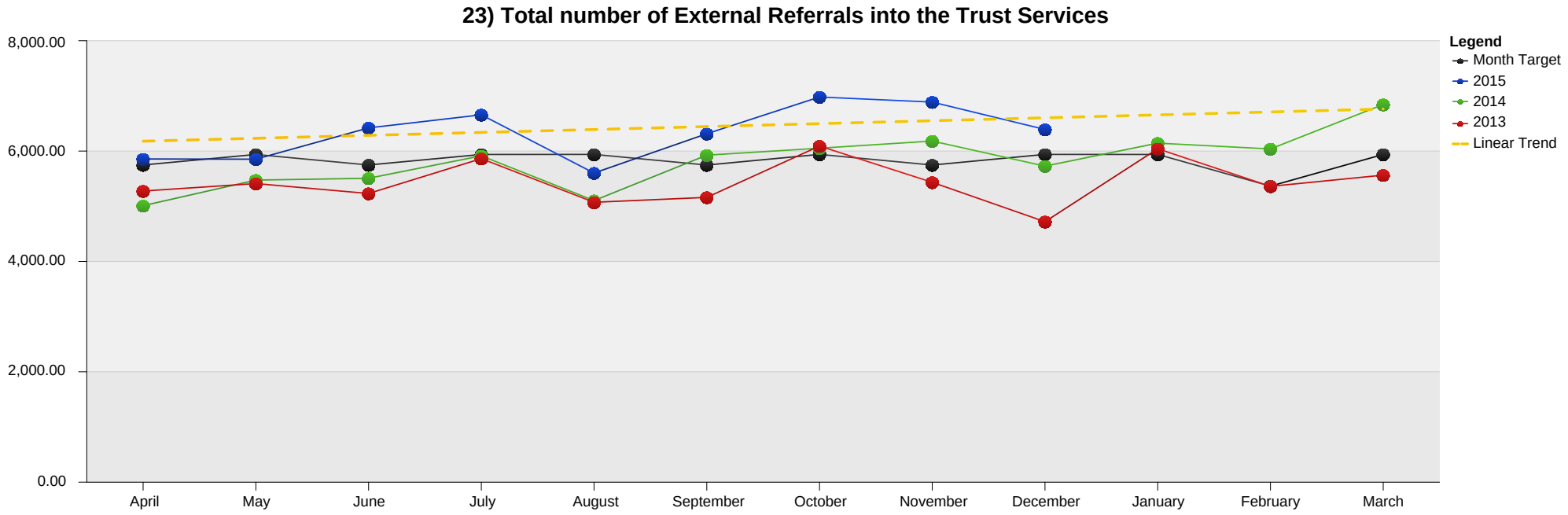
22) Number of reds on CQC action plans (including MHA action plans)



	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 December 2015 is zero, which is consistent with 2014/15 reporting.Based on past performance and December's performance, it is anticipated that we will achieve the annual target.The annual outturn for 2014/15 was 0.

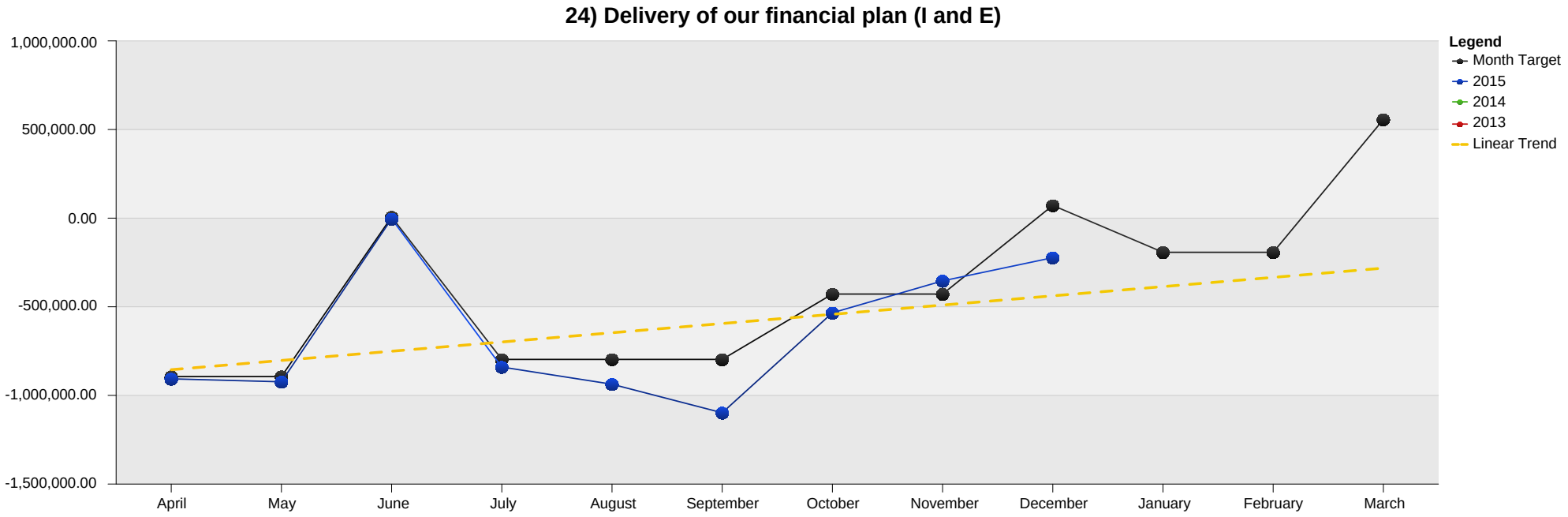
Trust Dashboard Graphs for TRUST



	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	6,392.00	56,963.00	1,859.00	17,272.00	1,705.00	17,754.00	1,941.00	16,873.00	887.00	5,046.00		

Narrative
The Trust position for December 2015 is 6,392, which is 452 above the Trust target of 5,940 but a decrease on the number received in November. This decrease is often the case in December as a result of Bank Holidays. The Trust position for the financial year to date is 56,963 which is 4,275 above target. This increase in referrals is in line with patterns in previous years and should this continue it can be expected that referrals will rise as the year progresses and we will receive more external referrals than the expected number of 69,931.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)	-223,000.00	-5,820,000.00	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The Trust achieved a surplus of £5,820k for the financial year to date period ending 31 December 2015 which is equivalent to 2.6% of turnover and is marginally ahead of plan. The forecast outturn for the Trust is a surplus of £4,908k which is £124k ahead of plan due to non-recurrent surplus' in Corporate Services and higher than planned contract income. This is offsetting deficits due to a combination of non-delivery of CRES schemes (particularly in the Durham and Darlington Locality) and flexible staffing expenditure across clinical localitiesData only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

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

	December 2015												April 2015 To December 2015											
	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%	84.40%	98.00%	77.92%	98.00%	92.24%	98.00%	76.57%	98.00%	99.70%			98.00%	82.64%	98.00%	78.14%	98.00%	89.65%	98.00%	75.00%	98.00%	99.86%		
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	86.47%	98.00%	76.46%	98.00%	95.04%	98.00%	87.22%	98.00%	75.76%			98.00%	86.97%	98.00%	81.53%	98.00%	92.53%	98.00%	89.73%	98.00%	53.76%		
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%	66.67%	50.00%	53.33%	50.00%	85.71%	50.00%	50.00%	NA	NA			50.00%	72.69%	50.00%	62.50%	50.00%	81.44%	50.00%	72.84%	NA	NA		
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	88.38%	75.00%	98.05%	75.00%	42.61%	75.00%	89.64%	NA	NA			75.00%	83.33%	75.00%	98.42%	75.00%	56.91%	75.00%	73.19%	NA	NA		
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	94.65%	95.00%	99.41%	95.00%	73.04%	95.00%	94.82%	NA	NA			95.00%	94.21%	95.00%	99.80%	95.00%	79.76%	95.00%	92.96%	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%	12.61%	15.00%	10.54%	NA	NA	15.00%	15.80%	NA	NA			15.00%	13.28%	15.00%	12.54%	NA	NA	15.00%	14.42%	NA	NA		
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	44.54%	50.00%	45.57%	50.00%	40.71%	50.00%	44.35%	NA	NA			50.00%	46.00%	50.00%	45.07%	50.00%	45.04%	50.00%	48.10%	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%	96.62%	95.00%	94.34%	95.00%	98.51%	95.00%	96.43%	NA	NA			95.00%	97.19%	95.00%	96.31%	95.00%	97.36%	95.00%	97.99%	NA	NA		
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.09%	95.00%	98.46%	95.00%	98.44%	95.00%	96.43%	NA	NA			95.00%	97.71%	95.00%	97.98%	95.00%	98.26%	95.00%	96.18%	NA	NA		
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.86%	98.00%	98.69%	98.00%	99.85%	98.00%	97.84%	98.00%	100.00%			98.00%	98.86%	98.00%	98.69%	98.00%	99.85%	98.00%	97.84%	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%	91.02%	85.00%	87.25%	85.00%	94.68%	85.00%	88.15%	85.00%	66.67%			85.00%	89.87%	85.00%	89.38%	85.00%	90.95%	85.00%	87.74%	85.00%	89.47%		

Trust Dashboard - Locality Breakdown for TRUST

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

	December 2015												April 2015 To December 2015											
	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%	22.54%	15.00%	13.33%	15.00%	22.47%	15.00%	35.94%	NA	NA			15.00%	17.12%	15.00%	17.04%	15.00%	10.65%	15.00%	26.55%	NA	NA		
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	23.38%	15.00%	25.00%	15.00%	31.82%	15.00%	15.38%	NA	NA			15.00%	24.70%	15.00%	22.87%	15.00%	22.42%	15.00%	28.99%	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)	17.00	28.00	6.00	8.00	6.00	9.00	7.00	11.00	NA	NA			157.00	200.00	49.00	70.00	49.00	58.00	60.00	72.00	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	115.50	146.00	98.00	146.00	130.50	146.00	152.50	NA	NA			146.00	114.50	146.00	120.00	146.00	140.00	146.00	80.00	NA	NA		
16) Percentage of appointments cancelled by the Trust	0.67%	1.02%	0.67%	0.97%	0.67%	0.88%	0.67%	1.43%	0.67%	0.07%			0.67%	1.06%	0.67%	1.06%	0.67%	1.00%	0.67%	1.28%	0.67%	0.09%		
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.74	1.00	0.00	1.00	1.86	1.00	0.82	1.00	0.00			9.00	12.14	9.00	10.07	9.00	11.58	9.00	16.40	9.00	25.72		
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	71.11%	75.00%	88.89%	75.00%	90.91%	75.00%	50.00%	75.00%	56.25%			75.00%	74.12%	75.00%	87.00%	75.00%	87.64%	75.00%	68.75%	75.00%	41.33%		

Trust Dashboard - Locality Breakdown for TRUST

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

	December 2015												April 2015 To December 2015											
	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%	83.75%	95.00%	80.34%	95.00%	87.79%	95.00%	82.39%	95.00%	88.40%	95.00%	50.00%	95.00%	83.75%	95.00%	80.34%	95.00%	87.79%	95.00%	82.39%	95.00%	88.40%	95.00%	50.00%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.57%	95.00%	88.73%	95.00%	91.98%	95.00%	87.13%	95.00%	91.88%	95.00%	65.61%	95.00%	88.57%	95.00%	88.73%	95.00%	91.98%	95.00%	87.13%	95.00%	91.88%	95.00%	65.61%
21) Percentage Sickness Absence Rate (month behind)	4.50%	4.77%	4.50%	4.44%	4.50%	5.74%	4.50%	5.26%	4.50%	4.65%	4.50%	6.46%	4.50%	4.53%	4.50%	4.41%	4.50%	4.95%	4.50%	4.42%	4.50%	5.85%	4.50%	6.34%

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

	December 2015												April 2015 To December 2015											
	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	5,940.00	6,392.00	1,939.00	1,859.00	1,985.00	1,705.00	1,826.00	1,941.00	189.00	887.00			52,688.00	56,963.00	17,202.00	17,272.00	17,610.00	17,754.00	16,198.00	16,873.00	1,678.00	5,046.00		
24) Delivery of our financial plan (I and E)	71,700.00	-223,000.00	NA	NA	NA	NA	NA	NA	NA	NA			-4,957,000.00	-5,820,000.00	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

		Dec-15			October - December 2015			Annual
		Target	Month	Status	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%	87.50%		50.00%	56.67%		50.00%
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral *	75.00%	86.92%		75.00%	85.28%		75.00%
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral*	95.00%	99.23%		95.00%	99.17%		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%	9.48%		15.00%	7.73%		15.00%
7	Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery*	50.00%	35.85%		50.00%	38.93%		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%	75.00%		95.00%	91.67%		95.00%
9	Percentage CPA 7 day follow up (AMH)*	95.00%	100.00%		95.00%	93.75%		95.00%
10	Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.54%		98.00%	98.54%		98.00%
11	Percentage of community patients who state they have been involved in the development of their care plan (month behind)							

		Dec-15			April - December 2015			Annual
		Target	Month	Status	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%	50.00%		95.00%	50.00%		95.00%
20	Percentage compliance with mandatory and statutory training (snapshot)	95.00%	65.61%		95.00%	65.61%		95.00%
21	Percentage Sickness Absence Rate (month behind)	4.50%	6.46%		4.50%	6.34%		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								
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**

MONITOR SCORECARD - 2015/16 - AS AT 31ST DECEMBER 2015 - Overall Trust position includes York and Selby from October 2015

Indicator	Monitor Target	Area	Q1	Q2	Q3
Percentage CPA 7 day follow up (AMH only) (post validated position)	95%	Overall Trust Position	97.82%	97.57%	97.55%
Percentage of CPA Patients having a formal review documented within 12 months (AMH only) - Snapshot	95%	Overall Trust Position	98.35%	98.53%	98.83%
Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (AMH only) (post validated position)	95%	Overall Trust Position	97.65%	97.24%	96.57%
Percentage of non acute patients whose transfer of care was delayed	7.5%	Overall Trust Position	1.86%	1.88%	1.44%
Data completeness: outcomes - Snapshot	50%	Overall Trust Position	94.36%	94.47%	72.16%
Data completeness: identifiers - Snapshot	97%	Overall Trust Position	99.67%	99.71%	99.61%
Access to Healthcare	100%	Overall Trust Position	100.00%	100.00%	100.00%
Number of EIP new cases - cumulative	100%	Overall Trust Position	261.54%	259.23%	263.59%
Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral *.	50%	Overall Trust Position	N/A	N/A	68.10%
Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75%	Overall Trust Position	N/A	N/A	87.56%
Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95%	Overall Trust Position	N/A	N/A	95.86%

Please note: the Q1 position is reported as at the 30th June 2015, Q2 position as at the 30th September 2015 and Q3 position as at 31st December 2015.

* Please note: The national definition for this indicator has not yet been publicised

Data Quality Assessment

Appendix 4

		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																					**0**
Suicides	6	2	5														1				**14**
Open	1		1																		**2**
Drug related death	1	2																			**3**
Drowning																					**0**
Misadventure	1																				**1**
Awaiting verdict	9	8	9	1		1		1			2	2	3			1	4		1		**42**
Total	**20**	**12**	**15**	**1**	**0**	**2**	**0**	**1**	**0**	**0**	**2**	**2**	**3**	**0**	**0**	**1**	**5**	**0**	**1**	**0**	**65**

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	7	4			

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
25	19	19	2	0

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

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. 10

BOARD OF DIRECTORS
FOR GENERAL RELEASE

DATE:	**26TH JANUARY 2016**
TITLE:	**QUARTERLY WORKFORCE REPORT**
REPORT OF:	**DAVID LEVY, DIRECTOR OF HUMAN RESOURCES AND ORGANISATION DEVELOPMENT**
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 report provides information about key workforce performance for the period October to December 2015.

Performance improved in respect of most indicators during the period October to December 2015 when compared to the previous quarter.

Lower sickness absence rates and the time taken to complete disciplinary investigations are amongst the most positive developments whilst the appraisal completion rate and timely completion of the local induction checklist need further improvement.

Recommendations:

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

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**26TH JANUARY 2016**
TITLE:	**QUARTERLY WORKFOCE REPORT**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with information about key workforce performance during the period October to December 2015. Appendix 1 provides workforce performance information about the whole Trust workforce and Appendix 2 provides further details about medical staffing issues and performance.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The information within this report is shared with the Executive Management Team, The Workforce and Development Group and the Joint Consultative Committee to help raise awareness and inform related thinking and decision making.

3. KEY ISSUES:

3.1 Appendix 1 provides information about York and Selby locality services, for the first time. The information provided in this particular report is limited to staff in post numbers, sickness absence rate and age profile. Further York and Selby workforce information will be reported following validation and/or when there is sufficient quantity of data to report.

3.2 York and Selby has the lowest number of staff in post of the localities with 683 staff, has the highest rate of use of fixed term contracts and the highest sickness absence rate. The age profile of the York and Selby workforce is the oldest of the localities. As further information about other key performance indicators for York and Selby becomes available it will be included within future quarterly workforce reports.

3.3 The impact of age retirement as a reason for leaving continues to be significant and is expected to grow over the coming years particularly amongst registered nursing staff. A 25% increase in age retirement amongst registered nurses between now and 2018 is thought to be likely given the number of registered nurses approaching 55 years of age who possess Mental Health Officer status. Such an increase means that success with efforts to improve recruitment and retention will be even more important if workforce supply is to be maintained at the required level.

3.4 The overall rate of sickness absence from April to November 2015 was the lowest reported to date since the Trust was established and the year to date rate almost meets the target rate of less than 4.5%. It should be noted however, that sickness absence rates typically rise during the months of December, January and February. The improved position can be attributed to efforts made by a large number of people and the impact of a range of health

and wellbeing initiatives within the Trust particularly in respect of long term sickness absence. A more detailed report about health and wellbeing is to be presented to the Quality Assurance Committee at its February meeting.

3.5 The average time taken to conclude disciplinary investigations fell markedly during the reporting period. The use of a dedicated disciplinary investigation team commenced in October 2015 and to date the average time taken by the team to complete disciplinary investigations has been just over one month. This figure compares to the average time of over five months taken for completion of disciplinary investigations as previously reported. Clearly it is early days for the disciplinary investigation team however, a good start has been made and the associated benefits for staff and services involved and the level of financial cost avoidance for the Trust will be evaluated and could prove to be significant.

3.6 The number of on-going grievances as at December 2015 was almost three times as high as that reported in September 2015. Though at fifteen the actual number of on-going grievances is small the scale of increase is significant and the position will continue to be monitored. No locality or topic clustering explains the increase.

3.7 The Trust appraisal rate remained unchanged at 84% as at December 2015. In previous years appraisal rates have improved during the period January to March and improvement is anticipated this year also. A revised appraisal system has been piloted and agreed and associated training for over five hundred staff is planned to take place between March and August 2016 to support implementation.

3.8 The rates for local mandatory training and national information governance training increased to 91% and 92% respectively. The rate of completion of corporate induction within eight weeks of joining the Trust rose to 95% though local induction checklist completion fell to 63%. The Executive Management Team is to consider proposals for improving local induction performance during February.

3.9 Target recruitment timescales continue to be difficult to meet though the overall position improved a little compared to the previous quarter. Though the time taken to obtain references and occupational health clearance has come down the time taken to receive DBS clearance has increased a little. A new approach to recruitment, known as centralised recruitment, has been agreed by the Executive Management Team and is to begin to be implemented over the coming months. It is hoped that this new approach will increase the pace of recruitment and post fill rates.

3.10 Successful redeployment rates continued to be reported with some forty three staff managed through the redeployment service between October and December 2015. Though redundancies will prove necessary from time to time they continue to be very much the exception rather than the rule. A recent report produced by Leicester University for the Trust, as part of the Extending Working Lives national research programme, highlighted that between 2009

and 2015 there were fewer redundancies in TEWV than there were staff deaths in service. At a time when there are concerns expressed about security of employment within the Trust such information may help to provide some helpful perspective about the Trusts redeployment record to date.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The standards described in Regulation 18 continue to be met.

4.2 **Financial/Value for Money:** The cost of sickness absence, though falling, continues to be significant with an estimated annual spend on sick pay of approximately £8,000,000.

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

4.4 **Equality and Diversity:** Using the TEWV processes described in the report to promote and act upon related Equality and Diversity issues continues to be a key consideration.

4.4 **Other implications:** None identified.

5. RISKS:

5.1 No specific risks have been identified arising from this report.

6. CONCLUSIONS:

6.1 Encouraging progress is evident in respect of most workforce indicators though recruitment timescales, appraisals and evidence of completion of local induction checklists remain concerns.

7. RECOMMENDATIONS:

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

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1

HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT DIRECTORATE

QUARTERLY WORKFORCE REPORT KEY PERFORMANCE INDICATORS OCTOBER TO DECEMBER 2015

1.0 INTRODUCTION

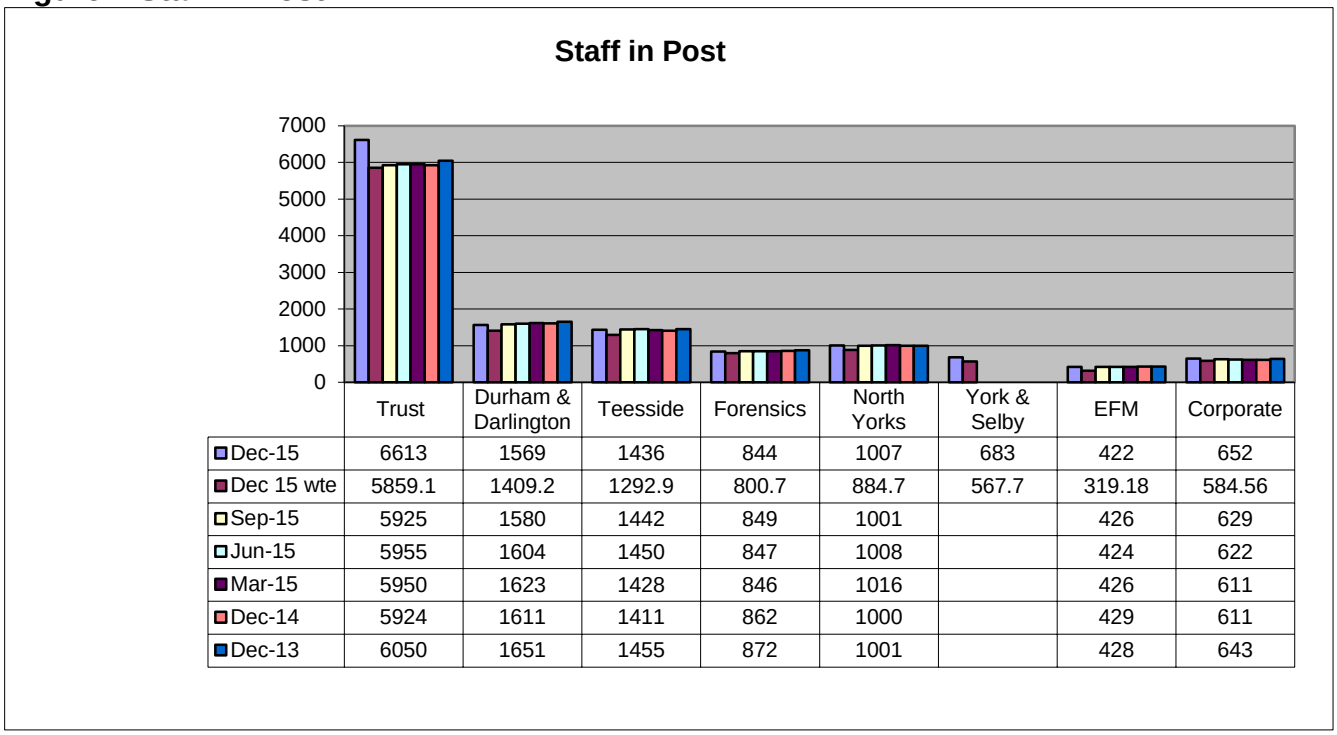
This report provides information about key workforce performance during the last quarter, October to December 2015.

2.0 Staff in Post

Figure 1 shows the staff in post position during the last quarter.

- The total Trust workforce has increased by 12% over the last 12 months following the transfer of York and Selby services**.**

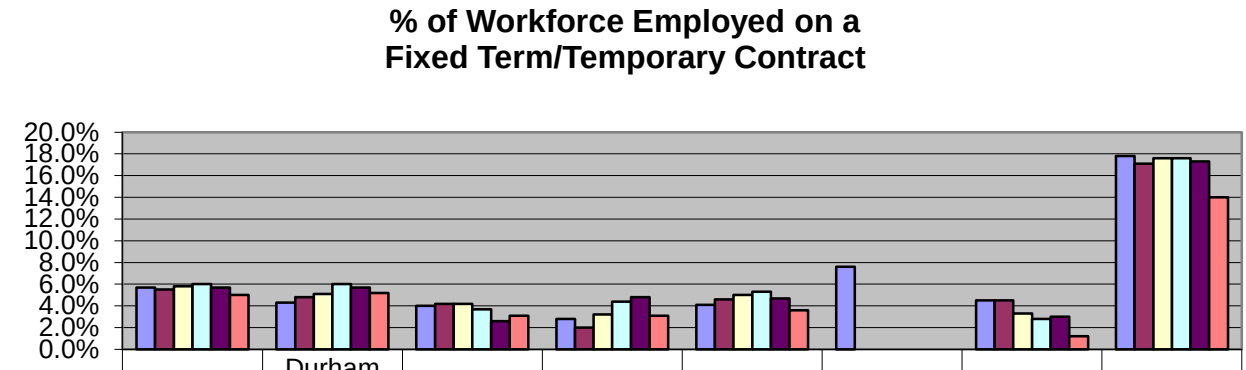
Figure 1 Staff in Post



	Trust	Durham & Darlington	Teesside	Forensics	North Yorks	York & Selby	EFM	Corporate
Dec-15	6613	1569	1436	844	1007	683	422	652
Dec 15 wte	5859.1	1409.2	1292.9	800.7	884.7	567.7	319.18	584.56
Sep-15	5925	1580	1442	849	1001		426	629
Jun-15	5955	1604	1450	847	1008		424	622
Mar-15	5950	1623	1428	846	1016		426	611
Dec-14	5924	1611	1411	862	1000		429	611
Dec-13	6050	1651	1455	872	1001		428	643

Figure 2 highlights the number of staff employed on a fixed term/temporary contract as a percentage of the total number of staff employed. Corporate Services continue to have the highest percentage of staff employed on a fixed term/temporary contract, due to the use of project-related posts.

Figure 2 Fixed Term Employment

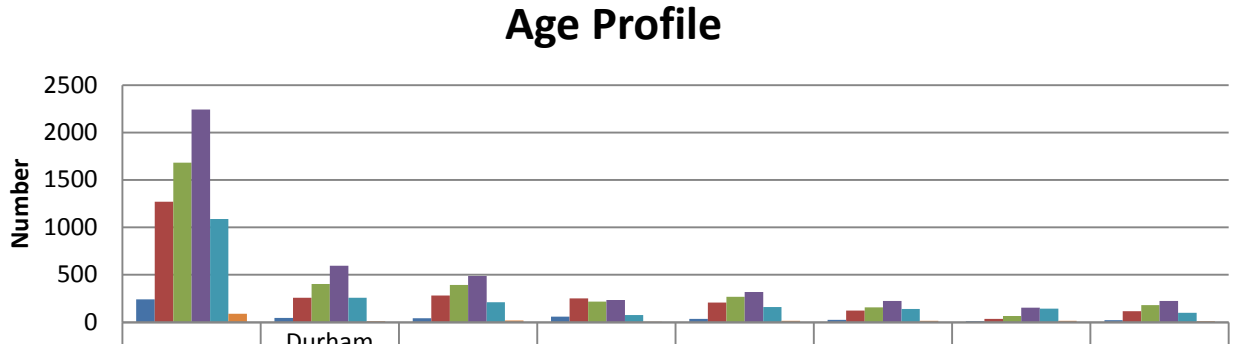


	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	York and Selby	EFM	Corporate
Dec-15	5.7%	4.3%	4.0%	2.8%	4.1%	7.6%	4.5%	17.8%
Sep-15	5.5%	4.8%	4.2%	2.0%	4.6%		4.5%	17.1%
Jun-15	5.8%	5.1%	4.2%	3.2%	5.0%		3.3%	17.6%
Mar-15	6.0%	6.0%	3.7%	4.4%	5.3%		2.8%	17.6%
Dec-14	5.7%	5.7%	2.6%	4.8%	4.7%		3.0%	17.3%
Dec-13	5.0%	5.2%	3.1%	3.1%	3.6%		1.2%	14.0%

- **figures exclude doctors in training and trainee clinical psychologists**

Figure 3 highlights the age profile of the Trust. Analysis shows 51.7% of staff aged between 44 and 65. This trend is comparable within Teesside, North Yorkshire Localities and Corporate Services. The figure increases to 55.1% in Durham and Darlington and 55.3% in York and Selby. Forensic Services is considerably lower at 37.4%. The figure is significantly higher in Estates and Facilities Management at 73.7%.

Figure 3 Age Profile

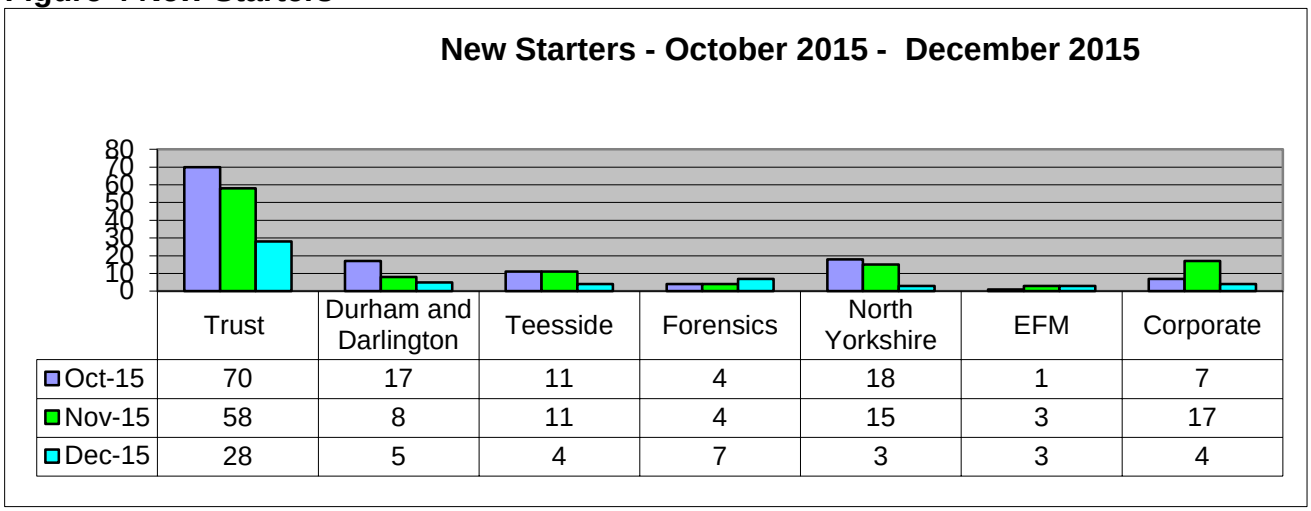


	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	York and Selby	EFM	Corporate
16-24	240	45	43	60	34	25	12	21
25-34	1272	258	282	250	209	124	34	115
35-44	1682	402	394	218	268	156	65	179
45-54	2242	596	488	236	320	225	153	224
55-64	1087	257	210	76	162	139	142	101
65+	90	11	19	4	14	14	16	12

4.0 New Starters

Figure 4 highlights the number of new starters within the Trust during the last quarter. There were a total of 156 new starters during the quarter compared to 169 reported in the previous quarter. **The graph excludes new starters to York and Selby.**

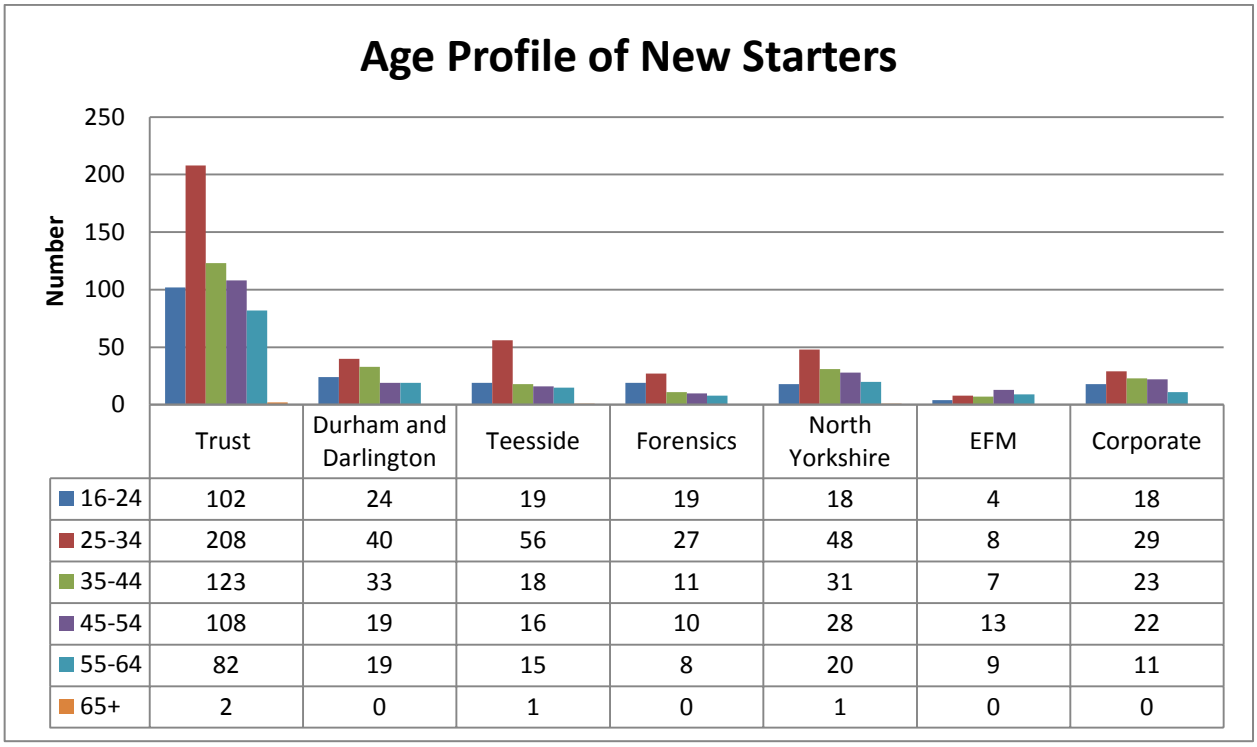
Figure 4 New Starters



	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
Oct-15	70	17	11	4	18	1	7
Nov-15	58	8	11	4	15	3	17
Dec-15	28	5	4	7	3	3	4

Figures 5 shows an age profile of new starters over the last 12 months. Analysis highlights that 33.3% of new starters are aged between 25 and 34. This figures increases to 44.8% for Teesside and 36.0% in Forensic Services. The figure for Durham and Darlington is 30.0%. Estates and Facilities Management show 31.7% of new starters within the age range 45 – 54.

Figure 5 – Age Profile

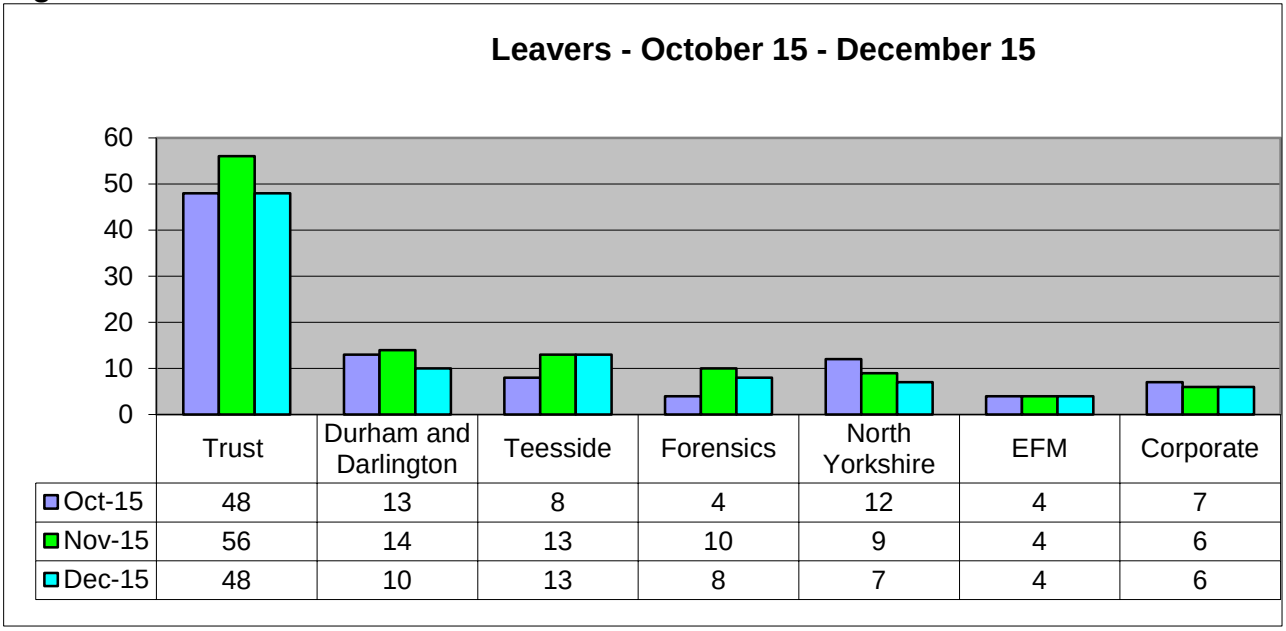


	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
16-24	102	24	19	19	18	4	18
25-34	208	40	56	27	48	8	29
35-44	123	33	18	11	31	7	23
45-54	108	19	16	10	28	13	22
55-64	82	19	15	8	20	9	11
65+	2	0	1	0	1	0	0

5.0 Leavers

Figure 6 shows the number of leavers during the last quarter.

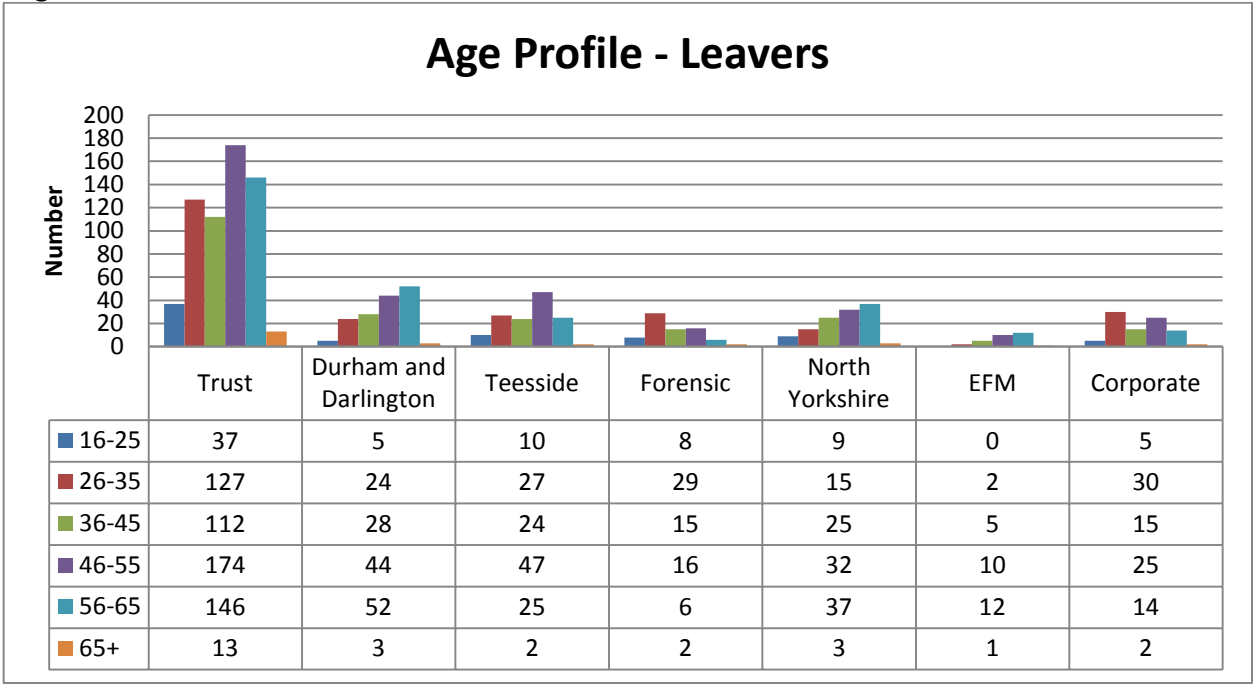
Figure 6 Leavers



	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
Oct-15	48	13	8	4	12	4	7
Nov-15	56	14	13	10	9	4	6
Dec-15	48	10	13	8	7	4	6

Figures 7 shows an age profile of leavers over the last 12 months. Analysis highlights that 28.6% of leavers were aged between 46 - 55, this figure increases to 34.8% in Teesside. 24.0% of leavers were aged 56 – 65 across the Trust, this figure was significantly higher in Durham and Darlington at 33.3% and Estates and Facilities Management at 40.0%.

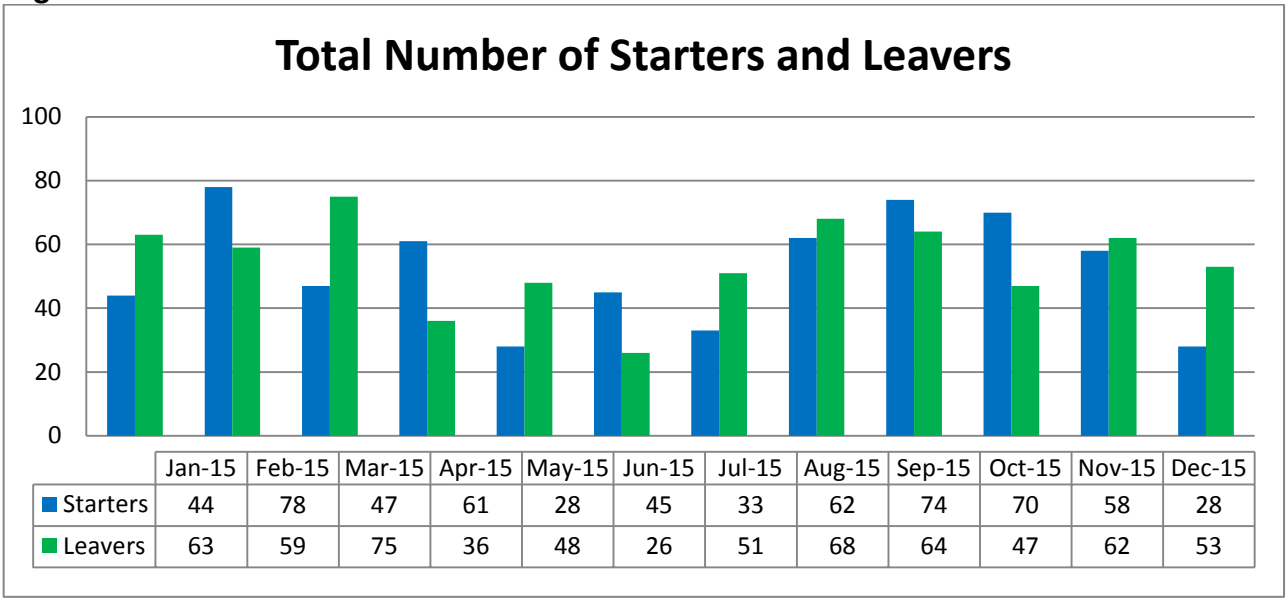
Figure7



	Trust	Durham and Darlington	Teesside	Forensic	North Yorkshire	EFM	Corporate
16-25	37	5	10	8	9	0	5
26-35	127	24	27	29	15	2	30
36-45	112	28	24	15	25	5	15
46-55	174	44	47	16	32	10	25
56-65	146	52	25	6	37	12	14
65+	13	3	2	2	3	1	2

Figure 8 shows the total number of starters and leavers during the period January 2014 to December 2015. The average number of starters over the last 12 month period has increased slightly to 52 per month. The average number of leavers over the last 12 month period has remained at 54 per month.

Figure 8 New Starters and Leavers Numbers



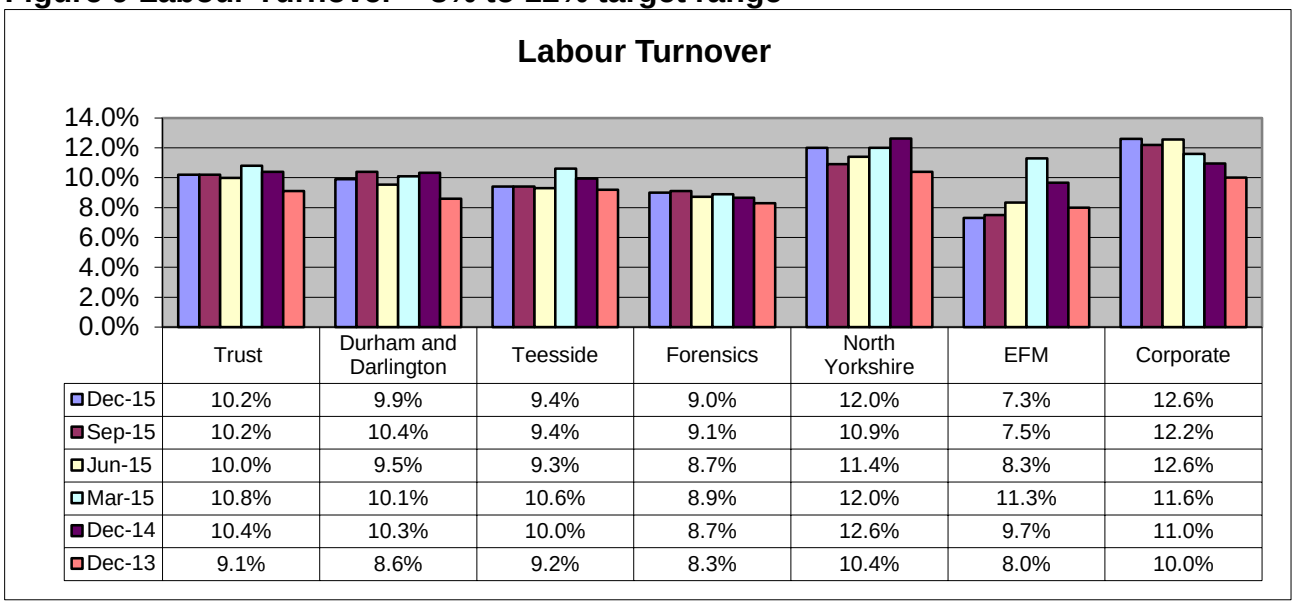
	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Starters	44	78	47	61	28	45	33	62	74	70	58	28
Leavers	63	59	75	36	48	26	51	68	64	47	62	53

6.0 Labour Turnover

Figure 9 provides information about labour turnover rates up to 30th December 2015. A total of 610 staff left the Trust during the last 12 months. The calculation **excludes doctors in training** that have left the Trust.

- 98 leavers were employed on a fixed term contract when their **employment with the Trust ended.**
- The Trust turnover rate falls to 8.6% when fixed term contract leavers are excluded from the labour turnover calculation.
- 41 members of staff chose to retire flexibly and return to the Trust after the requisite break in service.
- 121 members of staff left for reason of age related retirement and 14 voluntarily retired early.

Figure 9 Labour Turnover – 8% to 12% target range



	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
Dec-15	10.2%	9.9%	9.4%	9.0%	12.0%	7.3%	12.6%
Sep-15	10.2%	10.4%	9.4%	9.1%	10.9%	7.5%	12.2%
Jun-15	10.0%	9.5%	9.3%	8.7%	11.4%	8.3%	12.6%
Mar-15	10.8%	10.1%	10.6%	8.9%	12.0%	11.3%	11.6%
Dec-14	10.4%	10.3%	10.0%	8.7%	12.6%	9.7%	11.0%
Dec-13	9.1%	8.6%	9.2%	8.3%	10.4%	8.0%	10.0%

***figures exclude doctors in training.

The table below highlights analysis undertaken in to the **most prevalent reasons** for leaving the Trust over the last 12 months. The analysis excludes doctors in training and staff leaving with a reason of end of fixed term contract.

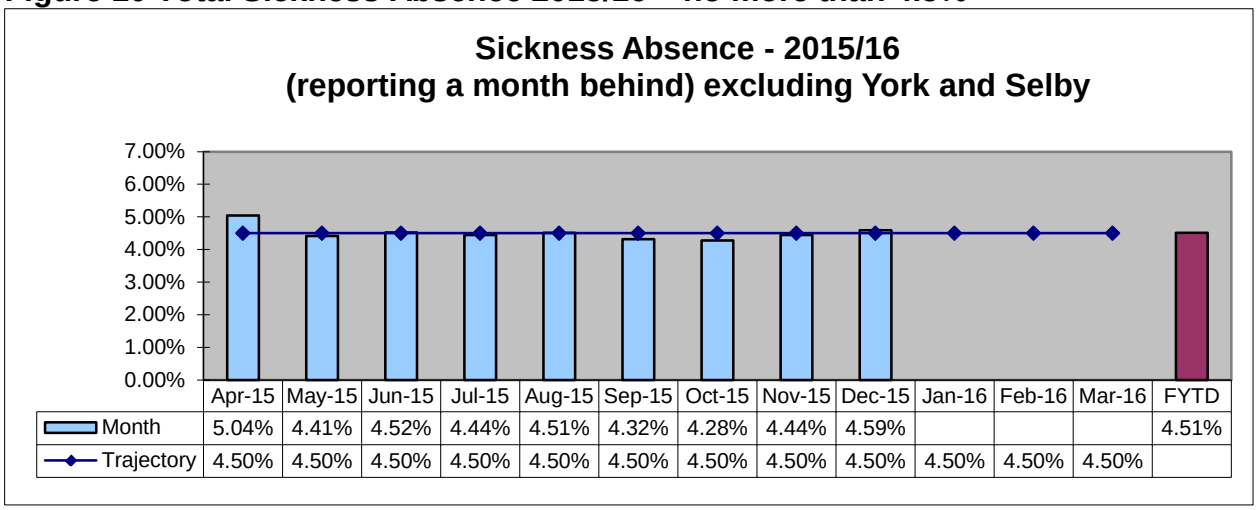
	Trust	Durham & Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
Number of leavers	513	141	124	67	107	28	45
Age retirement	20.5%	31.2%	17.7%	3.0%	23.4%	21.4%	20.0%
Voluntary resignation – Other/ unknown	17.5%	9.9%	16.9%	37.3%	17.7%	21.4%	11.1%
Voluntary resignation -relocation	11.9%	10.6%	8.1%	14.9%	18.7%	10.7%	4.4%
Voluntary resignation -promotion	8.2%	7.8%	7.3%	7.5%	9.3%	0.0%	17.8%
Voluntary resignation – work-life balance	5.5%	3.5%	4.8%	4.5%	7.7%	10.7%	6.7%

The average length of service of staff leaving the Trust is 9 years.

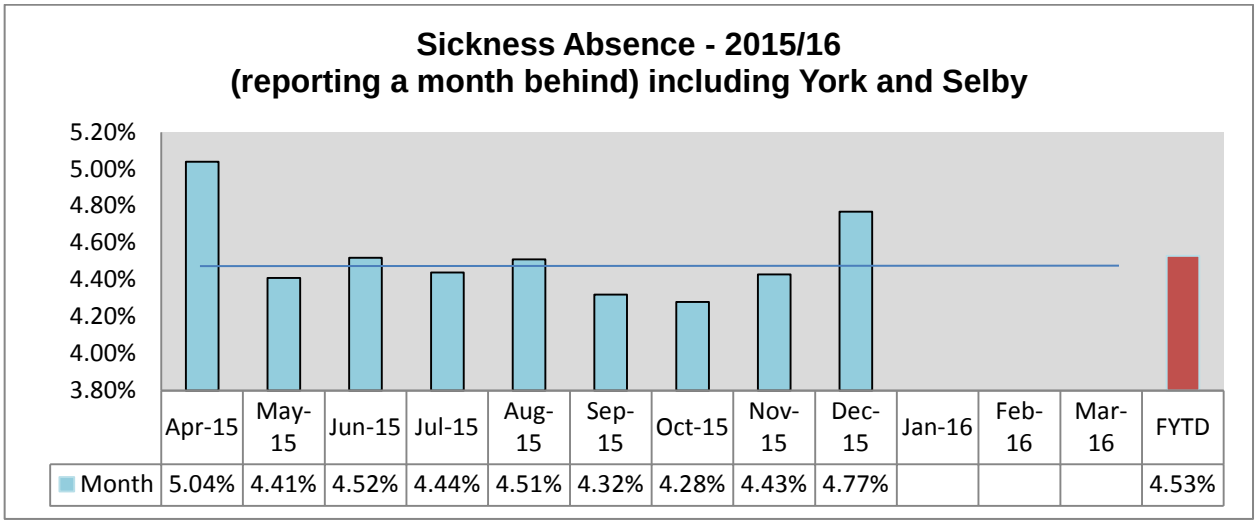
7.0 Sickness Absence

Figure 10 provides details of performance compared to target. The first graph shows the absence rate excluding York and Selby data. The second graph shows the rate including York and Selby data.

Figure 10 Total Sickness Absence 2015/16 – no more than 4.5%



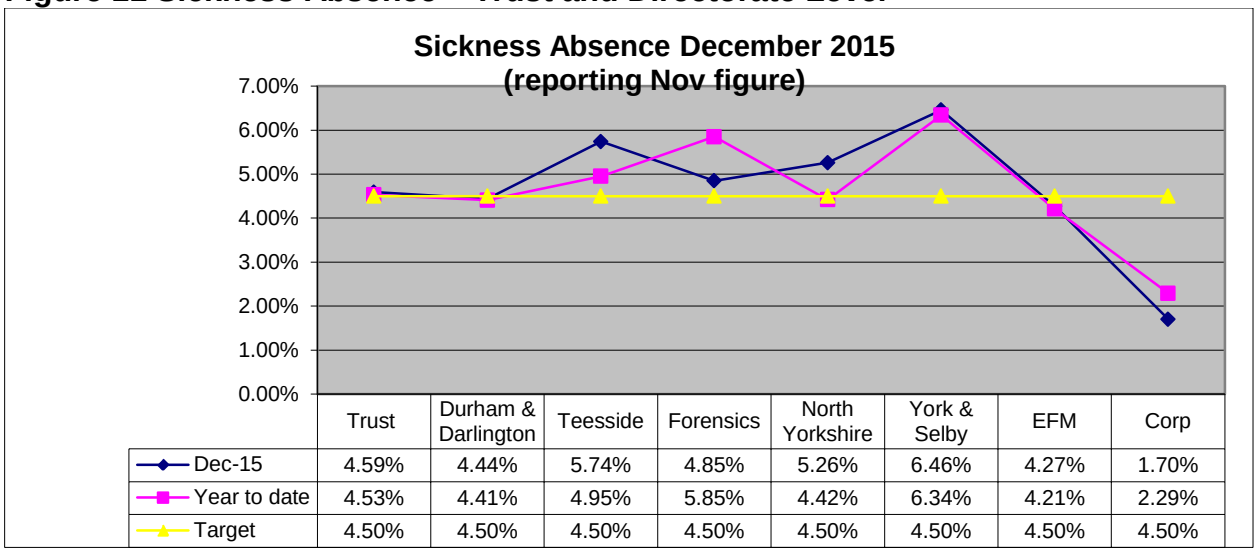
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	FYTD
Month	5.04%	4.41%	4.52%	4.44%	4.51%	4.32%	4.28%	4.44%	4.59%				4.51%
Trajectory	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	FYTD
Month	5.04%	4.41%	4.52%	4.44%	4.51%	4.32%	4.28%	4.43%	4.77%				4.53%

Figure 11 provides sickness absence percentage rate information at Trust and directorate level. Variations between directorate rates are apparent. York and Selby data is included.

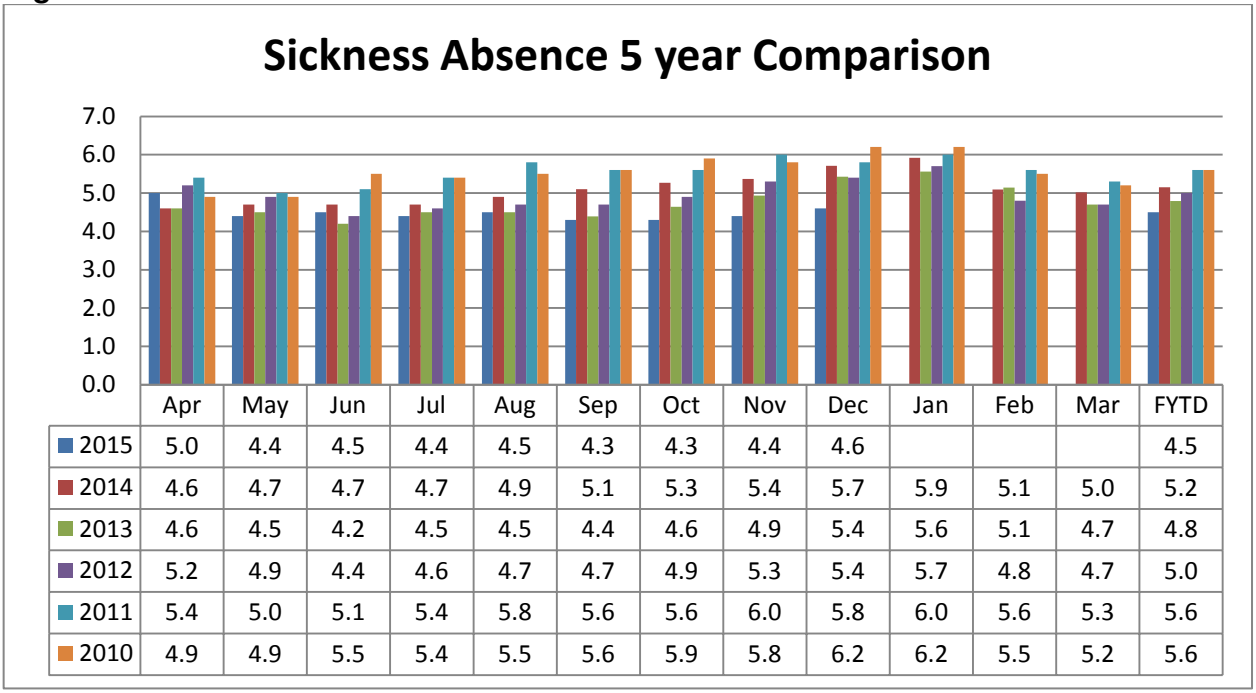
Figure 11 Sickness Absence – Trust and Directorate Level



	Trust	Durham & Darlington	Teesside	Forensics	North Yorkshire	York & Selby	EFM	Corp
Dec-15	4.59%	4.44%	5.74%	4.85%	5.26%	6.46%	4.27%	1.70%
Year to date	4.53%	4.41%	4.95%	5.85%	4.42%	6.34%	4.21%	2.29%
Target	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%

Figure 12 includes monthly sickness absence rates over the last five years, the graph **excludes** York and Selby data.

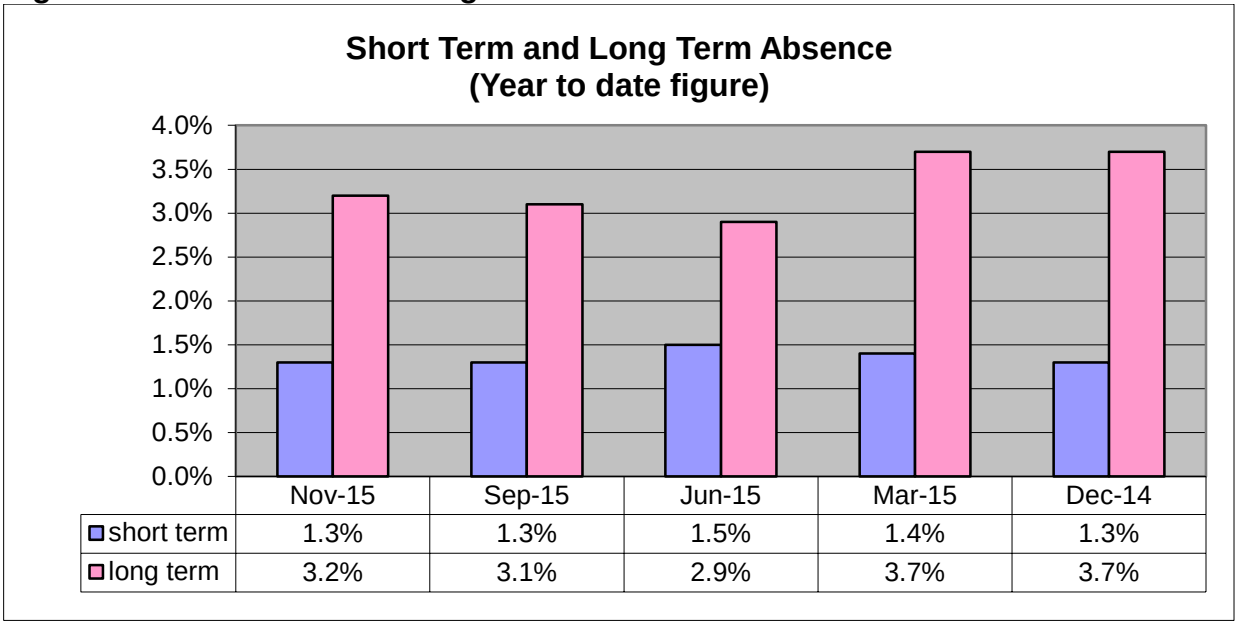
Figure 12 Sickness Absence Rates 2010-2016



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	FYTD
2015	5.0	4.4	4.5	4.4	4.5	4.3	4.3	4.4	4.6				4.5
2014	4.6	4.7	4.7	4.7	4.9	5.1	5.3	5.4	5.7	5.9	5.1	5.0	5.2
2013	4.6	4.5	4.2	4.5	4.5	4.4	4.6	4.9	5.4	5.6	5.1	4.7	4.8
2012	5.2	4.9	4.4	4.6	4.7	4.7	4.9	5.3	5.4	5.7	4.8	4.7	5.0
2011	5.4	5.0	5.1	5.4	5.8	5.6	5.6	6.0	5.8	6.0	5.6	5.3	5.6
2010	4.9	4.9	5.5	5.4	5.5	5.6	5.9	5.8	6.2	6.2	5.5	5.2	5.6

Figure 13 provides a breakdown of absence by short-term and long-term percentage rates between the period December 2014 and November 2015. The graphs **exclude** data for York and Selby.

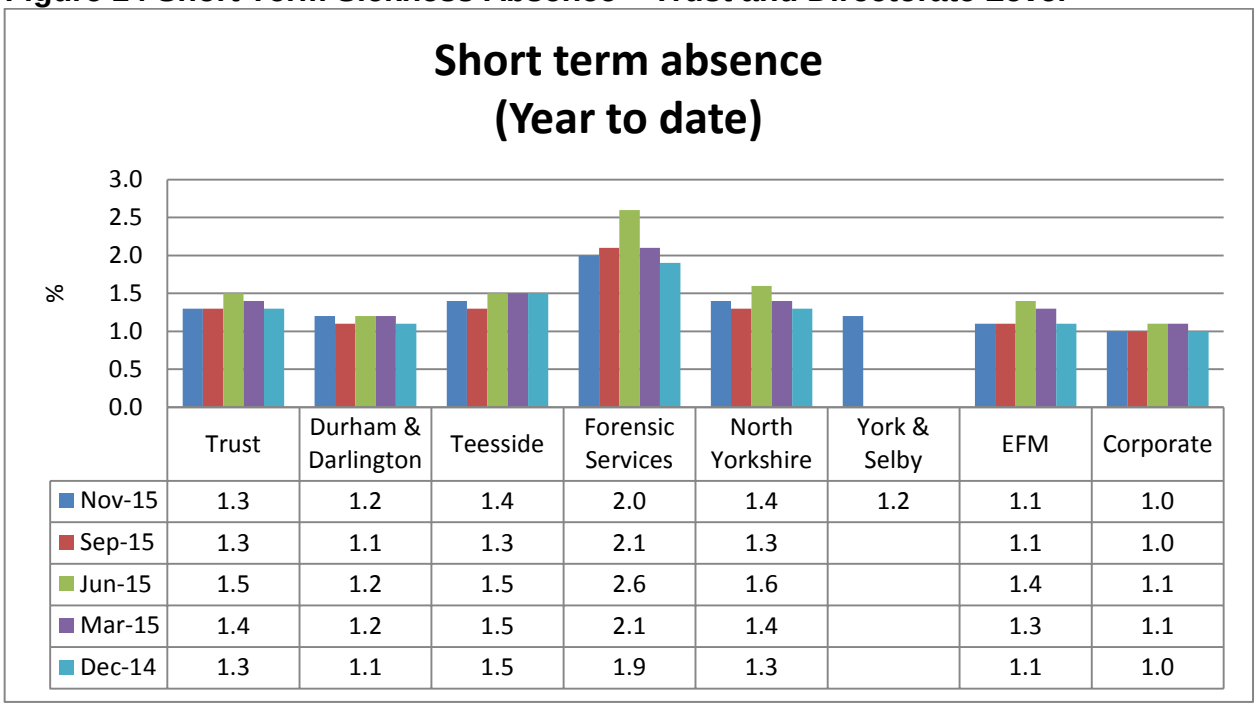
Figure 13 Short Term and Long Term Sickness Absence Rates



	Nov-15	Sep-15	Jun-15	Mar-15	Dec-14
short term	1.3%	1.3%	1.5%	1.4%	1.3%
long term	3.2%	3.1%	2.9%	3.7%	3.7%

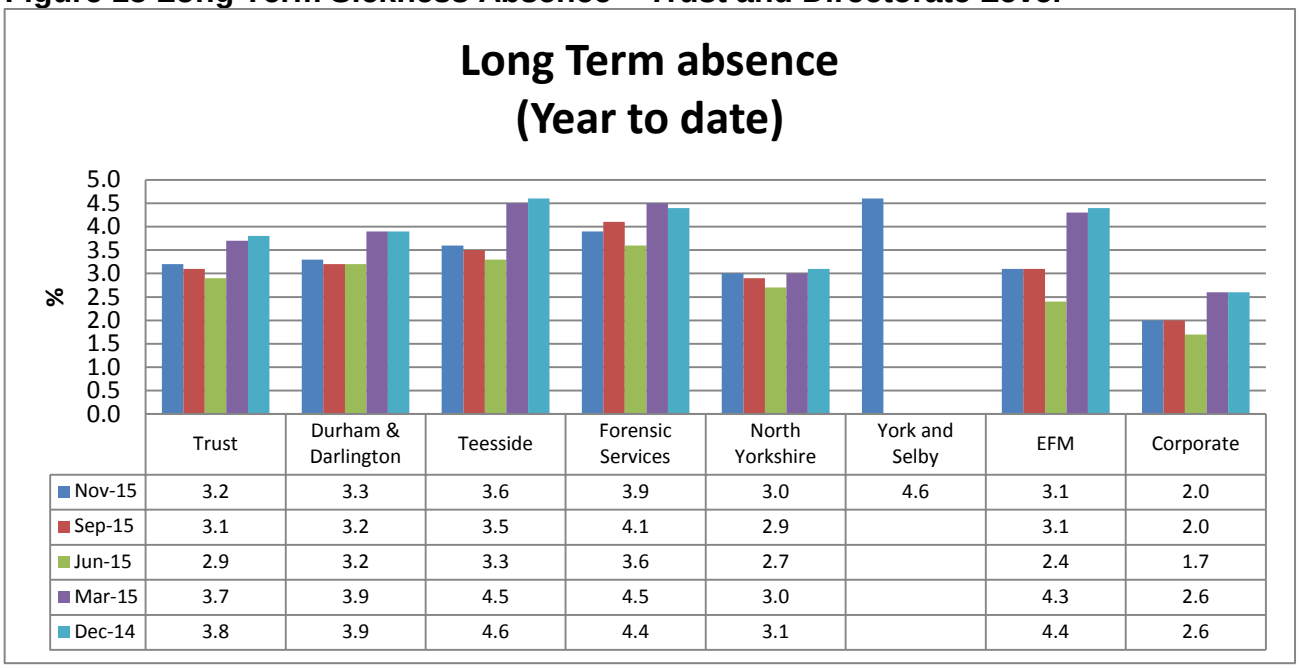
Figures 14 and 15 provide a breakdown of absence by short-term and long-term percentage rates respectively by locality from December 2014 to November 2015.

Figure 14 Short Term Sickness Absence – Trust and Directorate Level



	Trust	Durham & Darlington	Teesside	Forensic Services	North Yorkshire	York & Selby	EFM	Corporate
Nov-15	1.3	1.2	1.4	2.0	1.4	1.2	1.1	1.0
Sep-15	1.3	1.1	1.3	2.1	1.3		1.1	1.0
Jun-15	1.5	1.2	1.5	2.6	1.6		1.4	1.1
Mar-15	1.4	1.2	1.5	2.1	1.4		1.3	1.1
Dec-14	1.3	1.1	1.5	1.9	1.3		1.1	1.0

Figure 15 Long Term Sickness Absence – Trust and Directorate Level



	Trust	Durham & Darlington	Teesside	Forensic Services	North Yorkshire	York and Selby	EFM	Corporate
Nov-15	3.2	3.3	3.6	3.9	3.0	4.6	3.1	2.0
Sep-15	3.1	3.2	3.5	4.1	2.9		3.1	2.0
Jun-15	2.9	3.2	3.3	3.6	2.7		2.4	1.7
Mar-15	3.7	3.9	4.5	4.5	3.0		4.3	2.6
Dec-14	3.8	3.9	4.6	4.4	3.1		4.4	2.6

8.0 Employee Relations

Disciplinary Episodes

There were a total of twenty one concluded disciplinary cases during the last quarter, a increase on the figure of nineteen reported at the end of the previous quarter. Sixteen of

the concluded cases resulted in a disciplinary hearing, the remaining five investigations resulted in the following outcomes:-

- 2 investigation was found to have no case to answer
- 3 investigations resulted in counselling.

At the end of December 2015 there were twenty five ongoing disciplinary cases, at varying stages of the disciplinary process, representing a slight increase on the figure of twenty four reported in the previous quarter.

A total of 71 safeguarding cases occurred during quarter three, representing a significant increase on the figure of 42 from quarter two. 8 of the cases involved TEWV staff which is comparable to the previous quarter. One of the cases has progressed to a disciplinary investigation. The remaining seven staff included a bank worker whose registration with the bank was removed and the individual was referred to the DBS.

The following provides an update on cases referred to in previous reports.

- 2014-15 quarter 3 report: the hearing was held on Friday 8th January 2016 and the Determining Manager is considering the decision which should be finalised on Friday 15th January 2016. The individual was made aware at the conclusion of the hearing that it would not be possible communicate a decision within 5 working days but that he could expect the outcome within 2 weeks.
- 2015-16 quarter 1. The individual was summarily dismissed.

Figure 16 provides a breakdown of all ongoing disciplinary cases by directorate.

Figure 16 Current Locality Disciplinary Case Numbers

Trust	Durham & Darlington	Tees	Forensic Services	North Yorks	York & Selby	EFM	Medic Staff	Corp
25	5	6	5	3	3	2	0	1

Figure 17 provides the outcomes of the sixteen disciplinary hearings held during the last quarter. It can be seen that all of the disciplinary hearings held during the last quarter resulted in disciplinary action being taken.

Figure 17 Disciplinary Hearing Outcomes

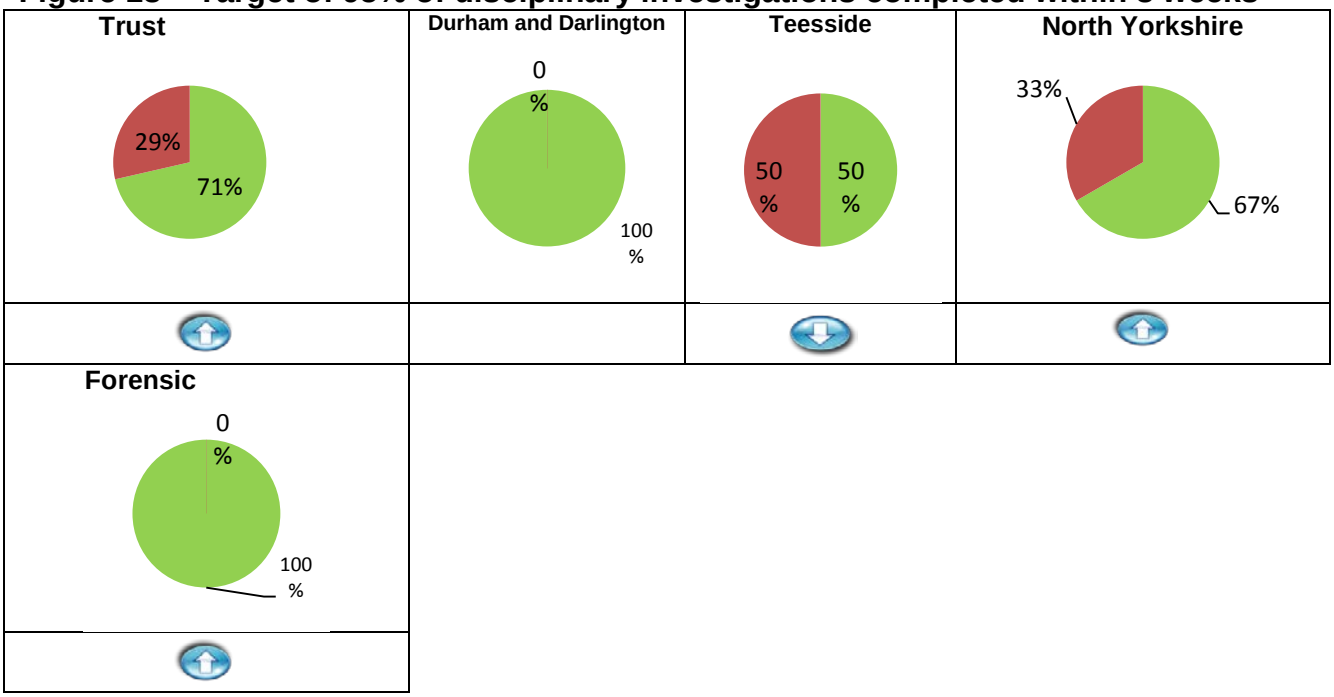
Summary Dismissal	Alternative to Dismissal	Final Written Warning	Written Warning
3	1	5	7

Figure 18 provides information about performance against the target of completing 95% of disciplinary investigations within 8 weeks, excluding cases delayed due to sickness absence. A total of fourteen disciplinary investigations were concluded during the reporting period. The compliance rate of 71% represents a significant improvement on the figure of 12% reported for the previous quarter.

The disciplinary investigation team was introduced in October 2015, early indications are that the team are able to drastically reduce the length of time taken to complete an investigation. The average length of time taken to complete an investigation is just over 1

month as oppose to the average length of over 5 months taken by investigators from within operational services.

Figure 18 – Target of 95% of disciplinary investigations completed within 8 weeks



Grievances

There were a total of thirty concluded grievances within the last twelve months**.** The following table confirms the percentage of grievances concluded within three months of being raised and the average length of time taken to bring to a conclusion.

	Dec 15	Sept 15	Jun 15	Mar 15	Dec 14
% of grievances concluded within 3 months	70%	79%	64%	58%	51%
Average length of time in months taken to conclude grievance	2.3	2.1	2.6	2.9	3.1

- A total of 14 ongoing grievances were recorded at the end of December 2015 which is a significant increase on the figure of 5 recorded at the end of September 2015.

Figure 19 shows the percentage of concluded grievances over the last twelve months that were completed within the three months target time. The time taken to conclude grievances has traditionally been less than the time taken to conclude disciplinary matters, and this remains the case.

Figure 19 Grievances Concluded Within 3 Months

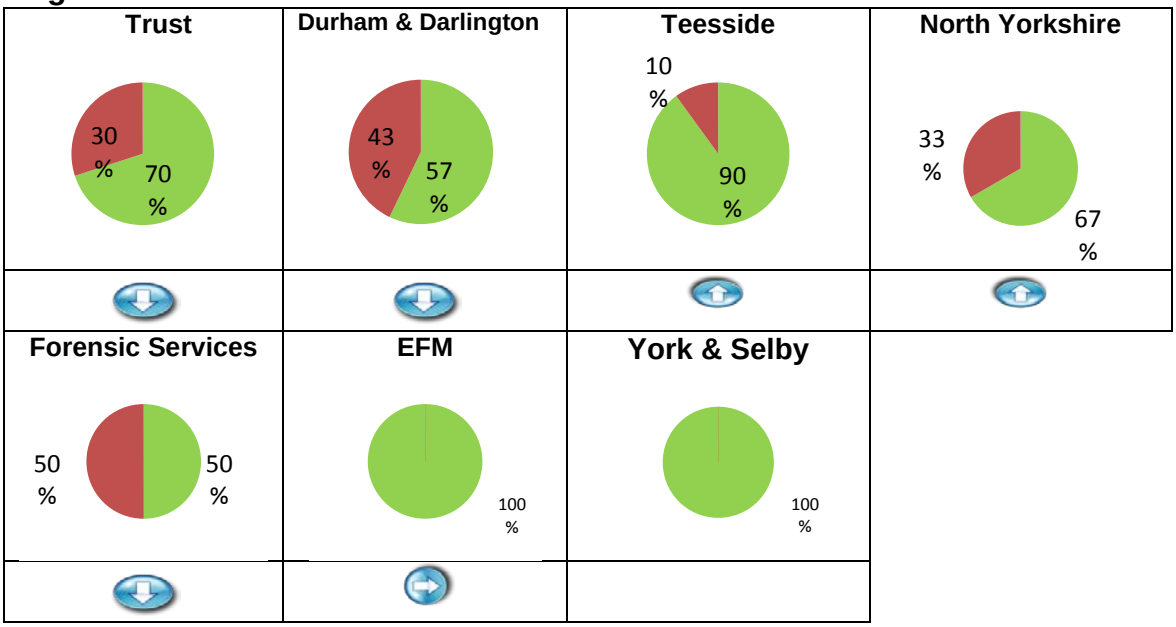
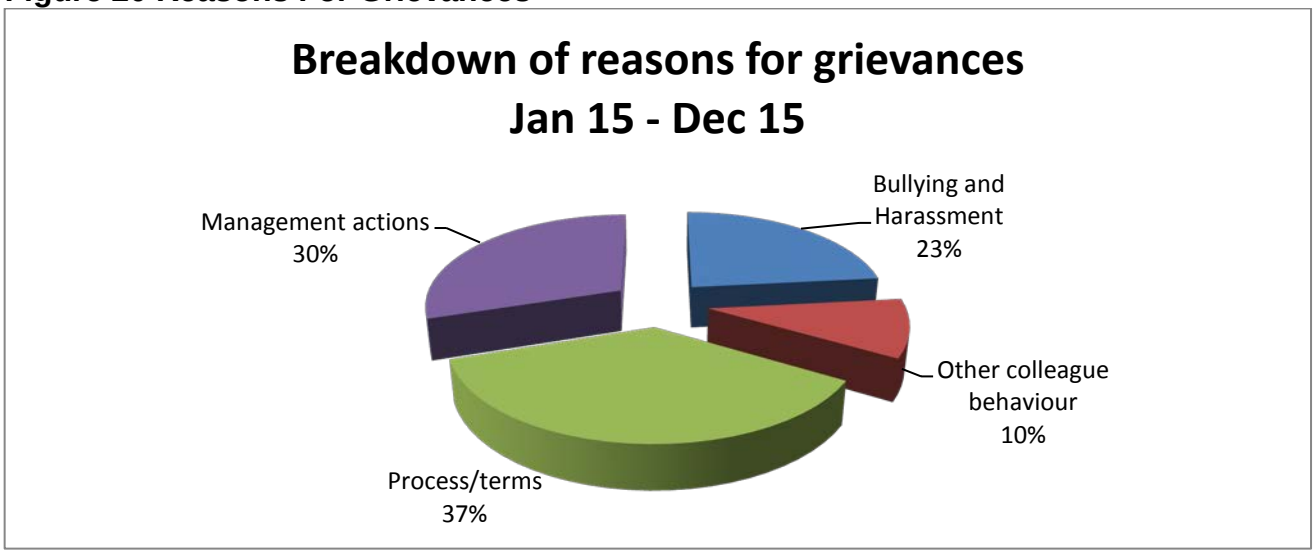


Figure 20 provides a breakdown of the reasons for grievances being lodged. It can be seen that grievances associated with bullying and harassment account for a 23% of all grievances within the Trust. Though the number of such grievances is less than 0.5% of the total Trust workforce it is important to monitor developments in this area and identify any significant trends that may require action on the part of the Trust. 37% of grievances relate to concerns raised relating to process or terms and conditions.

Figure 20 Reasons For Grievances



The following table highlights the outcome of grievances lodged during the 12 month reporting period.

Grievance Outcomes

Not upheld	Upheld/resolved	Partially upheld resolved	Mediation	Withdrawn before hearing
8	7	10	4	1

Mediation

The Trust has invested in training a number of staff to act as mediators as another source of conflict resolution. There have been 15 requests for mediation between April and January 2016. 7 of the cases are ongoing. Of the remaining 8 cases, 5 were deemed to be successful mediations. The remaining 3 did not proceed either because the mediator did not feel it was appropriate or one of the participants decided not to proceed. The number of requests for mediation has increased from the previous year when 14 requests were received.

Bullying and Harassment

There is one bullying and harassment case under investigation at the end of December 2015. There have been no bullying and harassment cases that have resulted in a disciplinary process being invoked following the submission of a complaint during the last quarter.

9.0 Competence

Figure 21 provides information about the key performance indicator that 95% of staff should receive an annual appraisal resulting in a personal development plan. Teesside is the only locality showing an increase in compliance on the previous quarter and appear to be making progress towards the target of 95%. The report shows performance as at end of December 2015. The report **excludes** York and Selby data. Appraisal reports have been produced and are currently with managers to validate the information.

Figure 21 Appraisal and PDP Completion Rates

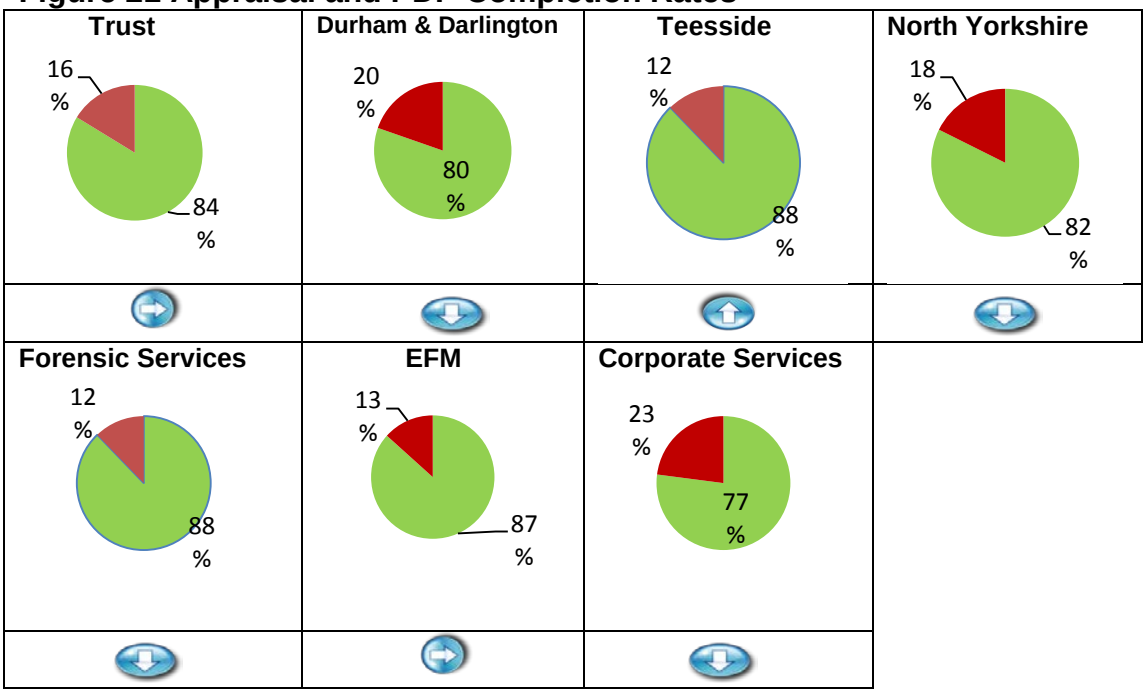
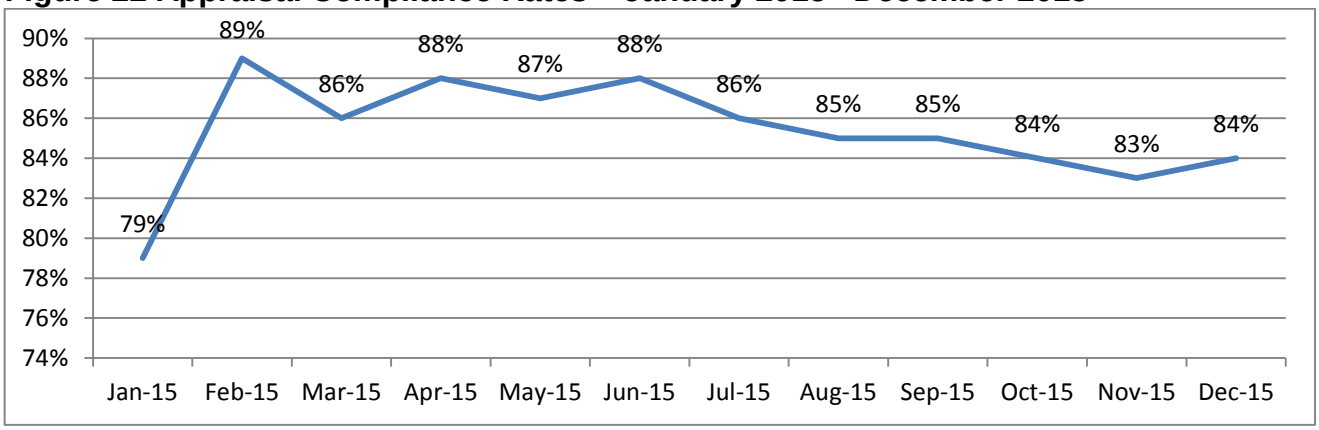


Figure 22 Appraisal Compliance Rates – January 2015 –December 2015



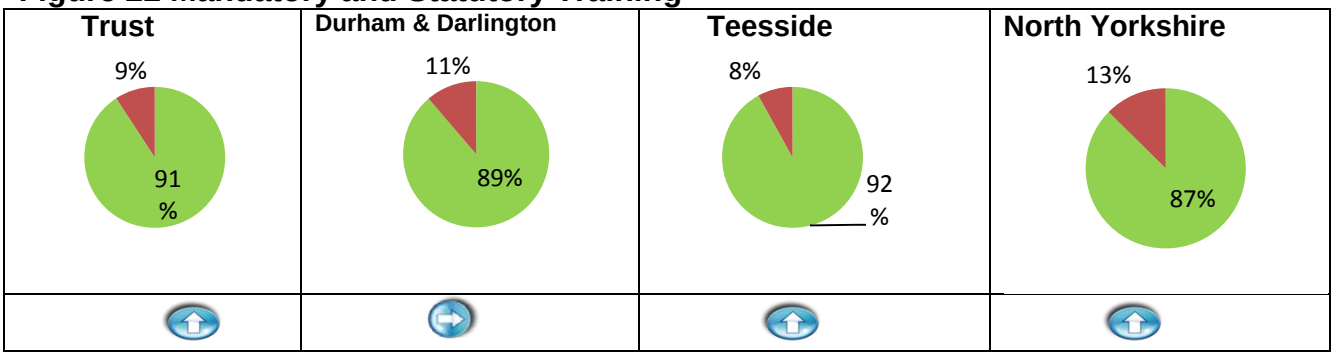
Monthly compliance reports are now available on the Integrated Information Centre (IIC) for managers to access and monitor compliance. Managers are able to update appraisal records directly within ESR Manager Self Service. The number of concerns being raised regarding the accuracy of the figures reported appears to have decreased since the roll out of the IIC.

Each locality has arrangements in place to proactively monitor and manage the HR related key performance indicators. A number of performance monitoring groups are in operation where team managers are required to provide updates on progress made against the performance indicators. Where deficiencies are identified action plans are developed and implemented. Directors of Operations and Heads of Service participate in a monthly Trust wide Performance Improvement group chaired by the Chief Operating Officer which includes providing updates on progress being made in relation to key HR related indicators.

Mandatory and Statutory Training

Figure 22 provides information about the percentage of staff undertaking core mandatory and statutory training at the end of December 2015 compared to the Trust target rate of 95%. All localities and services are reporting an increase in compliance compared with the previous reporting period. Estates and Facilities Management are reporting 95% compliance and Corporate Services reporting 94%. The figures **exclude** York and Selby data which is currently being validated.

Figure 22 Mandatory and Statutory Training



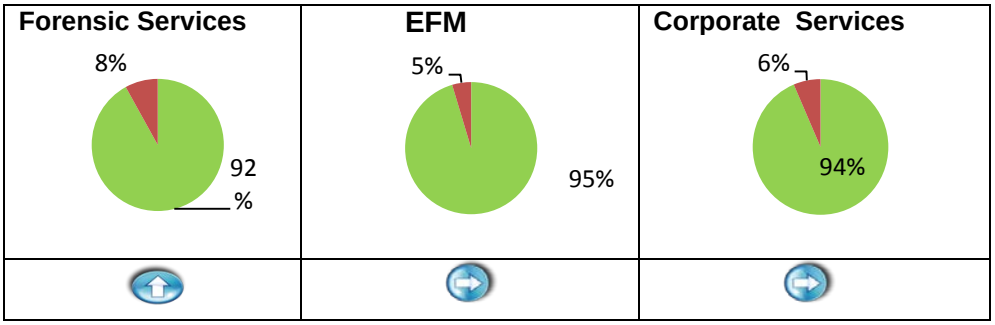
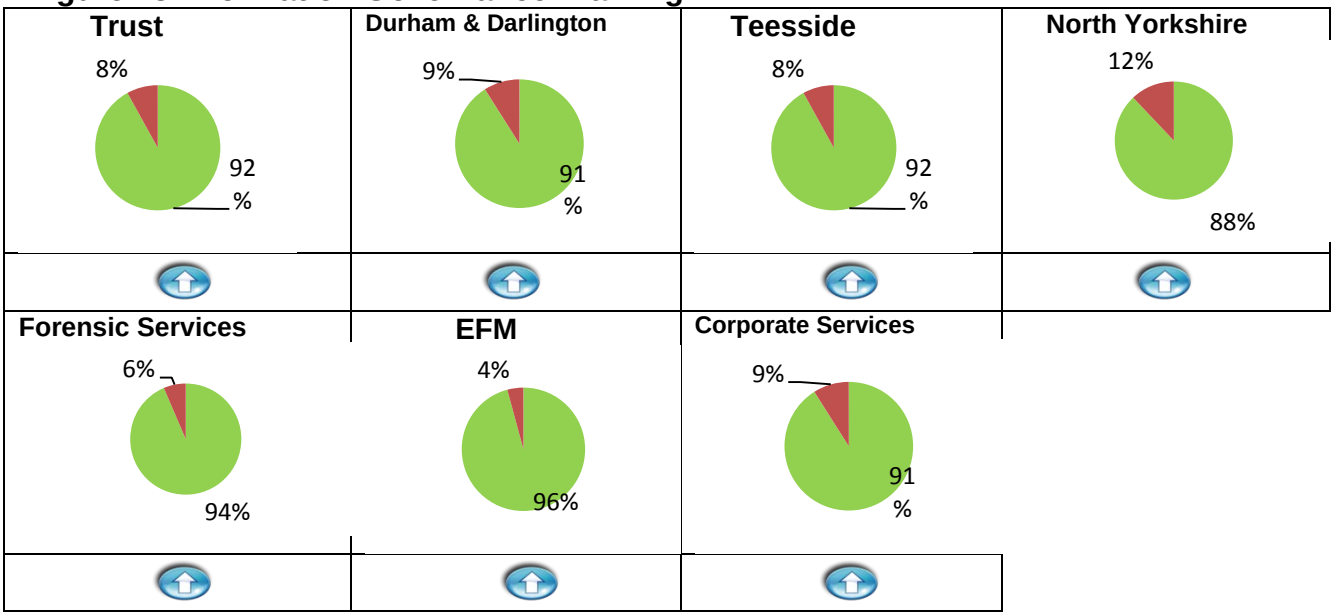


Figure 23 shows the compliance rate for Information Governance training as at the end of November 2015 against a target of 95%. Information Governance compliance is based on all staff turning red on 1st April 2015. Estates and Facilities Management have achieved 96% which exceeds the target of 95%.

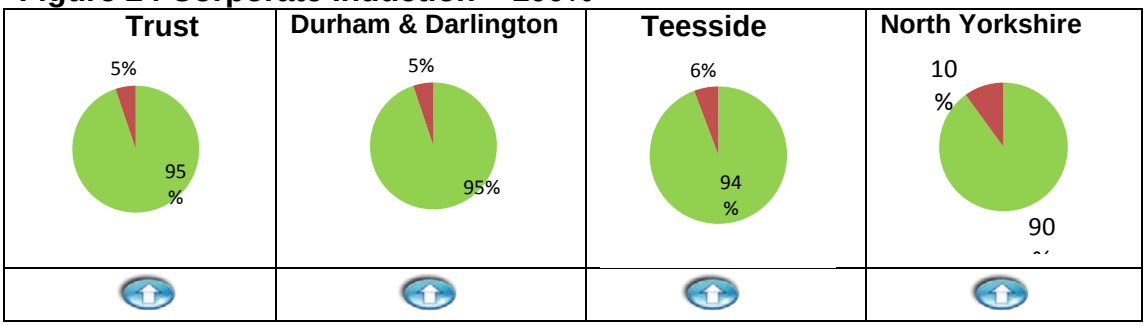
Figure 23 Information Governance Training



Induction

The 95% corporate induction compliance rate recorded for the last quarter in Figure 24 represents an increase on the figure of 90% reported at end of September 2015, however this remain below target. This was due to 10 members of staff failing to complete corporate induction within 2 months of commencement of employment during the reporting quarter. The compliance figure excludes bank workers whose compliance rate was 100%.

Figure 24 Corporate Induction – 100%



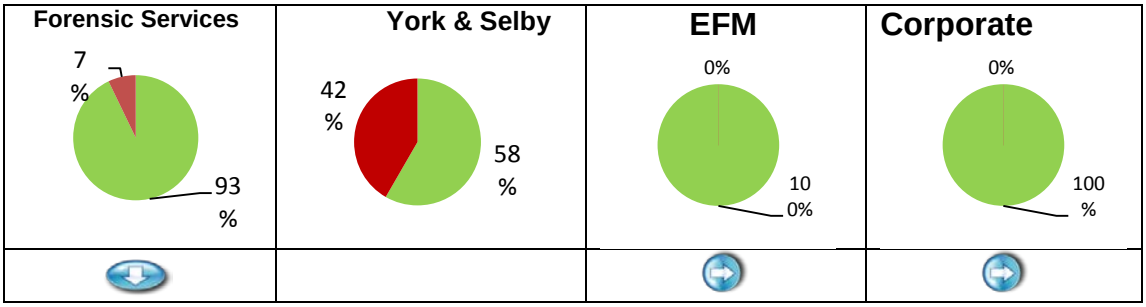
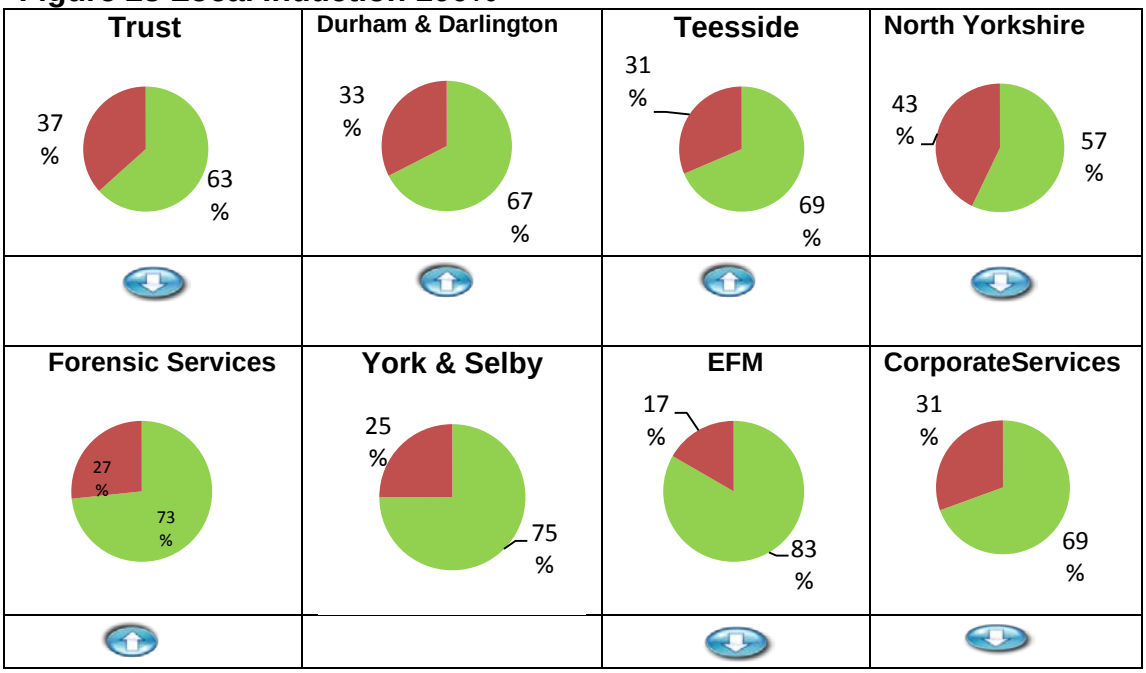


Figure 25 concerns the local induction compliance rate which decreased from 72% to 63% in the last quarter. A monthly report is sent out to Heads of Services highlighting those staff requiring local induction, along with a reminder in the middle of the month to confirm outstanding returns. Services are monitoring local induction compliance on a monthly basis through management meetings.

- The 37% non-compliance figure equates to 74 out of 202 staff failing to confirm completion of local induction within the 2 month timescale.
- The compliance figure excludes bank workers. The compliance rate for bank workers completing local induction is 100%

Figure 25 Local Induction 100%



10.0 Recruitment

- The key performance indicators below provide information about the time taken to recruit to vacancies.
- Percentage of band 1 – 5 vacancies recruited to within 13 weeks of advert being placed against a target of 75%.
- Percentage of band 6 – 9 vacancies recruit to within 15 weeks of advert being placed against a target of 75%

- Figures 26 and 27 show the percentage of staff recruited during the reporting period October to December 2015 compared to the performance indicators identified above.

There were 108 candidates recruited during the reporting period which is a slight decrease on the previous quarter of 118.

There has been a increase in the compliance against the target recruitment time for bands 1 – 5 from 29% to 56%. 79% of successful candidates were external applicants which is an decrease on the figure of 95% during the previous quarter. The number of external candidates may have an impact on the length of time taken to recruit due to notice periods required to leave current posts.

- 1 newly qualified staff nurses commenced employment during the reporting period.

The average length of time taken to recruit to bands 1 – 5 decreased to 14 weeks for the reporting quarter.

Figure 26 Bands 1- 5 Recruitment Within 13 weeks

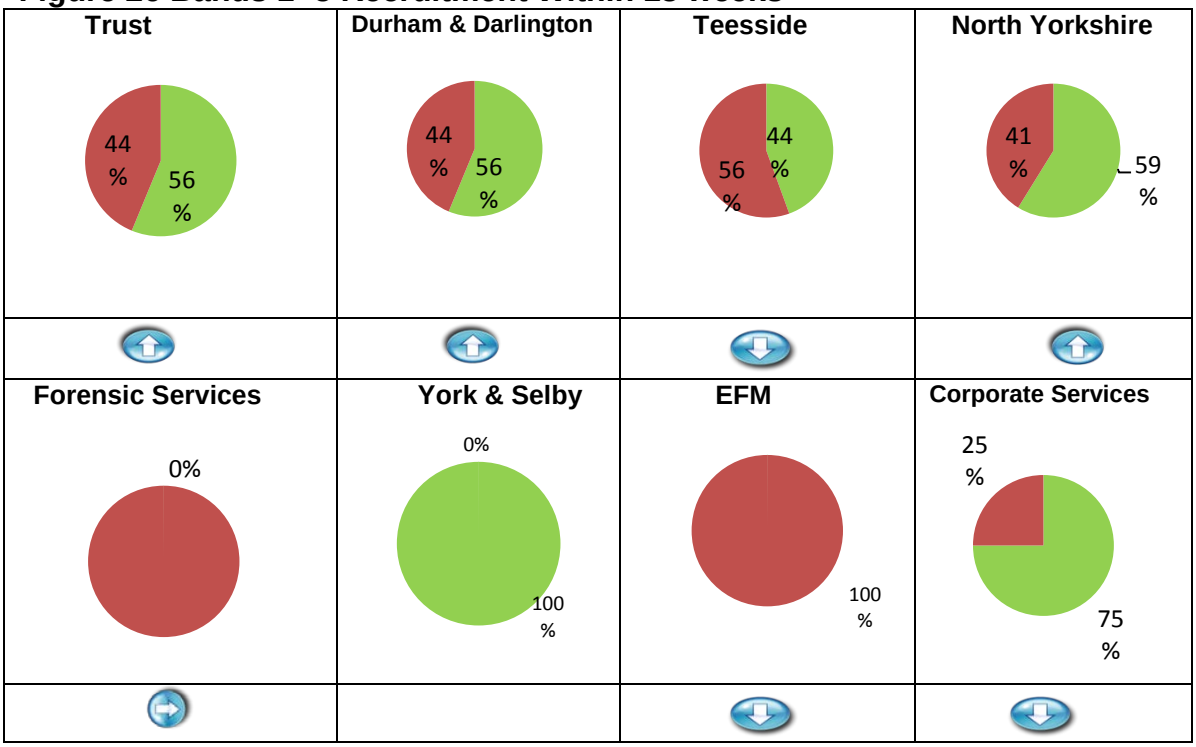
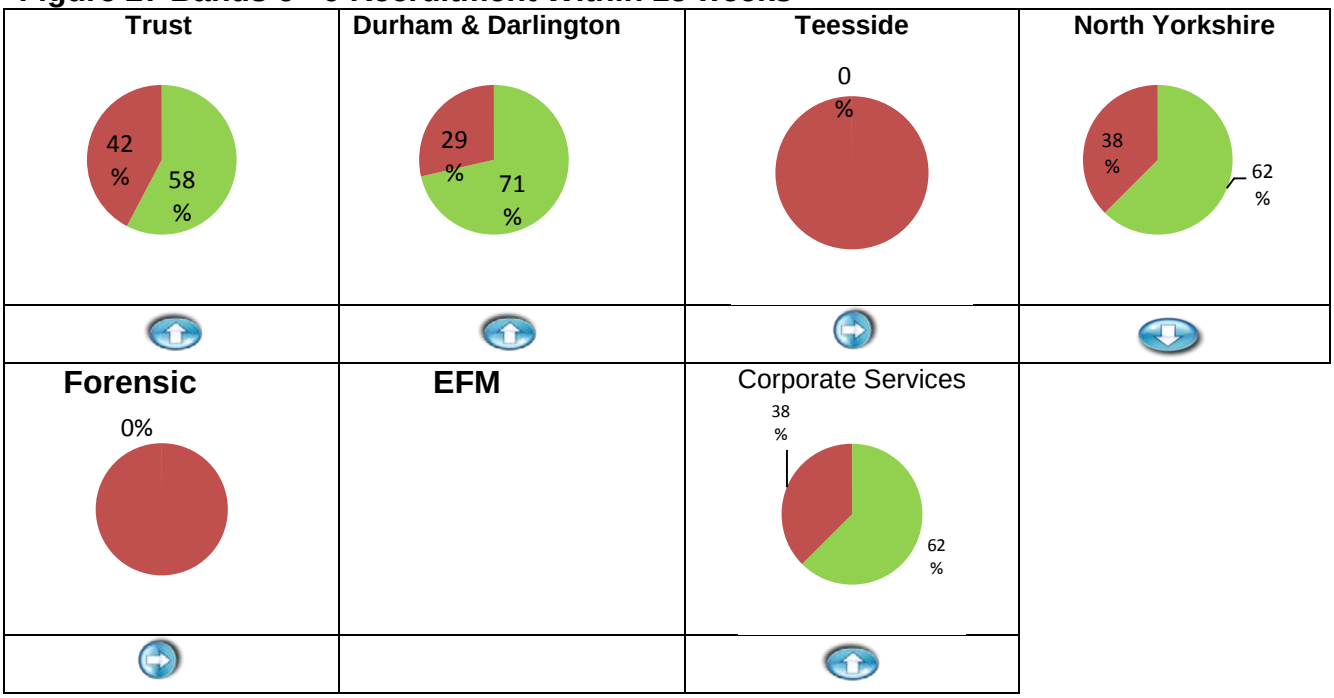


Figure 27 concerns the average length of time taken to recruit to bands 6 and above has increased to 17 weeks from 15 weeks during the last quarter. 77% of the successful candidates for band 6 and above were external applicants. This is an decrease on the figure of 100% reported in the previous quarter. There were no completed recruitment episodes for bands 6 and above for York and Selby.

Figure 27 Bands 6 - 9 Recruitment Within 15 weeks



Analysis of recruitment episodes undertaken during the last quarter highlights the following:-

- Average length of time taken for references to be received has decreased from 21 days to **18 days.**
- **44%** of references were received within **10 days** which is an increase on the figure of 40% reported in the last quarter**.**
- Average length of time taken for Occupational Health clearance to be received has decreased to **10 days** from 12 days.
- **75%** of Occupational Health clearances were received within 10 days representing an increase on the figure of 72% reported during the last quarter.
- Average length of time taken for DBS clearance to be received increased to **21 days** from 19 days.
- **63%** of DBS clearances were received within **21 days** representing a decrease on the figure of 66% reported during the last quarter**.**
- The average length of time taken for pre-employment screening to be completed has decreased to **40 days** from **41 days.**
- **41%** of pre-employment screening was completed within 28 days representing an increase on the figure of 28% reported during the last quarter.

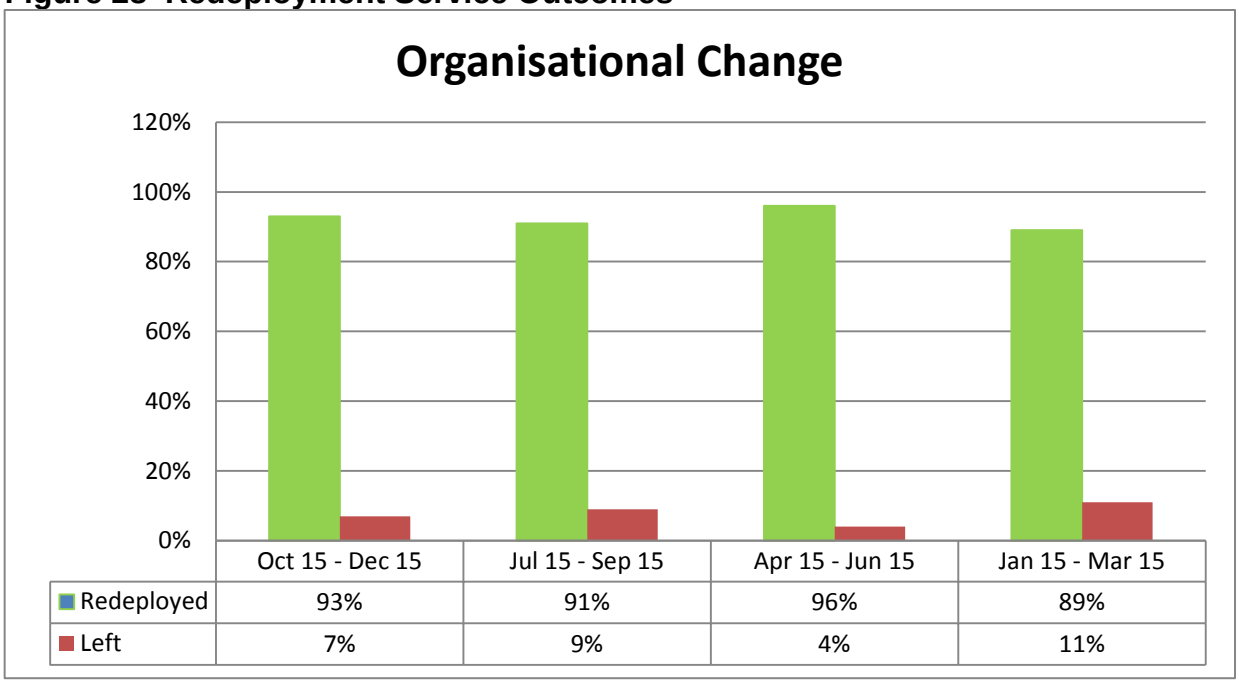
11.0 Redeployment Process

The redeployment process is the mechanism adopted within the Trust for searching for suitable alternative employment opportunities for staff finding themselves either displaced or at risk of being displaced from their post as a result of either Organisational Change or on due to medical incapacity.

The table below records the number of staff managed within the redeployment process since January 2015, who have either been successfully redeployed or have left the organisation. Figure 28 highlights the percentage of staff redeployed (green) compared to those leaving the organisation (red).

	Oct 15 – Dec 15	Jul 15 – Sep 15	Apr 15 – Jun 15	Jan 15 – Mar 15
Number of staff managed within process	43	11	49	52

Figure 28 Redeployment Service Outcomes

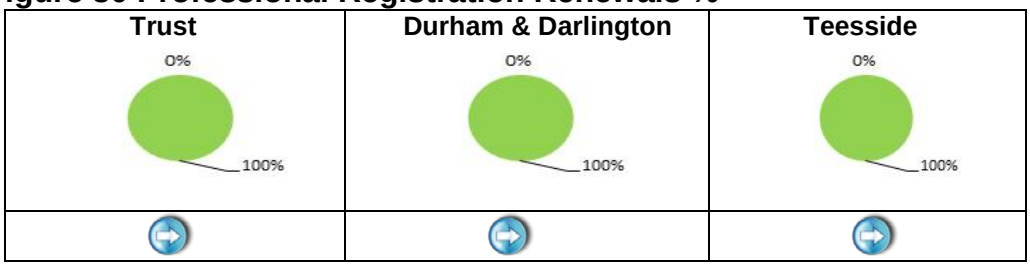


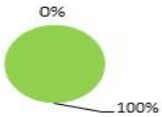
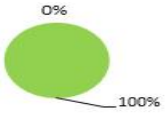
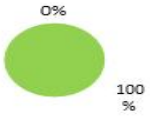
12.0 Professional Registration

The Trust target is that 100% of professional registered staff, required to have professional registration, do not allow their professional registration to lapse. Figure 30 below provides a breakdown of the position in respect of those staff whose registration was due to be renewed during the period October 2015 and December 2015.

A total of 645 staff were due to update their professional registration during the reporting period. **One bank member of staff failed to renew their professional registration during the reporting period.** The compliance rate is **99.84%** A monthly report has been introduced to alert line managers when a member of staff is due to renew their professional registration and a policy of suspending those staff whose registration lapses, on zero pay, is in place. Where the registration is still showing as not updated the team liaise directly with the employee and the line manager to alert them.

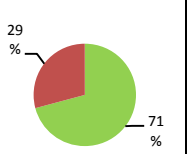
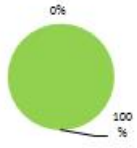
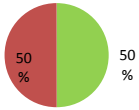
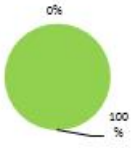
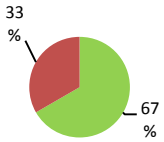
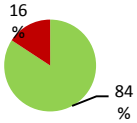
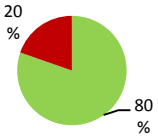
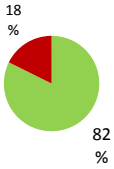
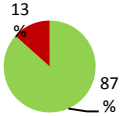
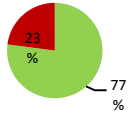
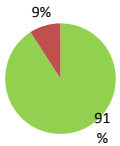
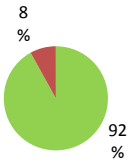
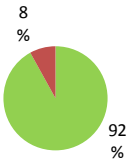
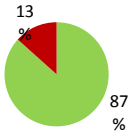
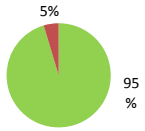
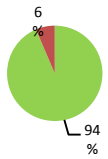
Figure 30 Professional Registration Renewals %

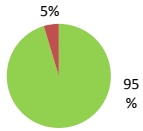
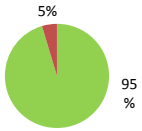
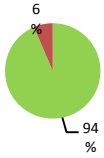
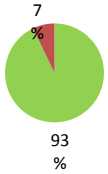
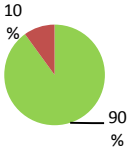
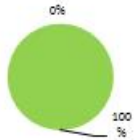
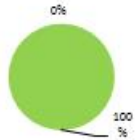
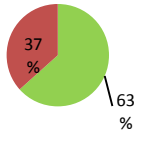
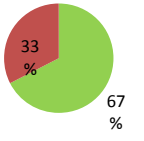
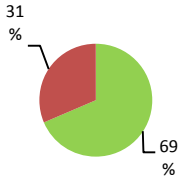
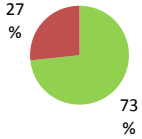
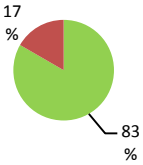
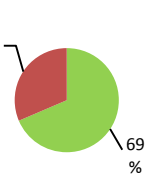
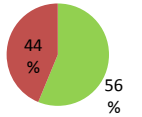
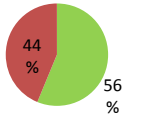
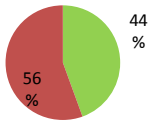
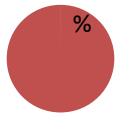
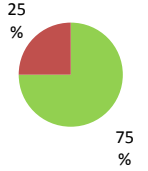
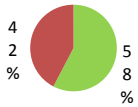
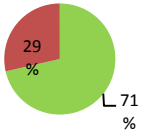
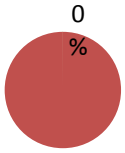
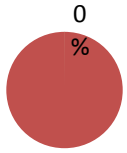
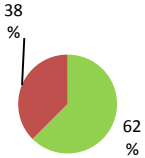
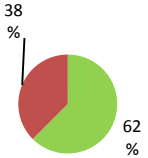


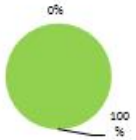
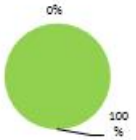
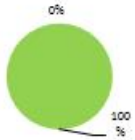
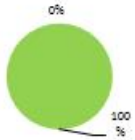
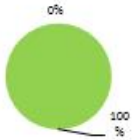
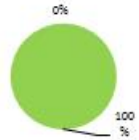
North Yorkshire	Forensic Services	Nursing& Governance
		
		

Work is underway to prepare for the implementation of nurse revalidation which comes in to effect from 1st April 2016. Compliance information reports relating to revalidation will be included in the quarter one HR Workforce report.

KEY PERFORMANCE INDICATOR SUMMARY

	Key Performance indicators	Target	Trust	Durham & Darlington	Teesside	Forensic	North York	EFM	Corp
1	Labour Turnover rate	8% - 12%	10.2%	9.9%	9.4%	9.0%	12.0%	7.3%	12.6%
2	Sickness Absence FYTD	4.5 %	4.5%	4.4%	5.0%	5.9%	4.4%	4.2%	2.3%
3	% of investigations concluded within 8 weeks	95%							
4	% of staff receiving an annual appraisal	95%							
5	% of staff compliant with mandatory and statutory training	95%							

	Key Performance indicators	Target	Trust	Durham & Darlington	Teesside	Forensic	North York	EFM	Corp
6	% of new starters attending corporate induction within 3 months of commencing employment	100%							
7	% of new starters confirmation of local induction checklist completed within 3 months of commencing employment	100%							
8	% of band 1 -5 recruited within 13 weeks	75%							
9	% of band 6 – 9 recruited within 15 weeks	75%							

10	% of professional registered staff with a current professional registration against a target of 100%	100%							

Medical Workforce Report (2015 Quarter 3)

MEDICAL DIRECTORATE

This report provides information about the medical workforce during the third quarter, October to December 2015.

The report will be divided into the following sections:

- Section 1 - Medical staffing profile
- Section 2 - Medical staffing monitoring profile
- Section 3 - Vacancies
- Section 4 - Sickness
- Section 5 - Appraisals & revalidation
- Section 6 - Turnover
- Section 7 - Mind the gap payments
- Section 8 - Medical education overview

Section 1: Medical Staffing Profile

The following table (Table 1) highlights the number of doctors working in the Trust categorised into our five localities. The status of the contract held is included on the left hand side of the table. It should be noted that the figures include all junior doctors on placement in the Trust.

Table 1	D&D	Tees	N Yorks	Forensic	York and Selby	Overall Total
Permanent	103	85	65	34	49	336
Trust Locums	5	6	6		2	19
Agency Locums	2	1	7	2	5	17
Flex Retirement	5	1	3			9
Career Break	1					1
Honorary	2		2	1	2	7
Total	118	93	83	37	58	**389**

Table 1 shows an increase in workforce since quarter 2 (336). This is due to the addition of York and Selby into TEWV. The table shows that 31% of our permanent workforce is in the Durham &Darlington locality. The number of agency locums remains unchanged, but has increased with the addition of York.

The table identifies that the permanent workforce make up 86% of the total medical workforce. This is comparable with the percentage in 2013.

The following tables (2, 3, 4 and 5) highlight the number of medical staff by grade – Consultants, Specialty Doctors and junior doctoring in training.

Consultant Psychiatrists

Table 2	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Permanent	65	34	31	14	11	8	163
Trust Locums	1		3				4
Agency Locums	4	1	3		1	1	10
Flex Retirement	4	4		1			9
Vacant not cov'd	2	4	1		1		8
Career Break	1						1
Honorary	3	1			1		5
Total	80	44	38	15	14	9	**200**

Table 2 shows the number of consultants currently working within the Trust defined by specialty. The overall numbers have increased due to the addition of York and Selby. Please note that out of the 10 agency doctors, 8 are covering vacant posts and 2 are covering maternity leave.

The consultant workforce in AMH is of concern given 19% of its workforce is not permanent and may pose a risk in the future. Figures from 2014 show the same ratio of permanent consultants and locum consultants.

SAS Doctors

Table 3	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Permanent	14	6	13	1	4	3	41
Trust Locums	3		1				4
Agency Locums		1	4				5
Flex Retirement							
Vacant not cov'd		1					1
Career Break							
Honorary							
Total	17	8	18	1	4	3	**51**

Table 3 shows the number of SAS grade doctors currently working within the Trust defined by specialty. This shows the position is largely unchanged from the last quarter. Out of the 5 agency locums, 1 is covering sickness, 2 are covering vacancies and 2 are helping out with the workload.

Junior Doctors

Table 4	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Current	69	16	28	7	8	1	129
Vacancies not covered	8	2	2	1	2		15
Trust Locums	7		3	1			11
Agency Locums	2		1				3
Total number of posts	86	18	34	9	10	1	**158**

Table 4 shows all Trust junior doctor training posts. This has increased since the last quarter due to the addition of York and Selby trainees. The number of vacancies are those posts that remain unfilled after trust doctor and agency locums have been appointed. For information, Trust doctors are used to fill vacant training posts and are not on a formal training programme. There are currently 29 vacancies that are either filled by locums or that remain empty.

You will note that the Trust has 11 Trust doctor posts compared to 3 in 2013. This is quite unique and is as a consequence of the Trust doctor initiative whereby the Trust advertised opportunities for Trust doctors, mostly equivalent to the level of foundation one or two, to work and receive a tailored development programme. The programme was developed to make the doctor better equipped to be succesful on their application for core training. Following a recent visit to Budapest with a neighbouring Trust, TEWV recruited 3 Trust doctors. One doctor successfully passed their IELTs test and is presenting her documents to the GMC in early January 2016, after which time she will be able to commence her shadowing period. The remaining two doctors scored just below the IELTs passmark and therefore will retake the test in January 2016.

Table 5	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Foundation Yr 1	9		5				14
Foundation Yr 2	10		3		1		14
CT 1-3	28	7	8	5	4		52
ST 4-6	10	8	8	2	3	1	32
GP Registrars	13		4				17
Total	70	15	28	7	8	1	**129**

Table 5 shows the breakdown of junior doctors that are currently in post in the Trust. We continue to do all we can to support core trainees in passing their written and clinical papers. We have introduced the independent assessment of clincial skills (IACS), and this is now held twice yearly. A

structured day long CASC programme was lauched last year and we continue to encourage opportunitist clincial skills training with trained supervisors.

Section 2: Medical Staffing Monitoring Profile

This section provides analysis of gender, age and ethnicity of the medical staff workforce.

Consultants by Age & Gender

	D&D		Tees		NY		Forensic		York & Selby		Total	
Table 1	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
30 – 34	1	1		1		1	1		2		**4**	**3**
35 – 39	2	8	9	5	3	2	3	2	2	1	**19**	**18**
40 – 44	9	3	5	3	6	1	3	3		5	**23**	**15**
45 – 49	8	4	4	2	8	6	5	1	4	2	**29**	**15**
50 – 54	6	8	4	2	2	2	2		2	3	**16**	**15**
55 – 59	4	3	1	3	2				1		**8**	**6**
60 – 64	2	1	2		2				1		**7**	**1**
65 – 69					1						**1**	
70+									1		**1**	
Total	**32**	**28**	**25**	**16**	**24**	**12**	**14**	**6**	**13**	**11**	**108**	**73**

Table 1 shows the number of male and female consultants categorised by age profile in each locality. The data includes all staff (eg permanent, locum, flexible retiree – except agency locums).

The majority of our consultant workforce is aged between 40 and 49 (46%), with the modal average being the 45-49 age group. This has increased since last quarter (35-39 age group) which could suggest an older age force in York and Selby. In contrast, Forensic Services remain relatively young with no-one over the age of 54. The male and female split in Durham and Darlington and York and Selby are fairly equal which is not replicated in the other localities. Overall, there is a 60/40% male/female split respectively (which has changed by 1% since last quarter – 59/41%).

Figures from the GMC are showing an increase in females graduating – in 2011, 53% of those gaining GMC registration were female. In addition, the number of females on the register is expected to exceed the number of males by 2017 (GMC, 2012). This suggests that the male to female ratio may even out in the Trust over the next few years.

Consultants by Age & Gender in Specialties

Table 2	AMH		CYPS		MHSOP		LD		Forensic MH		Forensic LD		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
30 – 34	1	2			2	1			1				**4**	**3**
35 – 39	7	6	2	5	4	3	3	2	2	1	1	1	**19**	**18**
40 – 44	11	7	4	1	3	2	2	2	2		1	3	**23**	**15**
45 – 49	11	4	5	7	7	3	1		4	1	1		**29**	**15**
50 – 54	10	2	3	7	1	4		2	1		1		**16**	**15**
55 – 59	3	2	1	2	2	1	2	1					**8**	**6**
60 – 64	4	1	2		1								**7**	**1**
65 – 69	1												**1**	
70+	1												**1**	
Total	49	24	17	22	20	14	8	7	10	2	4	4	**108**	**73**

Table 2 shows the number of male and female consultants in various age brackets defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Interestingly, Forensic Services has a relatively young workforce with only 2 out of 20 doctors over the age of 50, while the other specialties together make up 25% of the consultant workforce over the age of 50. In addition, the lack of a female workforce in Adult Mental Health and Forensic Mental Health is quite evident from the data.

SAS Doctors by Age & Gender

Table 3	D&D		Tees		NY		Forensic		York & Selby		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
30 – 34												
35 – 39	3					3	1				**4**	**3**
40 – 44	1	2	1	2			1	1			**3**	**5**
45 – 49	3	3		1	1	1	1	1			**5**	**6**
50 – 54	1	2	2	3	1	1	1				**5**	**6**
55 – 59		2	1	1		1		1			**1**	**5**
60 – 64				1								**1**
65 – 69												
70+	1										**1**	
Total	**9**	**9**	**4**	**8**	**2**	**6**	**4**	**3**	N/A	N/A	**19**	**26**

Table 3 shows the number of male and female SAS doctors in various age brackets defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Please note there are no specialty doctors in York and Selby. In comparison to the consultant workforce, there is a 42/58% split in favour of females (1% increase/decrease in males/females since last quarter), with noticably few males (2) in the North Yorkshire locality. In addition, the average workforce age is slightly higher (45-54) than consultants, with slightly under a half (45%) being over the age of 50. It is also worth noting that our Teesside locality has a high proportion of its workforce in the over 50 category (67%).

SAS Doctors by Age & Gender in Specialties

Table 4	AMH		CYPS		MHSOP		LD		Forensic MH		Forensic LD		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
30 – 34														
35 – 39	3	2		1		1			1				**4**	**3**
40 – 44		3		1	2	1			1			1	**3**	**5**
45 – 49	2	3		2	2	1				1	1		**5**	**6**
50 – 54	2	3		1	2	3					1		**5**	**6**
55 – 59	1	2		1		1				1			**1**	**5**
60 – 64								1						**1**
65 – 69														
70+					1								**1**	
Total	8	9		6	7	7		1	2	2	2	1	**19**	**26**

Table 4 shows the number of male and female SAS doctors in various age brackets defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. It should be noted that male and female numbers are fairly even, except in CYPS where all doctors are female.

Ethnic Origin

Consultants Table 5	D&D		Tees		NY		Forensic		York & Selby		Total	
	M	F	M	F	M	F	M	F	M	F	**M**	**F**
White British	12	17	8	10	12	10	8	2	9	10	**48**	**49**
White Irish	2								1		**3**	
White European	2	1	2	1	3						**7**	**2**
White Polish							1				**1**	
White Other			1							1	**1**	**1**
Asian British – Indian	11	5	11	1	4	1	2	4	3		**31**	**11**
Asian British–Pakistani					1		1				**2**	
Asian British–Bangladesh					1						**1**	
Asian British–Other	1		1	1							**2**	**1**
Black British–African		1		2	2					1	**2**	**4**
Black British - Nigerian	1										**1**	
Black British–Other	1		1				1				**3**	
Mix White/Black–African	1										**1**	
Mixed – Other			1				1				**2**	
Chinese	1									1	**1**	**1**
Other	1	1		1	1	1					**2**	**3**
Not Stated						1						**1**

Table 5 shows the number of male and female consultants in ethnic origin categories defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. The table shows that just over half of the consultant workforce are 'White British' (97 White British and 84 non-White British).

When considering BAME consultants, 112 are from the EU while 69 are from Asia, Africa or elsewhere (62/38% respectively). Interestingly, the male/female split between the EU area and BAME areas is quite distinct – 54% of the EU workforce are male and 46% are female; in BAME areas, 70% of the workforce are male compared to 30% female. North Yorkshire has twice as many EU consultants as BAME.

SAS Doctors

Table 6

	D&D		Tees		NY		Forensic		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
White British	3	4		3		2	1		**4**	**9**
White European					1				**1**	
White Other	2	1		1				1	**2**	**3**
Asian British–Indian		3	3	3	1			1	**4**	**7**
Asian British–Pakistani	1					1	1		**2**	**1**
Asian British- Banglaesh	1								**1**	
Asian British–Other						1		1		**2**
Black British–African		1					1		**1**	**1**
Black British-Nigerian	1								**1**	
Black British			1						**1**	
Mix White/Black African							1		**1**	
Vietnamese				1						**1**
Other	1	1				1			**1**	**2**

Table 6 shows the number of male and female SAS doctors in various ethnic origin categories defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. This table shows the opposite trend to consultants in that 29% of the SAS workforce are 'White British' (13 are White British and 32 (71%) are non-White British). When considering BAME SAS doctors, 19 are from the EU and 26 are from Asia and Africa or elsewhere (42/58% respectively). In contrast to consultants, the male/female split in BAME areas is (46/54% respectively) whereas the EU workforce is highly biased towards females (37% males/63% females).

Full Time / Part Time

Table 7

Consultant												
	D&D		**Tees**		**NY**		**Forensic**		**York & Selby**		**Total**	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	M	F
Full Time	25	13	25	12	16	6	12	6	9	5	**86**	**43**
Part Time	7	15		4	8	6	2		5	5	**22**	**30**
Specialty Doctors												
Full Time	7	5	4	2	2	2	3	2			**16**	**11**
Part Time	2	4		6		4	1	1			**3**	**15**

Table 7 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. This shows that overall, almost half (45%) of the career grade workforce are full time males with just under a quarter (24%) of females in full time positions. In addition, only 11% of males and 20% of females are working part time. The number of part time

workers could increase over the next few years due to the introduction of flexible working options open to all doctors.

Table 8

Consultant														
	AMH		**CYPS**		**MHSOP**		**LD**		**Forensic MH**		**Forensic LD**		**Total**	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
Full Time	42	15	9	9	18	10	5	3	9	2	3	4	**86**	**43**
Part Time	7	9	8	13	2	4	3	4	1		1		**22**	**30**
Specialty Doctors														
Full Time	6	4		3	7	2			2	2	1		**16**	**11**
Part Time	2	5		3		5		1			1	1	**3**	**15**

Table 8 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Of interest is that half the staff in CYPS are part time.

Section 3: Vacancies

This section considers the number of current vacancies in the trust and the plans for recruitment, including whether a locum is covering at present.

Table 1	**D&D**	**Tees**	**NY**	**Forensic**	**York & Selby**	**Total**
Consultant	7	6	7	1	4	25
SAS		1	1		2	4

Table 1 above shows the current vacancies in each directorate. The number of consultant vacancies has increased from 15 to 25 since last quarter.

Table 2	**AMH**	**CYPS**	**MHSOP**	**LD**	**FMH**	**FLD**	**Total**
Consultant	8	10	6		1		25
SAS		1	3				4

Table 2 above shows the current vacancies in each specialty. While LD remains with no vacant positions there is a noticeable increase in CYPS vacancies (4 in last quarter).

Vacancy Breakdown

Table 3

Vacancies	**Locum in place**	**Times Advertised**	**Date of Advert**	**Date of Interview**	**Appt made**	**Start date**
Consultant in AMH (Inpatient / Crisis) RPH	Agency Locum	0				
Consultant in AMH (PICU) RPH	No	0				
Consultant in AMH (Inpatient) RPH	Subs Cons	0				
Consultant in Liaison North Tees	No	0				
Consultant in CYPS The Ridings, Redcar	No	1	07/03/15	29/04/15	No	
Consultant in CYPS Viscount House, Stockton	No	0				
Consultant in CYPS LD (6PA) The Ridings, Redcar	No	1	21/11/15	25/01/16		

Vacancies	Locum in place	Times Advertised	Date of Advert	Date of Interview	Appt made	Start date
Senior Specialty Doctor in CYPS (specialist in Paediatrics) Viscount House, Stockton	No	1	22/08/15	30/09/15	Yes	01/02/16
Consultant in AMH (Community Eating Disorders) Imperial House	Agency Locum	0				
Consultant in AMH (Liaison) West Park Hospital	Flexible Retiree	0				
Consultant in AMH (Affective Disorders) North End House	Subs Cons	0				
Consultant in CYPS Acley Centre, South Durham	Subs Cons	1	28/08/15	28/09/15	Yes	05/02/16
Consultant in CYPS Winchester House, Peterlee	Subs Cons	0				
Consultant in MHSOP Easington	Trust Locum	3		18/03/15	No	
Consultant in MHSOP (Liaison) LRH	No	3		18/03/15	No	
Consultant in AMH (Working Age Psychiatry) Ellis Ct, Sbr	Trust Locum	2		27/04/15	No	
Consultant in MHSOP Cross Lane Hospital / Malton	Trust Locum	2	05/12/15	~~30/07/15~~ 19/01/16	No	
Consultant in MHSOP Whitby / Cross Lane Hospital	Acting Cons	0				
Specialty Doctor in MHSOP Friarage Northallerton	Trust Locum	0				
Consultant in CYPS (6PA) Dragon Parade, Harrogate	Subs Cons	0				
Consultant in CYPS (7PA) Dragon Parade, Harrogate	Subs Cons	0				
Consultant in CYPS Dragon Parade, Harrogate	Subs Cons	0				
Consultant in CYPS (Tier 4) West Lane Hospital	No	2		29/04/15	No	
Consultant in Forensic (Forensic Mental Health), RPH	No	1			No	
Consultant in AMH (9PA) York	Agency/ Trust Locum				No	
Consultant in MHSOP York					Yes	Feb 2016
Consultant in MHSOP (8PA) York					Yes	Feb 2016
Specialty Doctor in MHSOP York	Agency Locum					
Specialty Doctor in MHSOP York	Agency Locum					
Consultant in CYPS (6PA) York						

Table 3 shows the breakdown of each vacancy in the Trust and the number of times the post has been advertised (including any current adverts). The information around York is unknown at present.

The table below shows the recruitment activity in this period (October to December 2015). Within this period 2 posts were advertised and recruitment has been 100% successful.

Table 4

Vacancies advertised	Times advertised	No of candidates applied	No of candidates shortlisted	Appointment made
Consultant in MHSOP York	1	4	4	Yes
Consultant in MHSOP York	1	4	4	Yes

Section 4: Sickness

Doctors on Long Term Sick Leave by Locality

Figure 1

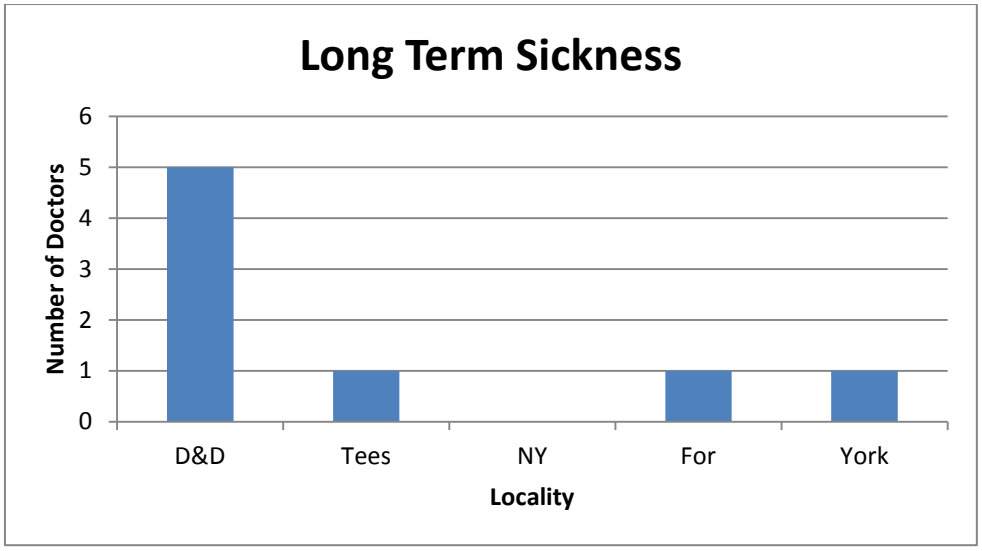


Figure 1 shows the number of doctors on long term sick (includes 5 consultants, 2 SAS and 1 Trainee). Four out of the eight doctors continued on long term sick from last quarter.

Reasons for Sickness Absence

Figure 2

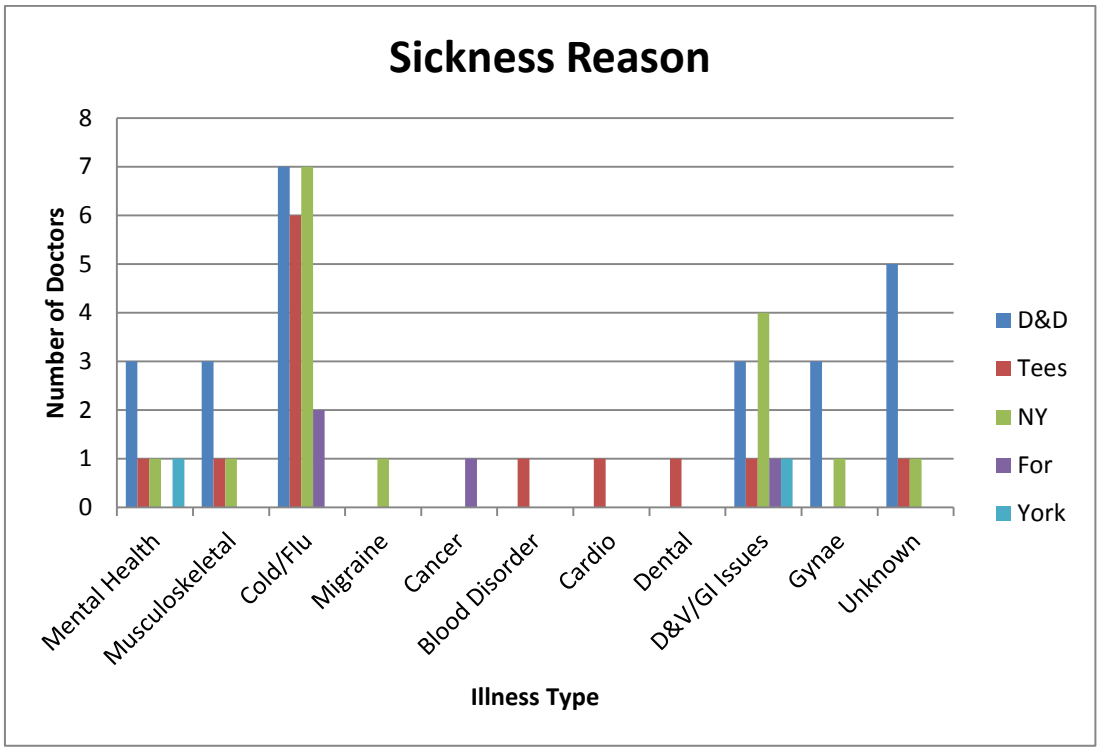


Figure 2 shows the reasons for sickness absence (including long term sickness) during the period October to December 2015. This includes all grades of doctor except agency locums. Interestingly, the number of cold and flu episodes has increased from 8 to 22 in all areas except York. The number of 'diarrhoea and vomiting' episodes remains high in Durham & Darlington and have increased in North Yorkshire. Overall, 658 days were lost due to sickness (47 days more than last quarter and 169 more than quarter 1) out of which 158 were for short term illnesses (an increase of 66 to last quarter) and 500 were for long term illnesses (a decrease of 14). This is probably down to this quarter being the winter season.

Section 5: Appraisals and Revalidation

Consultants

Table 1	D&D	Tees	NY	For	Y&S	Total
Appraisals Due	17	12	10	4	5	48
Appraisals Actual	14	10	10	4	3	41

Table 1 shows the number of consultant appraisals that were due between 1st October 2015 and 31st December 2015 and how many were actually completed. The total number is broken down into locality.

Table 2	D&D	Tees	NY	For	Y&S	Total
Revalidation Due	4	4	2	0	0	10
Revalidation Actual	4	4	2	0	0	10

Table 2 shows the number of consultants who were due revalidation between 1st October 2015 and 31st December 2015 and those who were successfully revalidated. The numbers are broken down into locality.

SAS

Table 3	D&D	Tees	NY	For	Y&S	Total
Appraisals Due	8	6	1	3	0	18
Appraisals Actual	8	5	1	3	0	17

Table 3 shows the number of SAS doctor appraisals that were due between 1st October 2015 and 31st December 2015 and how many were actually completed. The total number is broken down into locality.

Table 4	D&D	Tees	NY	For	Y&S	Total
Revalidation Due	3	1	0	1	0	5
Revalidation Actual	2	1	0	1	0	4

Table 4 shows the number of SAS doctors who were due revalidation between 1st October 2015 and 31st December 2015 and those who were successfully revalidated. The numbers are broken down into locality.

Trust Doctor

Table 5	D&D	Tees	NY	For	Y&S	Total
Appraisals Due	0	0	1	0	0	1
Appraisals Actual	0	0	1	0	0	1

Table 3 shows the number of Trust doctor appraisals that were due between 1st October 2015 and 31st December 2015 and how many were actually completed. The total number is broken down into locality.

Table 6	D&D	Tees	NY	For	Y&S	Total
Revalidation Due	0	0	0	0	0	0
Revalidation Actual	0	0	0	0	0	0

Table 4 shows the number of Trust doctors who were due revalidation between 1st October 2015 and 31st December 2015 and those who were successfully revalidated. The numbers are broken down into locality.

Section 6: Turnover

This section considers the number of doctors who have commenced in the Trust between 1st October 2015 and 31st December 2015. It also highlights the number of doctors leaving the Trust and their leaver destination.

New Starters vs Leavers by Locality

Table 1	D&D	Tees	NY	Forensic	York & Selby	Total
New Starters	1				5	6
Leavers	1	1	2	1		5

Table 1 highlights the number of new starters against the number of leavers. Again, this includes all types of staff except agency locums. This shows that turnover is relatively even.

New Starters vs Leavers by Specialty

Table 2	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
New Starters	3		3	3			6
Leavers	2	1	1			1	5

Table 2 shows the number of new starters against the number of leavers defined by specialty. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

New Starters vs Leavers Grade Breakdown

Table 3	Consultants	SAS	Trust Doctors
New Starters	5		1
Leavers	5		

Table 3 shows the number of new starters against the number of leavers defined by grade. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

Leaver Destination by Locality

Table 4	D&D	Tees	NY	Forensic	York & Selby	Total
Flexible Retirement						
Retired (ill health)			1			1
Moved Abroad				1		1
Needed to Relocate						
Joined Another Trust	2					2
Joined Train Scheme						
End of Contract			1			1

Table 4 shows the destination of doctors after leaving the Trust, defined by locality. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums. The leaver in Forensics was on a career break in Canada and chose to remain there, one came to the end of his contract and one retired after 12 months on sick leave. The other two joined trust's elsewhere (one of which was in a private healthcare setting).

Leaver Destination by Specialty

Table 5	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Flexible Retirement							
Fully Retired (ill health)		1					1
Moved Abroad						1	1
Needed to Relocate							
Joined Another Trust	2						2
Joined Training Scheme							
End of Contract			1				1

Table 5 shows the destination of doctors after leaving the Trust, broken down by specialty. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

Leaver Destination by Grade

Table 6	Consultants	SAS	Trust Doctors
Flexible Retirement			
Fully Retired (ill health)	1		
Moved Abroad	1		
Needed to Relocate			
Joined Another Trust	2		
Joined Training Scheme			
End of Contract	1		

Table 6 shows the destination of doctors after leaving the Trust, broken down by grade. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

Leavers over the last 2 years

The tables below show a breakdown of the leavers over the last 2 years (from 1st January 2014).

Table 7	D&D	Tees	NY	Forensic	Total
Flexible Retirement	1	2	2		5
Retired (ill health)		1	1		2
Retired Fully	1	3	1	1	6
Moved Abroad	1	5	3	4	13
Needed to Relocate		1		1	2
Joined Another Trust	3	2		1	6
Joined Training Scheme	1	4	1		6
End of Contract	3	1	1		5

Table 7 shows that 42% of all leavers came from the Teesside locality. Interestingly, 29% of doctors left the Trust to move abroad.

Table 8	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Flexible Retirement	3	1		1			5
Fully Retired (ill health)	1	1					2
Fully Retired	2	2	1		1		6
Moved Abroad	7	2			2	2	13
Needed to Relocate	1					1	2
Joined Another Trust	4		1		1		6
Joined Training Scheme	6						6
End of Contract	3		1	1			5

Table 8 shows that 60% of leavers were from Adult Mental Health.

Table 9	Consultants	SAS	Trust Doctors
Flexible Retirement	5		
Fully Retired (ill health)	2		
Fully Retired	4	2	
Moved Abroad	10	3	
Needed to Relocate	1	1	
Joined Another Trust	6		
Joined Training Scheme		2	4
End of Contract	5		

Table 9 shows that 73% of leavers were consultants.

Section 7: Mind the Gap Payments

This section includes the number of extra PA payments that are being made within 'Mind the Gap', eg for providing cover during sickness or vacancies, over the last 3 months. It is broken down into locality and specialty.

Table 1	AMH	CYPS	MHOSP	LD	FMH	FLD	Total
D&D	12.75	5		1			18.75
Teesside	8	12	2.5	2			24.5
NY	3.5	4	8				15.5
Forensic					13	10.5	23.5
Total	24.25	21	10.5	3	13	10.5	**82.25**

Table 1 shows the number of additional PAs under Mind the Gap. This shows that additional PAs in all areas except Forensics have increased from last quarter. Forensics has decreased most likely due to the return of a consultant on maternity leave and the addition of an agency locum.

Section 8: Medical Education Overview

Review of 2015

With the acquisition of York and Selby locality, the Trust now has just over ***150*** junior doctor placements approved for training under the different medical programmes. These programmes include Foundation Training, GP Training, Core Training and Higher. The Trust also hosts medical students from four universities offering placements annually.

The ongoing cycle of quality control continues a pace and the process used to provide assurance to external bodies is through the self-assessment report (SAR) and quality improvement paper (QIP). These reports are shared with Health Education North East (HENE) and Health Education Yorkshire and the Humber (HEY&H) and they set out how we aim to meet the GMC domains for training.

This year we have had more external visits to quality assure the medical education programmes. This includes a GP Scheme ADQM and a School of Psychiatry ADQM within HENE. Panels from regional bodies visit the Trust to monitor progress and set actions that must be strictly followed. The Trust continues to receive excellent feedback from HENE and at the Annual Deanery Quality Management visits.

As always, a number of surveys have been undertaken by medical students and junior doctors in the last 12 months and they have mainly demonstrated an ***exceptionally high level of training across our programmes***, especially so when comparing us to other providers in our region and to other mental health trusts.

The highlights this year from the feedback received includes:

- The Trust was ranked as number one in 9 of the 14 GMC indicators by our junior doctors when comparing TEWV against all other Trusts in the North East.

- The Trust was ranked as the number one provider of GP training when comparing all GP training schemes across the whole of the UK.

- The Foundation School Director from HENE congratulated the Trust for the superb GMC results which contributed to excellent results overall for the Northern Foundation School. He summarised that TEWV featured five times in the Top 10 Trusts in the UK and that this was an exceptional performance. Those areas were:

    - Feedback at F2 level (2nd)
    - Induction at F2 level (4th)
    - Workload at F2 level (4th)
    - Adequate Experience at F2 level (8th)
    - Clinical Supervision at F2 level (8th)

- The Trust has been ranked as the number one Trust in the North East for the last three years in GMC surveys when comparing all junior doctors.

- The report also highlights that the Trust has been nationally ranked in the top 15 (out of all 205 NHS Trusts) for the last three years. The Trust was ranked a higher place than last year and is now ranked 11th in the UK. The examples below outline specific areas of innovation or best practice that have taken place in the previous year.

Feeder Scheme for Core Training
Last year the Trust developed a unique and innovative programme to encourage Trust grade doctors to work in the Trust for an initial one year period. In this time they would receive close supervision and support and a tailored development programme. The doctors were generally equivalent to that of FY2 level and predominantly had trained overseas. This year we invited NTW Trust to join our initiative.

To date, this approach has proved successful and the Trust has recruited 12 doctors. The scheme therefore has two benefits, one to fill vacant posts for service and to encourage those doctors to

develop skills and apply for core training in our regions. The Royal College of Psychiatrists have since informed the Trust that they wish to use this model and will pilot a UK programme in 2016.

Leadership Programme now incorporates all Senior Health Care Practitioners
The newly established inter-professional health education group decided to expand the programme and invite specialist registrars and middle grade/senior health care practitioners to the programme to develop their knowledge and skills in leadership and management alongside the doctors. This comprehensive programme brought to life core management and leadership competencies, demonstrating how they can be applied in the workplace. The programme still covers the Medical Leadership Competency Framework five domains: Personal Qualities, Working with others, Managing Services, Improving Services and Setting Direction.

Core Clinical Skills Event
The Core Clinical Skills event was a one-off event held on behalf of the School of Psychiatry. It was a unique training opportunity for Psychiatric Registrars to develop their skills in assessment formulation and presentation in clinical psychiatry. The event contributed to the development of a unique multimedia training package on core skills in Psychiatry. The programme involved psychiatric registrars participating in three extended case scenarios around core clinical disorders involving assessment and presentation to senior tutors (who are also CASC examiners) and received detailed feedback on the day.

Clinical Assessment of Skills and Competencies (CASC) Club Event
The CASC Club event was focussed on Core Trainees and Trust Doctors based within Psychiatry and provided a unique learning opportunity, allowing trainees who were due to sit their CASC exam, the chance to practice their clinical skills and receive detailed feedback on the day from Senior Consultants.

Trainee Led Medical Education Conference
This year junior doctors were invited to project lead and deliver the conference from its initial concept. The group of junior doctors determined the theme as 'The role of Psychiatry within physical health care', and staff from across all clinical disciplines were invited to attend the event with feedback very positive from delegates and junior doctors. We aim to replicate this again in 2016 because of its success and the learning opportunities it provided for junior doctors.

The Dragons Den
The faculty decided to replicate the popular TV programme, with a twist, and focussed the entrepreneurs energy on how an idea could radically improve clinical education and training, encourage recruitment into the mental health profession, generate ideas for collaborative training amongst clinical professionals, improve the quality of clinical training and enhance patient care, make TEWV a centre of excellence and well renowned for training health professionals or finally create innovative products that support learning and generated income. This year the opportunity was broadened and clinical professionals were invited to pitch their ideas to the dragons.

Focussed induction for medical students
The undergraduate tutors within the faculty identified that it would be beneficial to have an **introduction to mental health as part of their induction that is delivered to all medical students on** placement in TEWV, irrespective of University programme. The faculty were invited to share comments on existing approaches used throughout the organisation and the key messages we wanted to focus on. A senior undergraduate tutor has led on this work, attending all existing programmes. The new programme will be rolled out from February to all medical students.

The Trust continues to have a pro-active and strong faculty of medical education. Feedback demonstrates more than ever that we continue to achieve high results in relation to the delivery of medical education across all programmes.

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th January 2016**
TITLE:	**Monitor Risk Assessment Framework Report – Quarter 3, 2015/16**
REPORT OF:	**Phil Bellas, Trust Secretary**
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 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 report seeks the Board's approval of the Trust's submission of information required by Monitor under its Risk Assessment Framework for Quarter 3, 2015/16.

In doing so the report provides assurance that the Trust has maintained its planned risk ratings for financial sustainability and governance. However, an exception report is required with regard to CQC compliance actions and the York and Selby transaction.

Recommendations:

The Board is asked to approve the Trust's Quarter 3, 2015/16, Risk Assessment Framework submission to Monitor.

MEETING OF:	**The Board of Directors**
DATE:	**26th January 2016**
TITLE:	**Monitor Risk Assessment Framework Report – Quarter 3, 2015/16**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek the Board's approval of the Trust's proposed submission to Monitor under the Risk Assessment Framework (RAF) for Quarter 3, 2015/16 (period covering 1st October 2015 to 31st December 2015).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Risk Assessment Framework provides details of the in-year information which the Trust must submit to Monitor, based on its risk ratings.

2.2 The Risk Assessment Framework is used by Monitor to assess compliance with two specific aspects of a Foundation Trust's Provider Licence: the continuity of services (financial sustainability) and governance licence conditions. Each of these elements is assigned a risk rating which are based on a range of metrics and information derived from a number of sources.

2.3 The information and declarations supporting the Financial Sustainability Risk Rating are due for consideration under agenda item 8.

2.4 This report focusses on the Trust's RAF submission with regard to governance including seeking the Board's:

(a) Self-certification of two governance statements as follows:

"The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards."

"The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Table 3) which have not already been reported."

(b) Approval of:

- A declaration on the number of subsidiaries which are consolidated in the financial results submitted.
- Information on Executive team turnover which is used as a potential indicator of quality governance concerns.
- Exception reports prepared in accordance with Table 3 of the RAF.

2.4 The Board is asked to note that, in a letter dated 1st December 2015, Monitor confirmed the Trust's risk ratings for Quarter 2, 2015/16, as submitted i.e:
(a) A Financial Sustainability Risk Rating of 4.
(b) A "Green" Governance Risk Rating.

2.5 The Trust is required to submit its Quarter 3 Risk Assessment Framework Return by 29th January 2016.

3. KEY ISSUES:

Governance Targets and Indicators and Declarations

3.1 Details of the healthcare targets and indicators, together with Monitor's thresholds and weightings, supporting the assessment of the Trust's Quarter 3 Governance Risk Rating are set out in Annex 1 to this report. The scoring of the metrics is based on the information provided in the Performance Dashboard report (see agenda item 9).

3.2 The Board is asked to note that, from Quarter 3, the Trust is required to report its performance on the new IAPT access indicators; however, these measures will not be used as a formal trigger until April 2016 (Q1 2016/17).

3.3 It is considered that the Board is able to sign off both governance declarations for Quarter 3, 2015/16.

Subsidiary Declaration

3.5 It is proposed to advise Monitor that no subsidiaries are consolidated in the financial results submitted as Positive Individualised Proactive Support Ltd has not yet commenced trading.

Quality Governance

3.6 The information required by Monitor on Executive Team turnover is as follows:

Executive Directors	Actual for Quarter ending 31/12/15
Total number of Executive posts on the Board (voting)	5
Number of posts currently vacant	0
Number of posts currently filled by interim appointments	0
Number of resignations in quarter	0
Number of appointments in quarter	0

Exception Report and Other Information to be provided to Monitor

3.7 In accordance with the requirements of the RAF, the Board is asked to approve an exception report, as set out in Annex 2 to this report, on the following matters:

(a) The actions taken by the Trust to address compliance issues raised by the CQC following its inspection of Forensic Learning Disability Services at Roseberry Park in March 2014 and its Trustwide inspection in January 2015.

(b) The position following the Trust becoming the provider of mental health and learning disability services in York and Selby on 1st October 2015 (a material transaction) and related CQC compliance issues.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Information provided by the CQC is used by Monitor to assess organisational and financial governance, including service performance and care quality.

4.2 **Financial/Value for Money:** This issue is covered in the report of the Director of Finance under agenda item 8.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust is required to hold a Licence in order to provide NHS services.

4.4 **Equality and Diversity:** There are no equality and diversity implications associated with this report.

4.4 **Other implications:** There are no other implications associated with the report.

5. RISKS:

5.1 There are risks that Monitor will take regulatory action if the Trust's Risk Ratings deteriorate.

6. CONCLUSIONS:

6.1 It is considered that the Trust is compliant with the requirements of Monitor's Risk Assessment Framework for Quarter 3, 2015/16.

7. RECOMMENDATIONS:

7.1 The Board of Directors is asked to approve the Trust's Quarter 2, 2015/16, Risk Assessment Framework submission to Monitor including:

(a) The signing off of both Governance Statements.

(b) The Information on Executive Team turnover.

(c) The signing off of the declaration that no subsidiaries are consolidated in the financial return.

(d) The exception report set out in Annex 2 to this report.

Phil Bellas, Trust Secretary

Background Papers:
Monitor's Risk Assessment Framework (August 2015)

Annex 1

Analysis of Governance Risk Rating, Quarter 3, 2015/16

Component	Threshold	Weighting	Outcome for Quarter 3	Score for Quarter 3
Mental Health Targets -				
▪ Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	1.0	Target achieved	0
▪ Care Programme Approach (CPA) formal review within 12 months	>95%	1.0	Target achieved	0
▪ Minimising delayed transfers of care	<=7.5%	1.0	Target achieved	0
▪ Admissions to inpatient services had access to crisis resolution home treatment teams	>95%	1.0	Target achieved	0
▪ Meeting commitment to serve new psychosis cases by early intervention teams	>95%	1.0	Target achieved	0
▪ Data Completeness: identifiers	>97%	1.0	Target achieved	0
▪ Data Completeness: outcomes	>50%	1.0	Target achieved	0
▪ Improving Access to Psychological Therapies – Patients referred within 6 weeks (new indicator)	75%	-	-	-
▪ Improving Access to Psychological Therapies – Patients referred within 18 weeks (new indicator)	95%	-	-	-
Compliance with requirements regarding access to healthcare for people with a learning disability.	n/a	1.0	Achieved	-
Risk of, or actual failure, to deliver Commissioner Requested Services	n/a	Report by exception	No	-
Date of last CQC Inspection	n/a	-	January 2015	-
CQC compliance action outstanding (as at time of submission)	n/a	Report by exception	Yes	Exception report to be submitted
CQC enforcement notice within the last 12 months (as at time of submission)	n/a	Report by exception	No	-

CQC enforcement action (including notices) currently in effect (as at time of submission)	n/a	Report by exception	No	-
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	n/a	Report by exception	Yes	Exception report to be submitted
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	n/a	Report by exception	No	-
Overall rating from CQC at time of submission	n/a	-	Good	-
CQC recommendation to place Trust into special measures (as at date of submission)	n/a	-	No	-
Trust unable to declare ongoing compliance with minimum standards of CQC registration	n/a	Report by exception	No	-
			Total Score	**0.0**

Note: Reporting on the metric relating to access to EIP services is not due to commence until Quarter 4, 2015/16.

Annex 2

Draft Exception Report

(1) At Quarter 4, 2014/15 the Trust advised Monitor that it had declared its Forensic Learning Disability services at Roseberry Park, Middlesbrough to be fully compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 following action taken to address compliance issues and "moderate concerns" raised by the Care Quality Commission (CQC) arising from an inspection in March 2014.

Since that time the Trust has been awaiting a follow up inspection by the CQC so that the compliance issues and concerns can be formally signed off. The CQC has yet to confirm the arrangements for this re-inspection.

(2) On 11th May 2015 the CQC published its reports on the inspection of the Trust in January 2015.

Whilst the overall rating provided to the Trust was "Good", the CQC issued requirement notices with regard to compliance with regulations 10, 12, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A copy of the Trust's action plan to address the CQC's requirements has been provided to Monitor.

As at the end of Quarter 3, all actions have been completed with the exception of certain environmental works, which are pending, and an extension to the timescale of one action from January 2016 to May 2016.

(3) On 1st October 2015 the Trust entered into a contract with the Vale of York CCG to provide mental health and learning disability services in York and Selby.

At that time Monitor advised that the risks arising from the transaction, which was deemed material, would be monitored by way of the quarterly Risk Assessment Framework submissions.

Further to the previous update provided, Monitor is asked to note that as at Quarter 3, 2015/16:

(a) Following an inspection by the CQC, the Trust re-opened the Section 136 Suite at Bootham Park Hospital on 16th December 2015.

(b) Negotiations with the CQC with regard to returning outpatient services to the Hospital are continuing and it is probable that it will be achieved in February 2016.

(c) On 8th January 2016, the CQC published its reports on the inspection of the Hospital in September 2015. These reports included requirement notices with regard to regulations 12 (2) (a, b, d and h) and 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Discussions are to be held with the CQC on the process for responding to the compliance actions identified as, at the time of the inspection, Leeds and York Partnership NHS Foundation Trust was the registered provider of the services.

(d) In accordance with the undertaking given in the Board certification dated 29th September 2015, a Corporate Governance Statement and Statement on Quality Governance will be provided by 31st January 2016 under separate cover.

(e) With the approval of the Business Case, the contract for the refurbishment of Peppermill Court, to provide a 24 bed adult inpatient unit, will commence on 1st February 2016. This will enable patients to be repatriated to the Locality in July 2016.

(f) The Trust has been named as one of four organisations in an application for judicial review relating to the closure of Bootham Park Hospital in September 2015 and related matters.

The Trust has submitted information to the claimants' solicitors; however, the date for the application for permission to apply for judicial review is, at present, unknown.

An update on the above matters will be provided to our Relationship Manager at Monitor during feedback discussions on the Quarter 3 Risk Assessment Framework submission.

Item No. 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th January 2016**
TITLE:	**To consider the publication of information on compliance with the public sector duty under the Equality Act**
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:

The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users and staff who share a relevant protected characteristic who are affected by its policies and practices. The attached paper contains the necessary information in relation to service users. The purpose of this report is to seek ratification of this information.

Recommendations:

- The Board is asked to ratify the publication of equality data documents.
- The Board is asked to recommend that the data included in the publication of equality data document be used in the annual planning cycle 2016/ 17 so that any issues highlighted in it can be addressed locally

MEETING OF:	**Board of Directors**
DATE:	**26 January 2016**
TITLE:	**To consider the publication of information on compliance with the public sector duty under the Equality Act**

1.0 INTRODUCTION & PURPOSE:

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

2.0 BACKGROUND INFORMATION AND CONTEXT:

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

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

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

3.0 KEY ISSUES:

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

3.2 This information needs to be used in planning and delivering services and in identifying areas for service development and improvement

4.0 IMPLICATIONS:

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

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

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

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

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

5.0 RISKS:

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

6.0 CONCLUSIONS:

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

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

7.0 RECOMMENDATIONS:

7.1 The Board is asked to ratify the publication of equality data document (attached).

7.2 The Board is asked to recommend that the data included in the publication of equality data document be used in the annual planning cycle 2016/17 so that any issues highlighted in it can be addressed locally.

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

Background Papers:
None

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

PUBLICATION OF EQUALITY DATA

1 November 2014 – 31 October 2015

Published 31 January 2016

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

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

Arabic:
إذا أردت منا تلخيص هذه المعلومات بلغة أخرى أو بصيغة مختلفة مثل لغة بريل أو شريط صوتي أو قرص DVD
يرجى الاتصال برقم الهاتف التالي.

Bengali:
যদি আপনি অন্য একটি ভাষায় এই তথ্যের সংক্ষিপ্তসার চান অথবা ব্রেইল, কথা বলা টেপ অথবা ডি.ভি.ডি. ফরম্যাট-এ এই তথ্য চান, তাহলে অনুগ্রহ করে নিচের নম্বরে টেলিফোন করুন।

Farsi:
در صورتی که مایلید خلاصه این اطلاعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره زیر تماس بگیرید.

Hindi:
यदि आप इस सूचना का सारांश किसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टाकिंग टेप या DVD में चाहते हों, तो कृपया नीचे दिए गए नंबर पर फोन करें।

Kurdish (Kurmanji):
Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈੱਟ ਜਿਵੇਂ ਬ੍ਰੇਲ, ਟਾਕਿੰਗ ਟੇਪ ਜਾਂ DVD ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:
如果您需要该条信息用其他语言或格式概述，例如盲文，录音磁带或 DVD。请联系以下号码：

Urdu:
اگر آپ کو ان معلومات کے خلاصہ کی کسی دیگر زبان یا شکل مثلاً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو برائے مہربانی درج ذیل نمبر پر کال کریں۔

Telephone 0191 3336267

PUBLICATION OF EQUALITY DATA

1. INTRODUCTION

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

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

1.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are gender, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

1.3 The Trust has published information to meet its public sector duties for the last four years. During this time the quality of the data has steadily improved however the Trust recognises that there are still qualifications around the quality and validity of the data, particularly as in some areas the numbers are relatively low. The Trust wants to be transparent in demonstrating its compliance with its Equality Act duties and has decided to publish raw data. The information published must therefore be viewed as descriptive and any interpretations of it must be conservative.

1.4 The information in this report includes:

- An analysis of service users who were referred to Trust services between 1st November 2014 and 31st October 2015 by race and ethnicity, gender, disability, religion, sexual orientation, age, marriage and civil partnership. The data is taken from information given by service users who at times refuse to provide information requested, giving incomplete data.
- Health and Social Care Information Centre (HSCIC) have published information based on the national returns for the Mental Health Minimum data set (MHMDS) for 2014/15.These are the expected rates of access to specialist mental health services per 100,000 of the population by ethnicity and ethnic groups and their respective rate of access to hospital services per 100 service users. These figures have been compared to the Trust's MHMDS returns for 2014/15 and include figures for service users whose ethnicity is not known or not stated as these are valid returns for this purpose.
- An analysis of the length of waiting time from referral to first contact by ethnicity and an analysis of length of hospital stay by ethnicity.
- This year's report does not contain figures for York and Selby as the trust only assumed responsibility for services in this area in October 2015 and the figures

published are for the period 1.11.14 – 31.10.15 which were not available to the trust for York and Selby. Next year's publication of information document will contain figures for York and Selby and information about the work the trust has undertaken to understand the issues those from protected groups experience when accessing our services and to develop appropriate actions

Where possible the Trust's data has been compared to that of the 2011 Census produced by the Office of National Statistics. Copyright is acknowledged as adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0.

2. ACCESS TO SERVICES

2.1 The following data is for the year 1st November 2014 to 31st October 2015 and is the information contained on the Trust's electronic clinical record system. Some of the fields are incomplete for some service users and some service users have preferred not to give the Trust certain information. The level of missing values and non disclosure is indicated in each section.

2.2 The data for the MHMDS is for the year 2014/15 as this is the latest information available from the HSCIC.

2.3 Where it is available the makeup of the Trust's service user population has been compared to the information on the general population that was gathered in the 2011 census.

2.4 Summary of Service Users by Ethnic Group Compared to ONS 2011 Census Information

Ethnic Group	Ethnic breakdown of service users in the Trust (number)	Ethnic Breakdown of service users in the Trust (%)	Ethnic Breakdown 2011 Census (number)	Ethnic Breakdown 2011 Census (%)
White; British	**143132**	**88.60**	1598854	94.55
White; Irish	**402**	**0.25**	5330	0.32
White; Other White includes Eastern European	**1553**	**0.96**	26434	1.56
Mixed; White and Black Caribbean	**208**	**0.13**	3995	0.24
Mixed; White and Black African	**93**	**0.06**	1964	0.12
Mixed; white and Asian	**236**	**0.15**	5166	0.31
Mixed; Other Mixed	**324**	**0.20**	3299	0.20
Asian or Asian British; Indian	**278**	**0.17**	6872	0.41
Asian or Asian British;	**537**	**0.33**	11953	0.71

Pakistani				
Asian or Asian British; Bangladeshi	**88**	**0.05**	1721	0.10
Asian or Asian British; Other Asian	**450**	**0.28**	7286	0.43
Black or Black British; Caribbean	**69**	**0.04**	848	0.05
Black or Black British; African	**271**	**0.17**	4526	0.27
Black or Black British; Other Black	**131**	**0.08**	1052	0.06
Asian or Asian British Chinese	**119**	**0.07**	5664	0.33
Other Ethnic Group includes Iranians and Arabs	**521**	**0.16**	4400	0.26
Travellers including Gypsy, Roma Traveller/Irish Traveller	82	0.2	1600	0.09
Not stated	**4352**	**2.69**		
NULL	**8694**	**5.40**		
Total	**161540**		**1690,964**	

2.4.1 8694 or 5.4% of service users' race/ ethnicity is not available as it has not been provided. This compares to 4.76 % last year. There are variations from the census norms which the Trust will use to explore access issues.

2.4.2 Summary of rates of access to specialist mental health services based on the information in the mental health bulletin annual report 2014/15

Ethnic Group	Standardised rates of access per 100,000 population	Anticipated number using TEWV services	Actual number using TEWV services
White; British	3634	58102	67916
White; Irish	3125.8	167	213
White; Other White includes Eastern European	5037.3	1332	767
Mixed; White and Black Caribbean	3581.2	143	60
Mixed; White and Black African	3794.6	74	42

Mixed; white and Asian	2373.1	123	64
Mixed; Other Mixed	6021.8	199	123
Asian or Asian British; Indian	2520	173	129
Asian or Asian British; Pakistani	3923.7	469	251
Asian or Asian British; Bangladeshi	4549.6	78	30
Asian or Asian British; Other Asian	4055.9	296	221
Black or Black British; Caribbean	4795.8	41	38
Black or Black British; African	3177.6	144	127
Black or Black British; Other Black	11379	120	48
Chinese	1544.1	87	62
Other Ethnic Group includes Iranians and Arabs	16117.8	709	235
Null			1
Not stated			1060
Traveller			41

A degree of caution must be applied in interpreting these figures because of the number of service users whose ethnicity is not known or not stated which could significantly affect the figures in each category.

2.4.3 Summary of rates of access to hospital inpatient care based on the information in the mental health bulletin annual report

Ethnic Group	Standardised rate of access per 100 service users	Anticipated numbers using inpatient care	Actual number using TEWV services
White; British	6.95	4720	2806
White; Irish	8.96	19	12
White; Other White includes Eastern European	7.95	61	51
Mixed; White and Black Caribbean	10.70	6	8
Mixed; White and Black African	10.67	4	0
Mixed; white and Asian	8.41	5	4
Mixed; Other Mixed	8.90	11	4
Asian or Asian British; Indian	7.64	10	16
Asian or Asian British; Pakistani	7.46	11	20
Asian or Asian British; Bangladeshi	7.58	2	2
Asian or Asian British; Other Asian	8.19	18	14
Black or Black British; Caribbean	13.66	5	4
Black or Black British; African	13.29	17	14
Black or Black British; Other Black	13.54	6	5
Chinese	9.34	6	4
Other Ethnic Group includes Iranians and Arabs	5.88	14	12
Not known			95
Not stated			14

There does not appear to be a significant difference between the anticipated rate of access to hospital and the actual rates. However the differences between the expected rates of access and the actual rates of access in both tables 2.4.2 and 2.4.3 will be used by the Trust to explore issues of access.

2.4.4 Length of waiting time from referral to first contact by ethnicity

The Trust has produced its own figures on the length of waiting time from first referral to first contact analysed by ethnicity. There are some differentials in these which will be explored and appropriate action taken. A degree of caution must be applied in interpreting these figures because of the number of service users whose ethnicity is not known or not stated which could significantly affect the figures in each category.

Ethnic Group	No. of patients	Average length of time (days)
White; British	36338	12.53
White; Irish	93	9.16
White; Other White includes Eastern European	353	10.25
Mixed; White and Black Caribbean	36	8.44
Mixed; White and Black African	31	11.35
Mixed; white and Asian	65	11.75
Mixed - Other Mixed	78	15.62
Asian or Asian British; Indian	54	8.22
Asian or Asian British; Pakistani	137	10.06
Asian or Asian British; Bangladeshi	29	8.97
Asian or Asian British; Other	104	10.05
Black or Black British; Caribbean	9	2.78
Black or Black British; African	48	4.63
Black or Black British; Other Black	24	8.88
Asian/Asian British - Chinese	29	4.62
White - Gypsy	16	15.5
Irish - Traveller	13	8.62

Other Ethnic Group includes - Arabs	33	6.27
Not known	3095	9.02
Not stated	1905	20.70
Other Ethnic Group – any other	146	8.17

2.4.5 Length of hospital stays by ethnicity

The Trust has again analysed the length of inpatient stay by ethnicity. Following feedback last year these figures have been produced for long stay wards, acute wards and short stay respite to provide a more accurate understanding of differences between ethnic groups These figures are for the period 1st November 2014 to 31st October 2015. Some patients were admitted to hospital prior to 1st November 2014 and this is not reflected in these figures. There are some differences in these which will be explored.

Length of hospital stay by Ethnicity 01/11/2014 - 31/10/2015

ACUTE WARDS:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	2894	33.95	0	365
White; Irish	15	48.13	0	365
White; Other White includes Eastern European	40	35.44	1	332
Mixed; White and Black Caribbean	9	32.21	4	109
Mixed; White and Black African	1	41	41	41
Mixed; white and Asian	6	38.57	2	118
Mixed; Other Mixed	8	41.07	0	256
Asian or Asian British; Indian	10	61	3	277
Asian or Asian British; Pakistani	20	23.96	1	121
Asian or Asian British; Other Asian	13	27.40	2	77
Black or Black British; Caribbean	2	11.33	4	24
Black or Black British; African	10	25.44	2	78
Black or Black British; Other Black	5	16.86	3	31
Asian / Asian British - Chinese	5	48.17	1	241
Other Ethnic Group Any other	12	22.93	1	85
White - Gypsy	2	30.5	25	36
Not known	100	14.12	0	159
Not stated	21	37.12	0	259

Other Ethnic group includes Arabs	1	3.00	3	3

Long Stay wards:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	397	201.08	2	365
White; Irish	1	172.00	172	172
White; Other White includes Eastern European	7	98.14	5	365
Mixed; White and Black Caribbean	3	187	143	255
Mixed; Other Mixed	2	165.5	4	327
Asian, Asian British Bangladesh	3	109.33	85	151
Asian or Asian British; Pakistani	3	176	47	365
Asian or Asian British; Other Asian	3	140.67	11	365
Black or Black British; African	5	185.80	19	341
Black or Black British; Other Black	1	12.0	12	12
Asian / Asian British - Chinese	1	365	365	365
Not known	10	21.00	3	117
Not stated	1	2.00	2	2

Short stay/respite stay:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	283	3.11	0	58
Mixed white and Asian	1	5.00	5	5
White; Other White includes Eastern European	4	2.92	3	28
Mixed; Other Mixed	0	28.00	28	28
Asian, Asian British Indian	1	3.00	3	3
Asian or Asian British; Pakistani	5	2.26	0	4
Asian or Asian British; Other Asian	2	3.80	0	10
Black or Black British; African	2	18.50	1	36
Black or Black British; Other	1	17.00	17	17
Other ethnic group, any other	1	1.92	1	3
Not known	14	3.21	0	16
Not stated	6	2.67	1	35

2.5 Summary of Service Users by age compared to the ONS 2011 Census

Age	Breakdown of Service Users in the Trust by age (Number)	Breakdown of Service Users in the Trust by age (%)	ONS Census 2011 Breakdown by age (number)	ONS Census 2011 Breakdown by age (%)
0-18	27125	16.79	346436	20.5
18-29	30685	19.00	250209	14.8
30-44	31890	19.74	311330	18.4
45-64	32084	19.86	470521	27.8
Over 65	39756	24.61	312469	18.5
Total	**161540**	**100**	**1,690,965**	

2.5.1 Comparing the age categories of the Trust to those of the ONS 2011 Census the number of service users in the 0 – 18 and 45 – 64 category is less than the Census figures, which needs to be explored. The number of service users in the over 65 age group is expected due to the increased prevalence of age related mental health problems in this group, a finding which is supported by the information in the Mental Health Bulletin.

The Trust's data on the age of service users was complete.

2.6 Summary of Service Users by Sexual Orientation

Sexual Orientation	Breakdown of service users by sexual orientation (number)	Breakdown of service users by sexual orientation (%)
Person does not know	333	0.21
Blanks	68871	42.63
Persons of the opposite sex	88958	55.07
Persons of the Same or opposite sex	1260	0.78
Persons of the Same Sex	2118	1.31
Total	**161540**	**100**

2.6.1 In 2005 HM Treasury and the Department of Trade and Industry completed a survey to help the Government analyse the financial implications of the Civil Partnerships Act (such as pensions, inheritance and tax benefits). They concluded that there were 3.6 million gay people in the United Kingdom – around *6% of the total population* or 1 in 16.66 people.

Most of the time, the figure of between 5-7% of the population is used. Stonewall, a National Lesbian, Gay and Bisexual campaigning organisation feel this is a reasonable estimate. However, as this question was not asked in the 2011 UK census there is no way of knowing for sure how many Lesbian, Gay or Bisexual people there are in the UK.

Comparing these estimated figures with the Trust's service users the Trust has an under-representation of those who have declared that they are lesbian, gay or bisexual. This is a particularly sensitive area for many service users and this is possibly reflected in the fact that for 68,871 or 42.63% of service user's information about their sexual orientation is not stated, not known or they have preferred not to say. However this is a 1% improvement on last year's figures.

2.7 Summary of Marital and Civil Partnership Status of Service Users within the Trust compared to the ONS 2011 Census.

Status	Breakdown of service users in the Trust by Marriage Civil Partnership (number)	Breakdown of service users in the Trust by Marriage Civil Partnership (%)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (number)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (%)
Divorced/ Civil Partnership Dissolved	7324	4.53	132910	9.1
Married / Civil Partnership	29709	18.39	720888	49.31
Not known	154	0.10		
Null	19129	11.84		
Not Disclosed	8587	5.32		
Separated	3151	1.95	34250	2.34
Single	78884	48.83	464109	31.73
Surviving Partner/ Widowed	14602	9.04	109897	7.52
Total	**161540**	**100.00**	**1,462,054**	

2.7.1 For 19129 or 18.39 % of service users marital and civil partnership status information is not available as service users have refused to give it. This is an 18% deterioration in the data completeness compared to last year.
There is a variation between the Trust's data for marriage and civil partnership and that of the ONS 2011 in the categories of those who are divorced or whose civil partnership has been dissolved, those married or in civil partnerships, those who are single and those who are the surviving partner or widowed.

2.8 Summary of gender of service users within the Trust compared to the ONS 2011 Census.

Status	Breakdown of service users in the Trust by gender (number)	Breakdown of service users in the Trust by gender (%)	ONS Census 2011 breakdown by gender (number)	ONS Census 2011 breakdown by gender (%)
Male	76459	47.33	828146	48.97
Female	84037	52.02	862814	51.03
Null	1036	0.64		
Not known	8	0.01		
Total	**161540**	**100.00**	**1,690,960**	

2.8.1 The gender breakdown of the Trust's service users is very similar to that of the ONS data. For 1036 or 0.64 % of service users the data on gender is incomplete. This is a deterioration of 0.20% compared to last year.

2.9 Summary of Service Users by religion compared to the ONS 2011 Census service user Population by religion

Religion	Breakdown of Service Users in the Trust by religion (number)	Breakdown of Service Users in the Trust by religion (%)	ONS 2011 Census Breakdown by religion (number)	ONS 2011 Census Breakdown by religion (%)
Any other	3271	2.02	5124	0.30
Buddhist	262	0.16	3881	0.23
Christian	74819	46.32	1174586	69.46
Hindu	113	0.07	3516	0.21
Jewish	85	0.05	937	0.06
Muslim	1215	0.75	20143	1.19
Sikh	111	0.07	2440	0.14
None	28507	17.65	371479	21.97
Null	15647	9.69		
Not stated	37510	23.22	108854	6.44
Total	**161540**	**100.00**	**1,690,960**	

2.9.1 Data on religion is not available for 15647 or 9.69 % of the Trust's service users as it has not been given. This is almost identical to the level of data completeness last year.

There are differences between the data on the religion of the Trust's service users and the data in the 2011 Census in the categories of any other religion, Christian, Muslim, Hindu and none.

2.10 Summary of Servicer Users by Disability

Disability	Breakdown of Service Users in Trust (number)	Breakdown of Service Users in Trust (%)
Hearing Impairment	**7600**	4.70
Mobility impairment	**10156**	6.29
Multi-sensory impairment	**968**	0.60
Other Disability	**2658**	1.65
Physical disability	**5532**	3.42
Visual Impairment	**12394**	7.67
Speech Impairment	**1162**	0.72
Blanks	**119072**	73.71

2.10.1 The Trust has been able to report on the numbers of service users with hearing impairment, mobility impairment, multi- sensory impairment, other disability, physical disability, visual impairment or speech impairment. Some service users have more than one disability so may appear in more than one category. Figures from the Royal National Institute of Blind people suggest that 1 in 30 people have sight loss, and figures from Action on Hearing loss state that 1 in 6 people or 16.66 % have some kind of hearing loss. The figures for service users with mental health difficulties or learning disabilities have not been included. Information from the 2011 states that 38% of the population of the North East and 33% of the population of Yorkshire and Humber report a long standing illness or disability with 20% of the population of the North East and 19% of the population of Yorkshire and Humber reporting a limiting long standing illness or disability

3. Equality Objectives

3.1 Service user and carer involvement is essential to help the Trust deliver and develop services which are service user centred and feedback on services is essential in order to continually improve our services in response to what we are told. The Trust has well-established mechanisms for engaging with its service users and carers in a variety of ways.

3.2 The Trust undertook a number of consultations in 2011/12 with its diverse communities and identified a number of issues:

- There was no evidence that members of the protected characteristic groups found the Trust to be completely inaccessible or unable to meet their needs, but the view was consistently expressed that staff lack knowledge, awareness and confidence when working with people who identify with a protected characteristic.
- All these factors were compounded by general lack of understanding and awareness of the services the Trust provides, how its services can be accessed and in particular the referral processes
- That within some communities there is particular stigma around mental health problems

3.3 There is evidence that many members of protected groups can experience discrimination and subsequent social exclusion and isolation that can have a significant negative impact on their mental health. The Trust needs to ensure that it can meet the needs of people from protected groups.

3.4 In April 2012, in order to meet its public sector equality duties the Trust developed a number of equality objectives. Those relating to service delivery were:

3.4.1 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 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 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. One training session has been held in 2015,on disability which included 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.
Please see appendix 1 and 2.

3.4.2 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 users' 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.

3.4.3 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 workplan to improve the access to Trust services 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.

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 race on Paris to enable it to record services provided to this community.

3.4.4. 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 planned 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.

In North Yorkshire a lot of work is happening around the Crisis Concordat which LD are part of and an event is planned for March 2016 look at how all patients, including those with a learning disability are supported in Crisis. Work is ongoing in all localities to improve access and service provision for people with a LD and a mental health diagnosis, however the transformational agenda, spearing the national bed reduction for Learning Disabilities has subsumed much of the Greenlights agenda.

4. Analysis of the effects of the Trust's policies and practices

4.1 Equality analyses are carried out on all Trust policies and procedures and these are available on the Trust website.

4.2 Equality analysis is also carried out on service developments and improvements and is an integral part of the Trust's project management processes through which all major service changes are progressed.

5. Equality in Practice

The Trust is committed to ensuring that all people have equal access to its services. Some of the initiatives the Trust has taken to realising this vision are described in the information relating to the Trust's equality objectives in section 5. Others are described below.

5.1 Disability Access Audits

The Trust recognises the importance of ensuring that people with disabilities can access its premises. Following the pilot audits the EFM department are piloting an audit tool which will be used in all patient areas.

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5.2 Interpreting Services

In order to deliver an equitable service to those whose first language is not English the Trust has recently let a three year contract to an interpreting agency, ensuring quick access to appropriately qualified interpreters. The quality and usage of the service is regularly monitored.

5.3 Dementia

The North East Dementia Alliance commissioned a report on Dementia in minority communities in North East England in August 2012. In response to this the Trust has started to pilot some work with its South Asian communities in Stockton and Middlesbrough. It has worked with public health in Stockton to undertake some consultations with the South Asian community. These consultations highlighted the lack of awareness within the community about mental health in general and dementia in particular. It was also clear that some of the community felt reluctant to approach their GPs about mental health issues and that there were language and cultural barriers. As a result the Trust is working with a South Asian community organisation to raise awareness of dementia amongst the community and to seek to increase early referrals into services. It is also carrying out some consultations to better understand how MHSOP need to be changed to meet the needs of the community.

5.4 Data Completeness

Measurement is key to understanding whether there are differences in experience or outcomes for those in protected groups and then acting on these. Crucial to this is achieving a high level of data completeness and accuracy in the demographic data on PARIS. The Equality, Diversity and Human rights team are currently:

- Involved in the dataset working group which takes forward data quality issues for different departments across the Trust.
- Working with an information analyst to understand the issues impacting on the levels of data completeness.

- Requested changes to PARIS to enable LD and CAMHS services (perhaps MHSOP in some cases) to have new options in the sexual orientation field due to the needs of their service users
- Requested changes to the disability field in order to improve the levels of data completeness.
- The addition of 'partner' in marital status.
- Requested in all categories the removal of the fields 'not known' and 'not stated' and the addition of 'declines to disclose' to ensure consistency and that the reason for the lack of data is due to service user choice.

6 Conclusions

6.1 The levels of data completeness available to the Trust to measure its performance in its public sector duties have either remained static or slightly deteriorated. Further work is needed as detailed in 5.4 above. Higher levels of data completeness would allow the Trust to have greater confidence in its understanding of the makeup of its service users and their needs.

6.2 Good progress has been made on the Trust's equality objectives. This year is the final year for these particular equality objectives and work is ongoing to review the current objectives and to work with localities to develop new equality objectives from April 2016. A paper will be brought to the Board in March 2016 reviewing the current equality objectives and seeking approval for the 2016 – 2020 equality objectives.

6.3 In addition to the work on the equality objectives the Trust has a number of other initiatives (described in 5 above) in which clinical services have recognised a need for focused work with some of its minority communities to ensure that they have equal access to mental health and learning disability services.

7. Recommendations

7.1 It is proposed that the information contained in this report is published on the Trust's website as evidence that the Trust is meeting its public sector equality duties.

7.2 It is suggested that the data contained in points 2, 3 and 4 be fed back immediately to services so that they can identify any necessary actions for their 2016/17 business plans.

7.3 It is recommended that work be undertaken to understand the high level of blanks and not known in most categories on PARIS and to working to support staff to improve the level of data completeness.

7.4 It is recommended that work detailed in 5.4 above be undertaken.

APPENDIX 1. 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont know	2	1	2	3	0	8							
	not answered	0	11	0	2	17	30							

Appendix 2. SEXUALITY

		Number of surveys						Percentage						
		2011	**2012**	**2013**	**2014**	**2015**	**Total**	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**	
AHeterosexual	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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont 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							
	Dont know	0	1	1	5	0	7							
	not answered	0	8	0	11	1	20							

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th January 2016**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**26th January 2016**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3. The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
256	7/12/15	Deed of Assignment of Contract (SilverCloud Health Ltd).	Mr. M. Barkley, Chief Executive Mr. C. Martin, Director of Finance

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** None identified.

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

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

4.4 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution (October 2015)

ITEM NO 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**December 2015**
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:

December EMT

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.

January EMT

2 policies, 3 procedures and the guidance for writers of policies were approved for ratification:

CORP-0006-001-v1 Requests for Information Procedure
CORP – 0002- v5 Nicotine Management Policy

CORP-0001-v4 Governance of Policies, Procedures, Protocols and Guidelines
CORP-0001-001-v1 Policies and Procedures – Guidance for Writers
HR-0043-v2-Disciplinary Procedure

3 policies with minor amendments were ratified

IT –0006- v5 – Email Policy
IT - 0007- v5 – Internet Policy
IT –0006- 001-v2 –NHSMail Procedure

Recommendations:

The Board are asked to ratify the decisions made by EMT on 2 December 2015 and 7th January 2016.

DATE:	**January 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:

CLIN-0009-v5 Mental Capacity Act 2005
Review date: 2 December 2018

This policy has undergone full revision and has been rewritten onto the new Trust template.

CLIN-0013-001-v1 User of Visual and Audio Recordings in Clinical Procedures
Review date: 2 December 2018

This procedure has undergone a full revision and is renumbered to reflect its relation to the Records Management Policy.

CLIN-0085 v1 Risk Assessment for Venous Thromboembolism (VTE)
Review date: 2 December 2018

The VTE Risk assessment guidelines were written to support clinicians in monitoring the patient's risk of venous thromboembolism and subsequent management. The guidelines were developed by the PHC project team with support from members of the Physical Health and Wellbeing group and approved via D&T in September.

CORP – 0002- v5 Nicotine Management Policy
Review Date 31/01/2016

This policy replaces the current Smoke Free Policy. It has been extensively consulted upon and contribution sought from solicitors.

CORP-0006-001-v1 Requests for Information Procedure

This procedure replaces the Data Protection Policy and Freedom of Information Act Policy so that all requests for information are dealt with through a single control objective via the Information Governance Policy.

It was presented in the December EMT paper and changes have been made as requested.

HR-0043-v2-Disciplinary Procedure
Review Date July 2015

The Director for Human Resources requested that this procedure was ratified by EMT due to significant changes involving the panel procedure

CORP-0001-v4 Governance of Policies, Procedures, Protocols and Guidelines

CORP-0001-001-v1 Policies and Procedures – Guidance for Writers
Review date: 2 December 2018

This policy and procedure has been amended following presentation with the December EMT paper and was ratified at the EMT meeting that took place on the 6th January 2016.

3.2 The following policies have undergone minor amendment:

IT –0006- v5 – Email Policy
Review Date 24/10/2012

IT –0006- 001-v2 –NHSMail Procedure
Review Date 24/10/2012

IT - 0007- v5 – Internet Policy
Review Date 26/03/2014

3.3 The following document has had its review date extended:

CORP-0019-v8 Policy & Procedure for Management of Compliments, Comments, Concerns & Complaints
Requested review date: 1 March 2016

This policy is undergoing significant revision and requires extension to allow this work to be completed.

3.4 The following documents are to be removed from the policy portfolio.

CLIN//0077/v1 Percutaneous Endoscopic Gastrostomy (PEG) Feeding Guidelines
CLIN/0078/v1 Nasogastric Tube Feeding Guidelines
CLIN/0075/v1 ECG Guidelines
CLIN/0057/v2 Venepuncture Procedure
CLIN/0058/v2 Guidelines for Blood Glucose Monitoring
CLIN/0059/v2 Physiological Assessment Procedure

The Trust has introduced the online version of the Royal Marsden Manual of Clinical Nursing Procedures available via the Trust intranet under policies and procedures. The manual provides the most up to date evidence based clinical skills and procedures related to essential aspects of a person's care. The procedures are based on the latest research findings and advice from clinical experts, to enable students and qualified nurses to provide the best possible care.

As a result of the introduction of the Royal Marsden Manual, some of the policies and procedures previously developed by the Trust IPC and Physical Healthcare Team have now been replaced with the Royal Marsden, hence the request to remove the policies and procedures as above from the Trust intranet.

PHARM/0019/v4 Antibiotic Prescribing Policy

In May 2015, the Drug & Therapeutics Committee agreed to adopt the "North East and Cumbria antibiotic prescribing guideline for primary care" as Trust antibiotic prescribing policy – this was ratified by QuAC in September.

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:

The Nicotine Management Policy will form part of the smoke free initiative that is being launched on 9th March 2016.

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meetings on 2 December 2015 and 7th January 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