AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 23RD FEBRUARY 2016 VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting of the Board of Directors held on **26th January 2016**.		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 7	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 8	To consider the report of the Mental Health Legislation Committee.	**RS/EM**	**Attached**
Item 9	To receive and note a progress report on the Smoking Cessation and Nicotine Management Project.	**NL**	**Attached**
Item 10	To consider the results of the 2015 National Staff Survey.	**DL**	**Presentation**

Performance (10.50 am)

Item 11	To consider the Finance Report as at 31st January 2016.	**CM**	**Attached**
Item 12	To consider the Trust Performance Dashboard as at 31st January 2016.	**SP**	**Attached**

Item 13	To consider the proposed targets for the 2016/17 Trust Performance Dashboard indicators.	**SP**	**Attached**
Item 14	To consider the Strategic Direction Performance Report for Quarter 3, 2015/16.	**SP**	**Attached**

Items for Information (11.25 am)

Item 15	To receive and note a report on the use of the Trust's seal.	**MB**	**Attached**
~~**Item 16**~~	~~Policies and Procedures ratified by the Executive Management Team.~~ This item has been removed as there have been no new policies / procedures at EMT this month	~~**MB**~~	~~**Verbal**~~

Item 17 To note that the next meeting of the Board of Directors will be held on Tuesday **22nd March 2016** in the Board Room, West Park Hospital Darlington at 9.30 am.

Confidential Motion (11.30 am)

Item 18 **The Chairman to move:**

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

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

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

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

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
17th February 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 26TH JANUARY 2016 IN THE DURHAM CENTRE, BELMONT INDUSTRIAL ESTATE, DURHAM, DH1 1TN 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
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. P. Bellas, Trust Secretary
Ms. J. Dawson, Acting Director of Operations for County Durham and Darlington (minute 16/06 refers)
Mrs. J. Jones, Head of Communications

Ms. N. Allen, Mr. C. Baily, Ms. S. Bringloe, Ms. P. Dunn, Ms. T. Ellis and Ms. E. Garbutt, student nurses.

16/01 MINUTES

Mrs. Pickering reported that, whilst minute 15/326 (24/11/15) was a correct record, the recommended target for metric 19 ("Excess cost of employing medical agency versus substantive") had been misstated in the Strategic Direction Performance Report as "zero" rather than "400" as agreed with the Director of Finance and Medical Director.

Agreed –

(1) that the public minutes of the meetings held on 24th November and 15th December 2015 be approved as correct records and signed by the Chairman; and

(2) that the target for metric 19 ("Excess cost of employing medical agency versus substantive") in the Strategic Direction Scorecard be "400".

Action: Mrs. Pickering

16/02 PUBLIC BOARD ACTION LOG

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

Arising from the report:

(1) Mrs. Pickering asked for an extension to the timescale for the provision of a report to the Board on the context of Performance Dashboard indicators 13,14 and 15 and the relevance of their targets (minute 15/324 – 24/11/15 refers) as information was still awaited from services and the deferral would enable engagement with the Speciality Development Group.

The Board agreed to amend the timescale for the action to April 2016.

(2) The Board noted that the action to publish a revised version of the Nurse Staffing Report for December 2015 under minute 15/344 (15/12/15) had been completed.

Mr. Bellas undertook to make the required changes to the Action Log.

Action: Mr. Bellas

16/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/04 CHAIRMAN'S REPORT

The Chairman reported that:

(1) During the last few weeks she had spent time assessing and judging applications for the "Making a Difference Awards" and the "Ridgeway Recovery Awards".

(2) Other key issues were covered in the Chief Executive's Report (minute 16/C/20 refers).

16/05 GOVERNOR ISSUES

No issues were raised.

16/06 LOCALITY BRIEFING – COUNTY DURHAM AND DARLINGTON

Ms. Dawson (Acting Director of Operations) gave a presentation on the key issues facing the County Durham and Darlington Locality.

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

Arising from the presentation Board Members raised the following issues:

(1) The top three concerns of the Locality.

Ms. Dawson advised that these were:

(a) Waiting times in children and young people's services (C&YPS).

(b) Risks arising from the present consultation on the reconfiguration of organic bed provision in the Locality.

(c) The capacity of community teams to meet requirements.

(2) How it was intended to build resilience in C&YPS to maintain improvements in waiting times.

In response it was noted that:

(a) Externally, there was a need to work with relevant organisations (e.g. schools, GPs, etc.) and to review the social, emotional and wellbeing pathway to ensure a collaborative response to the increases in demand.

(b) Internally, work needed to be focussed on:

- Recruitment in order to fill the significant number of vacant posts in the service.
- Increasing staff resilience, building on the work of Paul Walker, Staff Resilience Consultant.
- Improving productivity to provide capacity to meet spikes in demand.

Board Members considered that additional capacity was not only required to deal with waiting times but needed to be provided along the whole pathway to ensure prompt provision of treatment as well as access to the services.

(3) Whether a single point of access should be developed in the Locality.

Ms. Dawson advised that:

(a) Single points of access had been developed in certain areas.

(b) Through discussions it was evident that there were differing opinions amongst GPs on the benefits of establishing a single point of access for the whole Locality.

(4) The potential availability of short-term funding to establish an all age crisis and liaison service linked to the national urgent and emergency care review.

The Board noted that the need for short-term investment to “pump prime” the service was recognised; however, there were concerns that this would not be made available due to affordability issues for the CCGs and the challenges of providing funding through generating savings from other services e.g. the Police and/or A&E services.

(5) The implications of the proposals for the North East Combined Authority, to take on responsibilities for health and social care, on the provision of mental health services.

The Board noted that:

(a) Discussions on devolution of health and social care were at an early stage and clarity was needed on this matter.

(b) The Trust had been represented at the one meeting held to date and would seek to continue to be involved in the process.

(c) The proposals for the Tees Valley Combined Authority did not include devolution of responsibilities for the provision of health services.

(6) The confirmation of recurrent funding for the Recovery College.

This was welcomed.

At the conclusion of the discussions, Board Members:
(1) Thanked Ms. Dawson for her leadership of the Locality over the last few months.
(2) Asked Ms. Dawson to pass on their appreciation to staff in the Locality for their work.

16/07 NURSE STAFFING REPORT

The Board received and noted the six monthly review report, for the period 1st June 2015 to 30th November 2015, on 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").

It was noted that, as the report provided a six month review, it did not include services in the York and Selby Locality.

Mrs. Moody reported that:
(1) Whilst no correlation had been found between staffing levels and quality data, the information had highlighted areas where further analysis might be useful.
(2) Forensic services had seen a noticeable reduction in the budgeted establishment for healthcare assistants (HCAs) as a result of the full year impact of 2015/16 CRES schemes.
(3) During the reporting period actual hours worked had exceeded those planned for each month; however, this was unsurprising given the levels of demand on services.
(4) The month on month trend showed deterioration in the fill rates for registered nurses with 31 wards having daytime shifts and 4 wards having night-time shifts with fill rates of less than 89.9%. However, fill rates for HCAs had improved.
(5) The data on temporary staffing showed that :
    (a) There were no trends on the use of bank staff as the six wards with the highest usage were spread across three Localities.
    (b) The majority of agency usage was within the North Yorkshire Locality.
(6) The triangulation of staffing data against SUIs, level 4 incidents, complaints and control and restraint data (Appendix 5 to the report) suggested that there were no direct risks or implications to patient safety from the staffing levels.
(7) In accordance with minute 15/317 (24/11/15) staffing levels would be considered as part of the root cause analyses of level 4 and 5 incidents to provide greater understanding and assurance.
(8) In the absence of guidance on safe staffing levels for mental health settings (work on which had come to a halt since the transfer of responsibility for its development from NICE to NHS Improvement) an analysis had been undertaken using the nine safe nursing indicators published by NICE for adult inpatient wards in acute hospitals (Appendix 6 to the report).

The Board noted that:
    (a) In undertaking the analysis it had been recognised that some of the indicators were more relevant to mental health services than others.
    (b) A key issue identified was the number of unpaid breaks which had not been taken; 7,414 shifts during the reporting period. This was important

as inadequate rest time during duty hours was linked to staff burn out, exhaustion and the risk that these might ultimately impact on patient care.

(c) It was recommended that, in future, monthly safe staffing reports should include data on missed breaks.

(d) In addition, a task and finish group had recently been established by the HR & OD Directorate which would focus on staff breaks and adherence to EU Working Time Directives.

(9) Work would be undertaken on the following areas as part of the Safe Staffing Project in 2016/17 in recognition that there was limited spare capacity in the nursing establishment:

(a) Effective rostering.

(b) Bank, agency and overtime usage.

(c) Patient contact hours.

(d) Staffing escalation procedures.

(e) Flexible staffing requirements.

(9) There was a typographical error in section 10 of the report in that NHS Improvement was due to publish further guidance on evidence based approaches to staffing in Autumn 2016 and not NICE as stated.

(10) The only risk highlighted in the report was that the absence of evidence based guidance for mental health could lead to an inconsistent professional judgement based approach to safe staffing.

The Chairman considered that, whilst it might not be possible to draw conclusions from the data, the report enabled the Board to identity areas of concern.

Arising from the report, the Board discussed:

(1) The graph in section 3.1 of the report which showed that actual hours worked had exceeded planned hours during the whole reporting period.

On this matter:

(a) The Chairman considered that the relatively consistent gap between the two variables might suggest that the Trust's planned staffing establishments were incorrect.

Mrs. Moody advised that it was difficult to make firm judgements about establishment levels until there was assurance that the rostering of staff was being undertaken effectively; that staffing was being deployed correctly and flexibly; and that enhanced observations were reviewed in accordance with clinical need.

It was noted that to address these matters:

- Data had been collected to test the professional judgement tools (in terms of staffing and skill mix), developed by NICE, in the County Durham and Darlington Locality during the next quarter.
- A project plan for the Safe Staffing Project had been developed and would be included in the next Nurse Staffing Report for information.

Action: Mrs. Moody

- Discussions were being held on establishing a task and finish group to take this work forward.

(b) Dr. Land highlighted that the position on actual versus planned hours was a good example of a "wicked problem" (i.e. a complex issue where there was no clear managerial response).

It was noted that, to date, the Trust had tended to put in place staffing establishments and draw down additional resources when spikes in demand occurred.

However, he considered that alternative approaches based on groupings of inpatient services providing mutual support, and including arrangements to bring in temporary staff at shorter notice, might be beneficial.

(c) Mr. Levy reported that proposals to support the provision of additional staffing at short notice were due to be considered by the OMT and EMT in the near future. If approved, evidence from a proposed pilot should be available for inclusion in the next six monthly Nurse Staffing Report.

(d) Mr. Barkley, whilst not advocating this view, considered that, alternatively, the gap shown on the graph could suggest that the Trust was grossly inefficient at rostering staff (producing significant waste) and a lack of confidence in clinical teams

Mrs. Moody responded that this view reinforced the need for further understanding of the issues e.g. rostering practices and whether wards had developed a culture of reliance on enhanced observations.

(e) Mr. Martin highlighted that, during the reporting period, additional staff hours would have been required in response to demand arising from the closure of Bootham Park Hospital in September 2015.

(2) The approach to seeking to establish a correlation between staffing levels and quality.

The Non-Executive Directors:

(a) Highlighted the expense for individual trusts of tracking staffing levels to quality and sought clarity on whether any work was being undertaken nationally on this issue.

Mrs. Moody advised that:

- Trusts took varying approaches due to the multifaceted nature of staffing. The recent release of information under the Freedom of Information Act on NICE safe staffing evidence reviews in mental health settings reinforced the lack of clear evidence in this area.
- Some national work was being undertaken to develop guidance on safe and sustainable staffing establishments for different care settings; the one for mental health being led by the Director of Nursing at Mersey Care NHS Trust
- Correlations found between staff competencies and training and patient safety highlighted that the skills of staff were important not just the numbers of them.

It was also noted that Prof. Mike West of Lancaster University had found a correlation between appraisals and mortality rates.

(b) Suggested that there might be scope for the NHS Benchmarking Club to look into this issue.

Mr. Barkley responded that the NHS Benchmarking Club did undertake work in this area. This showed that the Trust was in the lowest quartile on the number of registered mental health nurses per adult ward and the second lowest Trust in the Country for the number of serious incidents based on the number of beds. It appeared, therefore, that there was no correlation between the two issues.

(3) The high incidence of unpaid breaks not being taken by staff.

On this matter:

(a) Mrs. Moody reported that, in addition to inadequate rest time during duty hours, there were also risks and implications from staff not taking adequate breaks between shifts.

(b) Dr. Land considered that the ability of staff to take breaks depended on the nature of the wards, and the level of intensity in which they were working, and the Trust needed to develop different models in recognition of this.

(c) The Chairman highlighted the approach to volunteering at South Tees Hospitals NHS Foundation Trust (STHFT) which sought to reduce pressures on staff.

Mr. Levy advised that further information was being sought on the approach being taken by that Trust.

(d) Mr. Kilmurray advised that guidance on breaks had been issued to managers and this was due for review with Staff Side.

(e) It was suggested that the issue was connected with staff lacking flexibility in their work; however, the Chairman considered that the lack of breaks was related to the management and operation of wards.

(4) Concerns about the lack of compliance with mandatory training

Mr. Barkley considered that there was no excuse for wards reporting non-compliance with mandatory training requirements as sufficient headroom had been provided in their establishments.

Agreed -

(1) that the review framework and tools be piloted within Durham and Darlington and a report be presented to the Board outlining the key findings; and.

(2) that the monthly Nurse Staffing Reports be expanded to include incidents whereby staffing has been used to categorise the incident and any areas where breaks are not being taken.

Action: Mrs. Moody

16/08 SUMMARY FINANCE REPORT AS AT 31ST DECEMBER 2015

Consideration was given to the summary Finance Report as at 31st December 2015 including the declarations on the Financial Sustainability Risk Rating and Capital Expenditure for Quarter 3, 2015/16 as required under Monitor's Risk Assessment Framework.

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

(1) The Trust's overall financial position was tracking slightly above plan.
(2) The key financial indicators were on track.
(3) There were benefits of Trusts reducing capital expenditure from a national perspective and it was, therefore, unlikely that Monitor would raise concerns about the Trust's position on its capital programme being slightly behind plan.
(4) Expenditure on the development of the new inpatient facilities in Harrogate could fall either side of year-end.
(5) At present there were no political or financial risks relating to the Trust's cash balances.

It was noted that:

(a) Trusts were being encouraged not to spend cash in view of the overall financial position of the NHS.
(b) Unlike some Trusts, the Trust's cash position supported a carefully considered and costed programme.

Agreed –

(1) that the report be received and noted; and
(2) that the following declarations for Quarter 3, 2015/16, be signed off and submitted to Monitor:
(a) "The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months."
(b) "The Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return."

Action: Mr. Martin

(See also minute 16/11 below).

16/09 PERFORMANCE DASHBOARD AS AT 31ST DECEMBER 2015

The Board received and noted the Performance Dashboard Report as at 31st December 2015 including:

(1) The Dashboard Report produced from the Integrated Information Centre (IIC) attached as Appendix 1 to the report.

Mrs. Pickering reported that:

(a) With the exception of the workforce and financial indicators, the above Dashboard did not include data from the York and Selby Locality. This information would be incorporated once the Locality had transferred to the

Trust version of the PARIS system, which would be by April 2016 at the earliest.

(b) Where data in the Trust Dashboard included York and Selby, information had been provided in the narrative to enable the Board to understand the positions on the relevant indicators based on the pre-transfer geography of the Trust.

(c) No new key risks were highlighted in the report.

(d) The position on out of locality admissions had improved on the previous month but remained one of underperformance. The Trust had recently received the draft report from Dr. Paul Tiffin, commissioned by Mr. Barkley, and a meeting to discuss it had been arranged.

(2) A separate Dashboard based on available data for the York and Selby Locality was provided as Appendix 2 to the report.

(3) The Monitor Dashboard Report (Appendix 3 to the report) which included services in York and Selby and which provided assurance that all targets had been achieved for Quarter 3, 2015/16 (see also minute 16/11 below).

(4) The Data Quality Scorecard (Appendix 4 to the report).

It was noted that this scorecard did not include an assessment of data quality relating to York and Selby. Work on this issue would be undertaken once the services in the Locality had transferred to the Trust's PARIS system.

(5) Further information on unexpected deaths (Appendix 5 to the report) including a breakdown by Locality.

The Board discussed the risk of significant issues being missed due to the number of indicators continually reporting underperformance ("red" rated) and how this could be mitigated.

During the debate on this matter:

(1) The Chairman highlighted that, over time, the number of "red" rated indicators had reduced and more had upward trends; however, there were issues with sustaining improvements.

(2) Mrs. Pickering advised that those indicators reporting underperformance had remained consistent and this provided some comfort in that work to address them had not had a detrimental effect on performance in other areas.

(3) Non-Executive Directors sought clarity on how the Trust should respond to those metrics where action had been taken but underperformance persisted.

Mrs. Pickering responded that further discussions were needed on whether the targets were realistic; however, from discussions, for example on C&YPS waiting times in County Durham and Darlington (minute 16/06 refers), it was apparent that more action could be taken to address underperformance.

(4) Mr. Barkley:

(a) Considered that indicators 1 to 12 were the most significant and the Trust should continue to focus on them.

(b) Reported that he was due to attend a meeting of the MHSOP Speciality Development Group to discuss six action points, agreed by the EMT, to improve performance on metric 12 ("The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated").

(5) The Chairman considered that, as dashboards had been developed to provide a visual impact, there were options to make changes to provide greater clarity on the positions on individual metrics e.g. the use of "amber" ratings for those indicators where the Trust was not achieving target but there was an upward trajectory.

Mrs. Pickering responded that the Board could discuss the use of RAG ratings during its consideration of the 2016/17 Dashboard targets.

(6) Dr. Land:

(a) Highlighted that the graphs provided further details on each indicator and enabled the Board to consider whether, for example, changes on trends were due to seasonal variations/short-term issues or raised concerns.

(b) Suggested that it might be worthwhile for the Board to consider a number of indicators in detail at each meeting on a cyclical basis to gain further understanding and assurance.

(c) Considered that it was important to be mindful of context when considering performance information e.g. without an increase in funding it was not surprising that services were under pressure as a result of the significant increase in referrals on previous years.

In response, Mrs. Pickering:

- Cautioned that, whilst there had been an increase in referrals to some services (e.g. C&YPS in County Durham and Darlington), metric 23 ("Total number of External Referrals into Trust services") also included referrals to new services where investment had been provided.
- Considered that it was important for the Localities to understand the implications of, and to develop their response to, increases in demand.

(7) The Chairman sought views on how to deal with the issue, highlighted in the Locality Briefing (minute 16/06 refers), of referrals being directed to the Trust when it would be more appropriate for them to be dealt with by other agencies.

On this matter:

(a) Attention was drawn to:

- The work being undertaken on the social, emotional and wellbeing pathway and the role of Tier 2 services in educating other agencies; however, it was recognised that if the service did not have the capacity to undertake this work the situation would be self-perpetuating.
- The single point of access being developed in the North Yorkshire Locality.

(b) Mr. Kilmurray advised that all referrals needed to be assessed but, in doing so, the Trust needed a proportionate approach to how they were documented and to ensure that, where inappropriate, referrals were not converted onto the caseload.

(8) The Non-Executive Directors sought clarity on whether the NHS Benchmarking Club could provide contextual information on the Trust's performance e.g. to provide assurance where indicators were rated "red" but performance was comparatively satisfactory.

Mrs. Pickering responded that:

(a) The NHS Benchmarking Club provided some useful comparators but few were aligned to the indicators used in the Trust Dashboard.

(b) In comparison to other Trusts it appeared that for waiting times:
- The Trust's targets were more challenging.
- Waiting times for C&YP services were lower and the Trust had a higher number of contacts.

(c) The Trust was also measured against the performance requirements of its contracts. These were, in general, not as challenging as the Trust's own targets e.g. the target for waiting times was nine weeks.

In conclusion, Mrs. Pickering asked Board Members to contact her if they had any views on the targets to the included in the 2016/17 Dashboard.

In addition, Non-Executive Directors sought clarity on whether, in relation to out of locality admissions in MSHOP, it was possible to identify, at the point of admission, those patients who had nowhere to go when ready for discharge.

In response it was noted that:

(1) No data was collected on this matter but delayed discharges on wards might be able to be used as a proxy measure.

(2) On a day to day basis Locality Managers would be probably aware of these cases but this was not recorded.

(3) As previously discussed a key issue was that an out of locality admission from one area could create a domino effect across Localities.

16/10 QUARTERLY WORKFORCE REPORT

The Board received and noted the Workforce Report for the period October to December 2015 including:

(1) Performance information about the whole Trust workforce (Appendix 1 to the report).

(2) Information about medical staffing issues and performance (Appendix 2 to the report).

16/11 MONITOR RISK ASSESSMENT FRAMEWORK REPORT

Further to minutes 16/8 and 16/9 above, consideration was given to the Monitor Risk Assessment Framework Report for Quarter 3, 2015/16.

Agreed –

(1) that the Quarter 3, 2015/16 Risk Assessment Framework submission be approved including:

(a) confirmation of the following governance statements:
- "*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 Risk*

Assessment Framework page 21 Diagram 6) which have not already been reported."

(b) the declaration that no subsidiaries were consolidated in the financial information provided;

(c) the information required on Executive Team turnover, as included in the above report;

(d) the exception report set out in Annex 2 to the above report; and

(2) that the Quarter 3, 2015/16 Risk Assessment Framework return be submitted to Monitor by 29th January 2016.

Action: Mr. Martin and Mr. Bellas

16/12 EQUALITY ACT 2010 – PUBLICATION OF INFORMATION

Consideration was given to the report which sought the ratification of the information contained in the Equality Data Document (Appendix 1 to the covering report) for publication as required by the Equality Act 2010.

It was noted that a paper on proposed revisions to the Trust's equality objectives was due to be presented to the Board for consideration at its meeting to be held on 22nd March 2016.

Agreed –

(1) *that the Equality Data Document (attached as Appendix 1 to the covering report) be ratified and be published; and*

Action: Mr. Levy

(2) that the data included in the Equality Data Document be used in the annual planning cycle 2016/17 so that any issues highlighted can be addressed locally.

Action: Mrs. Pickering

16/13 USE OF THE TRUST SEAL

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

16/14 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.

16/15 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 23rd February 2016 in the Board Room, West Park Hospital Darlington.

16/16 CONFIDENTIAL MOTION

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

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 12.50 pm.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- 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

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

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

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Local
  - 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

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Tees, Esk and Wear Valleys NHS
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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

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ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd February 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
26/05/2015	15/133	Consideration to be given to providing greater flexibility within the Trust's 12 hour shift system as part of the Working Longer Review	DL	Mar-16	
23/06/2015	15/170	Information on the three wishes raised by teams to be included in future reports on Directors' visits	BK	Jun-16	
27/10/2015	15/293	The Board to discuss the closure of the Governance Action Plans	MB	Apr-16	
24/11/2015	15/319	The next progress report on the Francis 2 Action Plan to be prepared as a final "stock take" with those items remaining outstanding and those being taken forward through other workstreams being highlighted	MB	May-16	
24/11/2015	15/320	Information on the Kaizen event on reducing recording times to be provided to the Chairman	AC	Feb-16	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	

Date	Minute No.	Action	Owner(s)	Timescale	Status
24/11/2015	15/324	Report to be provided to the Board, following consideration by the QuAC, on the context of Performance Dashboard metrics 13 ("Percentage of patients re-admitted to Assessment & Treatment wards within 30 days"), 14 ("Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards") and 15 ("Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward") and the relevance of their targets	SP	Apr-16	
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	Completed
26/01/2016	16/01	Approval of the target for metric 19 in the Strategic Direction Scorecard at 400	SP	-	Approved
26/01/2016	16/07	The project plan for the Safe Staffing Project to be provided the Board	EM	Mar-16	
26/01/2016	16/07	The safe staffing review framework and tools to be piloted in the County Durham and Darlington Locality with a report to be provided to the Board on key findings	EM	Apr-16	
26/01/2016	16/07	The monthly Nurse Staffing Reports to be expanded to include incidents whereby staffing has been used to categorise the incident and any where breaks are not being taken	EM	-	See agenda item 7
26/01/2016	16/08 & 16/11	Approval of the Q3, 2015/16 Risk Assessment Framework for submission to Monitor	CM/PB	Jan-16	Completed
26/01/2016	16/12	Ratification of the Equality Data Document for publication	DL	-	Approved
26/01/2016	16/12	The Equality Data Document to be used in the 2016/17 Annual Planning Cycle	SP	Oct-16	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item 6

FOR GENERAL RELEASE

Board of Directors

DATE:	**Tuesday, 23 February 2016**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Assurance statement pertaining to QuAC meeting held 4th February 2016:
The Quality and Assurance Committee have consistently reviewed all relevant Trust quality related processes in line with the committee's Terms of Reference. Issues to be addressed have been documented, are being progressed via appropriate leads and monitored via the appropriate sub-groups of QuAC.

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

- LMGB reports were received from 3 localities (D&D, Tees, and York & Selby) - staffing levels, waiting times, out of area admissions, MHSOP pressures were noted.
- The Patient Safety Group is undertaking a piece of work to ensure the Trust meets any applicable recommendations from the Southern Health report. This includes the establishment of a mortality review group - this work will be discussed in greater detail at the Board Seminar in March 2016.
- An exception report was received from the Clinical Effectiveness Group in relation to the requirement for standardisation of pathway management and processes across both localities and specialities.

- The Trust has responded to several information requests (via Wardhadaway) relating to a potential Judicial Review relating to the closure of in-patient beds at Bootham Park Hospital.
- Data from the Force Reduction Project demonstrates an 81% reduction in the use of prone restraint during Q3 2015/16.
- The review of the Quality Strategy is underway with engagement workshops planned for staff, governors, service users and carers.

Recommendations:

That the Board of Directors receive and note the report of the Quality Assurance Committee from its meeting held on 4 February 2016.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 23 February 2016**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 4 February 2016.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

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

3.1 Durham and Darlington LMGB – where key issues raised were:

1. AMH waiting times and out of area admissions - work continued to reduce waiting times and to understand the peak in out of area admissions for Darlington patients.
2. MHSOP pressure on medical staffing - this workload had increased significantly due to a variety of factors and remedial actions are in pace to address. It was noted that this pressure was also being felt across other localities in MHSOP.
3. C&YPS capacity and waiting times - delivery of waiting times had been affected by staff sickness absence within the service and improvement action plans are in place.

3.2 Tees LMGB – where key issues raised were:

1. Adult inpatient staffing levels at RPH - measures had been put in place to address this and there is an increase daily establishment of 1 qualified nurse on each of the 4 wards, in light of the extra patient activity from York in the first 3 months.
2. Increasing numbers of MHSOP patients being admitted out of the area. It was noted that peaks of demand were sometimes difficult to manage within the bed numbers available. There had also been 2 further closures of residential homes recently in Hartlepool which has had an impact on activity.
3. The impact on additional patients now going to Roseberry Park for ECT due to the notice that had been served by the current providers at Auckland Park Hospital.

4. The column “inadequate or uncontrolled” on the risk register was discussed as it currently did not provide the Quality Assurance Committee with any assurances. It was agreed that this would be reviewed.

3.3 York & Selby LMGB Report – where key issues raised were:

1. Adult Inpatient services were operating under Business Continuity arrangements since the closure of the inpatient services at Bootham Park Hospital.
2. Significant changes were planned throughout the service which could potentially impact on service delivery and quality. It was noted that the majority of York and Selby staff were currently subject to Management of Change.
3. The reporting of information for the locality was limited at this time and the data that is available is of variable quality. Plans are in place for transition of IT systems by April 2016; however it was noted that staff would require ongoing training and support to enable new ways of working to become normal practice.
4. An important factor in managing York and Selby is the ongoing handling of public opinion and the media around the temporary closure of adult inpatient beds, together with the significant organisational change for the staff involved. It was felt that additional corporate support would be required going forward to minimise transition related issues.

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

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

3.1 Patient Safety Group

1. Following the recent report by Mazars into Southern Health NHSFT it has been identified that the Trust needs to establish a Mortality Review group. A gap analysis would also be undertaken of the Trust against the 23 recommendations from the report, with an action plan created for any necessary improvements. These matters will be discussed in greater detail at the Board seminar in March 2016.
2. The Patient Safety Team continues to monitor the completion of actions from any Serious Incidents, of which there were only 2 outstanding at the time of this report.
3. Key performance indicators were currently being agreed with the Head of Patient Safety and Head of Quality Data. These would be available to be reported on from the February Patient Safety Group meeting onwards.

4.2 Patient Experience Group

1. Assurances had been received from all localities that patient experience data and complaints were being reviewed and acted upon and any issues were being discussed at the relevant QuAGs and LMGBs.
2. Several indicators remained red on the patient experience scorecard, however these had been discussed by the Group and mitigating actions were in place. The indicator set is under review as part of the Quality Strategy update.
3. The Patient and Carer Experience Team had carried out briefings in York and Selby Community Services and feedback was being collected by the team during February 2016. Inpatient service briefings would commence in March 2016 following procurement of devices to allow electronic capture of feedback on the Wards.

4.3 Clinical Effectiveness Group Exception Report

1. An exception had been raised at the Clinical Effectiveness Group on 18 January 2016 around a community productivity work stream. The Group had discussed key aspects of the project, including products common to all teams and how standardisation of work could be achieved. This included things such as, daily huddles, critical process flows and caseload review.
2. A paper would go to EMT with firm proposals aligning the different pathways in due course.

4.4 Drug & Therapeutics Committee Report

1. A piece of work was underway to harmonise the York & Selby Medicines policies into Trust policies.
2. The D&T Committee had approved the guidelines on stop smoking products, which would enable registered nursing staff to be able to administer a limited range of nicotine replacement products for up to the first 72 hours of admission.
3. Prescribing expenditure reports were now available via the Trust shared drive for all prescribers and teams to view community prescriptions and inpatient prescribing and associated expenditure. These reports would become more focused in the future to break down prescribing expenditure by department.
4. The audit around High Dose Antipsychotic Treatment (HDAT) would be re-audited in April 2016 following its previous 'red' RAG rating.

5 Safeguarding Children and Adults

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

The Committee was assured that any risks were short term temporary issues and mitigating actions were in place to address these with short, medium and long term action plans.

6. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

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

1. A response to a potential Judicial Review regarding the decision to remove in-patient beds from Bootham Park had been sent to the claimant's solicitor.
2. The 136 Suite at Bootham Park had re-opened on 16th December 2015 and outpatient services are due to be resumed by mid-February 2016.
3. The draft Intelligent Monitoring Report had been received for comments prior to the report being published on 25 February 2016.
   There were 4 risk areas identified by the CQC:
   (i) Risk in relation to the number of deaths of patients detained under the MHA.
   (ii) Bed occupancy.
   (iii) Fully and partially upheld investigations into complaints.
   (iv) Targets for employment status and accommodation status fields.

4. The CQC had published its report following their inspection at Bootham Park Hospital in September 2015 when the hospital was managed by Leeds and York NHS Partnership Trust.

6.2 Quarterly Force Reduction Report

1. The project remained on track to implement the core interventions set out in the restraint reduction plan by Quarter 1 for 2015/16.
2. The Safewards Model had now been set up in 30 inpatient wards, with significant achievements in a number of Forensic and MHSOP services.
3. The project team had developed a debrief tool for both patients and staff to complete for the use of restrictive interventions. This would be piloted in 10 inpatient wards across the organisation from February 2016.
4. In the longer term, consideration would need to be given to the training around the management of violence and aggression, which was central to the force reduction framework.
5. The data around force reduction had revealed good results over Quarter 3, with a significant reduction in prone restraint.
6. Westwood continued to receive additional support due to the complexity of the patients.
7. Engagement with York and Selby regarding this project had commenced and more information would be available once they had migrated to TEWV Datix in April 2016.
8. Data demonstrated that there had been a reduction of 81% in the use of prone restraint during Quarter 3 2015/16.

6.3 Quality Strategy Review

1. The Committee were informed on the process for the Quality Strategy review, including stakeholder engagement and how the strategy would be disseminated across the Trust. There are several workshops planned in each of the localities during spring 2016 to engage staff, governors and service users.

7. GOVERNANCE

7.1 Workforce Staffing Report – Staff Health and Wellbeing

The Committee received and noted an update presentation on the current issues and developments around staff health and wellbeing.

7.3 QuAC Annual Schedule of Reporting 2016

The Committee received and approved an updated annual schedule of reporting**.**

8 IMPLICATIONS

8.1 Quality

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

8.2 Financial/value for money

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

8.3 Legal and Constitutional (including the NHS Constitution)

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

8.4 Equality and Diversity

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

9 CONCLUSIONS

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

10. RECOMMENDATIONS

There were 2 matters that the Committee recommended be escalated to the Board of Directors in February 2016:

1. Risk Registers and level of assurances – the need to ask the project team to review the current scoring mechanisms to ensure they are properly descriptive and do not give a false sense of assurance or non-assurance.
2. York & Selby – may need increased Board visibility over the coming months and a heightened sense of reporting due to issues with data quality, staffing, media interest and other external matters.

That the Board of Directors note the issues raised at the QuAC meeting and the confirmed minutes of the meeting held on 3 December 2015, (appendix 1).

Jennifer Illingworth
Director of Quality Governance

Appendix 1

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 3 DECEMBER 2015, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Dr Nick Land, Medical Director
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr David Jennings, Non-Executive Director
Mr Jim Tucker, Non-Executive Director

In attendance:
Mrs Karen Atkinson, Head of Nursing
Mr David Brown, Director of Operations, Teesside
Dr Lenny Cornwall, Deputy Medical Director for Teesside
Mrs Jennifer Illingworth, Director of Quality Governance, (for minutes 15/ & 15/)
Mrs Donna Oliver, Deputy Trust Secretary
Dr Paul Tiffin, Associate Clinical Director for Research & Development (for minute 15/212)
Dr Ingrid Whitton, Deputy Medical Director for County Durham & Darlington(for minute 15/169)

Claire Watson & Rosie Whittle, Students, University of Teesside.

15/201 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Karen Agar, Associate Director of Nursing and Governance, Mrs Jo Dawson, Acting Director for Op Services for Durham & Darlington, Mr Martin Barkley, Chief Executive, Mr Richard Simpson, Non-Executive Director, Mr Brent Kilmurray, Chief Operating Officer and Mrs Barbara Matthews, Non-Executive Director.

15/202 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 5 November 2015 be signed by the Chairman of the Committee.

15/203 ACTION LOG

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

The following updates were noted:

15/189 Rowan Lea was undergoing an AIMS accreditation process and verbal feedback, especially from the carer group had been very positive.
Dr Griffiths asked for confirmation if this accreditation had been successful.
Action: Mrs A Coulthard

15/137 Review the Scorecard metrics with Department Heads.
This action had been transferred to the Director of Quality Governance and it was anticipated that a new Scorecard would be in place for the first Quarter of 2016/17. An update would come back to February 2016 QuAC meeting.

Action: Mrs J Illingworth

15/139 Quality Account Stakeholder Event – reflect the outcomes back to Health and Well-being Boards. Review the current account and what we have learnt from that.
This action would be deferred to the February 2016 QuAC meeting.

Action: Mrs S Pickering

15/144 Look for any correlation between the outbreak of D&V on Springwood and nil return of audits for 2 months.
An email had been circulated to QuAC members, prior to the December 2015 meeting, with the outcome of re-audits taken in November, which had reported a 97% compliance level in the Environmental Audit and 100% with Essential Steps.

Completed

15/145 Discussion around the terms of reference for QuAC and approval of clinical policies.
It had been agreed at a meeting outside QuAC that unless policies contained any issues of significant controversy, they would report through to the Clinical Leaders Board and EMT, not to QuAC.

Completed

15/150 Reporting of SUIs found difficult to interpret due to no throughput or population. Future reporting to use more meaningful denominator. Further analysis into incident reporting, obtain raw numbers from NRLS to make some comparisons.
This matter was covered under minute 15/215.

Completed

15/152 Reporting to QuAC and MHLC to ensure QuAC are provided with assurances around actions following MHA visits.
It had been agreed at a meeting on 3 December 2015 that the Mental Health Legislation CQC Themes Summary report would no longer report through to QuAC, however a summary of MHA reports would still feature in the monthly CQC Compliance report.

Action: Mrs J Illingworth

15/153 Information Strategy & Governance Report – whether this report is required by QuAC.

An update on this would be brought back to the February 2016 QuAC, following further discussion with the Director of Finance.

Action: Mrs E Moody

15/182 (Item 15/164 from 1 October 15 minutes) Durham and Darlington locality report – reference to the validity of the data to be checked following the care plan scrutiny where only 50% had included a risk assessment.
Mrs J Dawson had confirmed via email, prior to the December QuAC meeting that this work had been undertaken and reported through to LMGB. The service was now progressing with a range of actions with teams and

individual staff to address the findings, which would report to LMGB next week.

Completed

15/186 Quality Account – further clarification required around the red line on the graph on page 5, reporting number of patient falls Trust wide.
Defer this action to February 2016, QuAC meeting.

Action: Mrs S Pickering

15/189 Patient Safety and Patient experience Data Report – consideration to be given to combining this report with the "Patient Safety and the Patient Experience report".

It had been agreed at the meeting on 3 December 2015 that these reports would be combined into 1 report – the Patient Safety & Patient Experience Report.

Action: Mrs J Illingworth
Completed

15/204 DURHAM & DARLINGTON LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Durham & Darlington Services LMGB Governance report.

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

4. The financial position in the locality, which was reporting a forecast financial deficit of £2,022k up to 31 March 2016. The key matters underlying this were flexible staffing, use of agency staff - predominantly for medical staff, the historical un-delivery of CRES and some non-staff spend, including prescribing.
   Clinical Directors and Heads of Services were working on an agreed set of management actions, which had been reviewed by the Chief Executive and Director of Finance. This would be monitored closely.

5. CRES – Directorates had been looking at emerging CRES schemes for 2016/17 to prevent an adverse impact on the quality of service provision.

6. Provision of LD beds – the locality had considered plans and trajectories developed through the Transforming Care programme on the reduction of beds and the impact this would have on Durham and Darlington. The Directorate would be working closely with the Crisis Recovery House to support out of hours emergencies.

Arising from the report it was noted that:

(a) All teams had reduced the number of waiters and work was underway to improve data quality.
(b) Sickness levels were causing concerns around the availability of AMHPs.
It was felt that a contributory factor to sickness levels could be due to staff feeling overworked and undervalued, which was also a similar theme found in Tees. One solution for the lack of AMHPS could be to train our own staff in house.
(c) There had been a large increase in admissions for Tees patients and additional beds had been opened to support this demand.
(d) Dealing with substance misuse on premises continued to be an issue.

(e) There was ongoing frustration around the lack of Section 12 doctors and the need to have a second doctor from outside the Trust present.
Assurance was given that the list of available doctors had recently been brought up to date.

Following discussions it was noted that:

(i) The staff at Bowes Lyons MHSOP services had been under pressure recently, due to high admissions and difficulty moving patients out into the community, with a lack of nursing home availability.
It was recognised that the lack of residential and nursing homes in the Durham and Tees areas was a growing problem and concern for the Trust. There were delays sourcing funding, coupled with a shortage of nursing home places and delayed assessments for any placements.
These problems centred around elderly services, where the pressure on Social Services had resulted in homes not meeting CQC regulations and subsequent closure of some nursing homes.

(ii) It would be useful to see the breakdown of the forecasted £2m deficit up to March 2016 and how this related to flexible staffing, use of agency, undelivered CRES and non staff spend, including prescribing.
Mrs Whitton gave assurance and confirmed that each line of the financial plan had been scrutinised with the Director of finance and would be regularly reviewed.

Action: Mrs J Dawson/Dr I Whitton

(iii) The increased prescribing budget had been attributed to a variation in prescribing practices, together with some wastage, which had been identified when patient's leave had been cancelled and drugs had been thrown away – this amounted to a figure of £1,400 for a 20 day period on Elm and Maple Wards. This would be re-audited in February 2016.

(iv) Consideration to be given to the format of the risk register.

Action: Mrs I Walker

Agreed: That the concerns around lack of residential and nursing home placements should be escalated to the Board of Directors for further debate and discussion to consider the clinical and business risks to the Trust. Consideration should also be given to how the current model could work more effectively and how the model might look in 2 years' time.

Action: Mr P Bellas

15/205 TEES LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Tees Locality Governance Report.

Mr Brown highlighted that the top 3 concerns at present were:

(1) Implications of the LD transformation.
CCGs were currently meeting to discuss future bed requirements and until these details were known action plans could not be put into place.

(2) Availability of nursing homes for patients with dementia.
There had been a further recent closure of a 44 bedded nursing home and there was a particular lack of nursing home availability for patients with dementia.

(3) Legacy cases in North Tees of patients who may have been wrongly diagnosed with ADHD.

A complaint about late identification of this condition and misdiagnosis had been upheld.

On this matter it was noted that:

(i) There were approximately 2000 adults/children from North Tees area that this involved, where education and CYPS services were unable to distinguish from ADHD and LD at an early stage.

(ii) The Committee were assured that cognitive testing and ADHD diagnosis were subjective and would remain so until the Trust adopted an objective test, such as Qb, however any children known to services with ADHD would be re-tested.

Arising from the paper it was noted that:

(a) There had been an increased demand experienced by Intensive Community Liaison Service, (ICLS) with referrals going up from 80 per month to over 150 and 193 referrals in October 2015. This was felt to be due to the pressure on the care home sector.

(b) There had been pressures within Tees MHSOP, resulting in 14 patients being admitted to out of area in October 2015. Again, lack of care home beds in Hartlepool was a contributory factor, coupled with a spike in admissions, (5 in one day) and longer length of stay.

(c) MHSOP had seen an underlying concern regarding daily leadership and effective planning of shifts, which had impacted on patient care. An action plan had been agreed between key managers and the clinical lead and the Head of Nursing would work with the Modern Matron on implementation and improvement of the issues.

(d) In LD services the transformation implementation has continued to cause concern over the plans to reduce beds, which was not supported by a community infrastructure.

(e) There were issues with ECT operational and service delivery with a proposal to use only Roseberry Park.

(f) The key issues around Children & Young People's services were waiting times and the ADHD legacy patients already mentioned.

Following discussion it was noted that:

4. Following the Commissioner visit to Bankfield Court the action plan they had been presented with had listed 15 areas, of which only 1 related specifically to Bankfield Court.

5. A paper on the Supervision Policy had gone to the Board of Directors in November 2015, which would now be shared Trust wide and a timetable for implementation would be agreed.

6. The model of training for resuscitation compliance would now need to include another 500 staff from York and Selby and the figures were being worked through in the original business case. At present there was only around a 50% compliance rate and course places had been increased by 3 together with overbooking of training sessions.

15/206 QUALITY STRATEGY SCORECARD, QUARTER 2, 2015/16

The Committee received and noted the Quarter 2 Quality Strategy Scorecard.

(Dr L Cornwall left the meeting)

Arising from the report it was noted that:

(1) The reporting of the Quality Strategy Scorecards would be reported in future from the Quality Governance Directorate.
(2) Following feedback from the Board of Directors the indicators had been decreased from 26 to 18.
(3) Work was underway with Sub Groups in order to revise the metrics of the Scorecard further, which currently showed a majority status of 'red' and a report would come back to QuAC in February 2016 with some suggested amendments.

Action: Mrs J Illingworth

(4) The number of serious incidents at the end of November 2015 had exceeded the figure reported for the overall year for 2014/15, with the actual position at 20.61, (112 incidents per average monthly caseload of 54,347) against a target of 14.15.
One of the contributing factors around this could be the changes made recently to the reporting culture with more incidents being recorded.

Arising from discussion it was highlighted that:

(a) It was reassuring to note that even though the number of serious incidents had gone up, there were no high level consistent themes and trends. Some comparative work and benchmarking would be undertaken retrospectively at the end of the financial year to compare the Trust with the national picture.
On this matter assurance was given to the Committee that there had been marked improvement around the data quality over recent months and effective training had led to more rigorous and consistent categorisation of the data.
(b) It would be important going forward to try to establish some Trust wide consistency with the information and categorisation of Scorecards across all areas of the organisation. It was intended that the Sub-Groups would receive the narrative around the scorecard to increase levels of assurance in the future.
(c) It would be helpful to include some explanatory narrative as a footnote to Appendix 2 - the Trust and Locality view for Quality Strategy Scorecard. This would then give some understanding to the background to a scorecard that currently showed a very high proportion of reds as the status position.
(d) That the radars for 3 indicators, which were not currently functioning should be resolved.
(e) That the typographical error in section 3.4.4, (page 4) be corrected.

Action: Mrs J Illingworth

15/207 CLINICAL EFFECTIVENESS GROUP ASSURANCE REPORT

The Committee received and noted the Clinical Effectiveness Group Assurance Report for the CEG meeting held in November 2015.

It was highlighted from the report that:

(1) There were 173 scheduled clinical audits for the 2015/16 programme, 96 of these were re-audits with 52 complete, 64 ongoing and 6 behind schedule.
(2) There were 20 outstanding action points, (more than 31 days overdue) from 12 action plans from the completed programmed clinical audit activities.

Following discussion it was agreed that the monthly Clinical Effectiveness Group report would be replaced with one quarterly Clinical Audit and Effectiveness Report, which would include an exception report.

Action: Mrs J Illingworth

15/208 CLINICAL AUDIT & EFFECTIVENESS QUARTERLY REPORT

The Committee received and noted the data contained in the Clinical Audit & Effectiveness quarterly report.

There were no comments raised around this item since they had been covered under minute 15/207.

15/209 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee considered and noted the report of the Patient Safety Group.

Arising from the report it was highlighted that:

1. There had been a long discussion at the recent Patient Safety Group meeting around Datix, ongoing issues and incident reporting and whether the system should be configured to allow multiple categories for incidents, when necessary.
2. The information received from York and Selby on serious incident actions plans would be reviewed.
   On this matter it was noted that it was too early to make a view on the quality of work around serious incidents from York and Selby.
3. Outstanding actions and progress updates around Trust wide incidents would continue to be chased, with monitoring and escalation to EMT where necessary.
4. The monthly Patient Safety Bulletin would continue in the format of a 1 page summary approved by the Patient Safety Group - This would highlight key learning messages and lessons learnt immediately from any incidents that had occurred.

Arising from discussion it was noted that there was a Trust protocol around the Duty of Candour, however there was a need to bring some level of consistency in approach to the protocol with centralised information.

15/210 PATIENT EXPERIENCE GROUP ASSURANCE REPORT

The Committee received and noted the Patient Experience Group Assurance Report.

Arising from the report it was highlighted that:

(1) There had been good representation at the Patient Experience Group meeting, held on 17 November 2015 from localities and a representative had been requested from York and Selby.
(2) Assurance was given to QuAC that complaints were being discussed at both QuAGs and LMGB and the Scorecard was being discussed on a monthly basis.
(3) The group had considered the option of future working with Dr Mark Lambert, Consultant Epidemiologist on the Quality Scorecard and other matters, however this matter would need a decision from EMT.

Arising from discussion it was noted that:

(a) There had been a lot of discussion at the Patient Experience Group around patients not feeling safe, which had declined in recent months and had been highlighted in the free text on national community surveys. Feedback received from the wards reported individual patients causing disruption, however staff were being asked to think about what steps they were taking to ensure the safety

of others around them when these instances occurred and this important matter would be picked up and monitored in future meetings.

On this matter it was pointed out that assurance was subjective and had to be considered in light of the increasing complexity of patients that were being looked after by services.

15/211 SAFEGUARDING CHILDREN & ADULTS EXCEPTION AND ASSURANCE REPORT

The Committee received and noted the exception report for Safeguarding Adults and Children.

Arising from the report it was noted that:

(1) A paper had been presented to EMT recently with proposed changes to the Safeguarding teams and the provision of Safeguarding in North Yorkshire. The service level agreement for NY would end on 31 December 2015.

(2) Work was underway to look at the services in York to establish the need and demand around Safeguarding.
(3) Attendance at the multi-agency risk Assessment Conference (MARAC) continued to be an issue
(4) Female genital mutilation would now be reported as a national requirement and would go through the Safeguarding Team.

Following discussion it was noted that there would be a reconfiguration of the Safeguarding team to address the needs of the service and to balance the priority of work.

15/212 RESEARCH GOVERNANCE GROUP ASSURANCE REPORT

The Committee received and noted the assurance report of the Research Governance Group.

Arising from the report it was noted that:

(1) The Research and Development strategy had been ratified on 24 November 2015.
(2) The R&D Strategy Implementation Plan had been approved at EMT on 18 November 2015.
(3) There had been approval granted for 6 large scale National Institute for Health Research (NIHR) portfolio studies and a further 4 study permissions to support research studies in the York and Selby locality.
(4) Plans were underway to increase the partnership with the University of York to collaborate on large grants and further opportunities in large studies.

In response to questions it was noted that:

(a) No firm conclusions had been reached following the work around implementation of research evidence; however there had been some interesting ideas put forward and the Research Governance Group would be working on the Research Strategy to take forward dissemination of research Trust wide.
(b) The internal Research Governance Group did not currently have any representation from the Universities.

15/213 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee considered and noted the position of compliance with Care Quality Commission registration requirements.

Arising from the report it was highlighted that:

1. The CQC would re-visit Bootham Park in 7 December 2015 to inspect the 136 suite in order to approve the application to register it, with a view to opening services from 16 December 2015.
2. Following a CQC inspection in January 2015, it had been highlighted to Ofsted the potential need for the Trust to register the Holly Unit, West Park Hospital as a children's home.
   This was due to the fact that the unit was operating as a short break facility for children with learning disabilities or complex health needs with challenging behaviour. This requirement also affected Baysdale Unit at Roseberry Park.
3. There had been 7 MHA inspections and various associated monitoring reports had been received with action plans put into place.
   On this matter it was pleasing to note that 2 of the reports had resulted in no further actions to address, at both White Horse View, Easingwold and Roseberry Ward, Lanchester Road.

In response to questions it was noted that:

(a) The seclusion room at Westwood, West Lane Hospital had been repaired to a safe standard.
(b) The review of Bootham Park had been commissioned by Margaret Kitching, Chief Nursing Officer of the North of England, following concerns raised at the Overview and Scrutiny Committee.

15/214 MENTAL HEALTH LEGISLATION CQC THEMES SUMMARY REPORT

Following earlier discussion it had been agreed that this report would not be considered in this or future QuAC meetings as the MHA Reports would be picked up in the CQC Compliance Report on a monthly basis.

15/215 PATIENT SAFETY INCIDENT BENCHMARKING DATA

The Committee considered and noted the Patient Safety Incident Benchmarking data.

Arising from the report it was noted that:

(1) The information set out in the report had been requested by QuAC to look at comparative data, primarily for patient safety incidents relating to service users that had died.
(2) The information from October 2012 to March 2015 had been obtained from the National Reporting and Learning System (NRLS).
(3) The Trust had been consistently reporting a higher than average percentage of incidents resulting in 'no harm' and a lower than average percentage of incidents resulting in 'low harm'

Arising from discussion it was noted that:

(a) The central approval team were looking more closely at what this data meant for the Trust.
(b) It would be useful to provide some benchmarking data against other Mental Health Trusts of a similar size.

Agreed: that benchmarking data from NRLS would be reported to QuAC every 6 months and should include more detail on fractured neck of femur, falls and restraint.

Action: Mrs J Illingworth

15/216 EXCEPTION REPORTING (LMGBs, QAC sub groups)

There was nothing to note under this item.

15/217 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD

The matter of lack of nursing home provision and placements be raised to the Board of Directors in January 2016.

15/218 ANY OTHER BUSINESS

The Committee acknowledged the hard work and commitment of staff under pressure at Westerdale South.

On this matter It was noted that there was a robust action plan in place to address staffing issues with 6 new members of staff planned to join the service, 2 of which were staff nurses in January 2016.

15/219 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 4 February 2016,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at pm

……..

Dr Hugh Griffiths
CHAIRMAN
4 February 2016

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd February 2016**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Update Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

The purpose of the report is to advise the Board of the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review).

This report refers to December 2015 and January 2016 data.

Key issues during the reporting period for York and Selby localities:

- York and Selby services have been reported separately to the wider report, all information has been provided at appendix 13.

Key issues during the reporting period for TEWV:

- In January there has been an improvement in relation to the month on month trend with 1 indicator showing as 'green' when compared to December. All other indicators are showing as 'red' although this is within acceptable tolerance.
- The number of wards showing as 'red' increased in December and remained at the same level in January both reporting at 47 (November there were 44 wards).
- North Yorkshire have the lowest number of red wards in both December (6) and January (8) whilst Forensic services have the highest number of red wards, 24 in December and 20 in January.
- The lowest fill rate in January related to Kingfisher/Heron as a result of sickness and maternity. Kingfisher is not currently open and patients are transferring to Heron this month.
- The lowest fill rate in December related to Robin which followed the split of the roster

from Kingfisher/Heron/Robin.

- The Highest fill rate was observed by Westerdale South in December and January with the unregistered shifts on days increasing in January from 258.2% (December) to 293.2% (January)
- In terms of triangulation:
  - ***January 2016:***
    - Wingfield had a low fill rate as well as an SUI and a level 4 incident
    - Westerdale South had high fill rates and high bank usage
    - Mallard Ward had a high fill rate and high bank usage
    - Westwood Centre continues to have the highest number of incidents involving control and restraint in particular the use of PRONE (6 episodes in January and 5 in December)
  - ***December 2015:***
    - Robin had a low fill rate as well as an SUI
    - Cedar (NY) had a low fill rate and agency use in addition to a level 3 incident
    - Bedale Ward had a low fill rate as well as an SUI and a complaint
    - Thistle Ward had a low staffing fill rate as well as an SUI and 2 PALS related issues
    - Swift Ward had a low fill rate and PALS related issues
    - Mallard Ward had a high fill rate and bank usage in addition to a complaint and PALS related issues
    - Westwood Centre had the highest number of incidents involving control and restraint.

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

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**23rd February 2016**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Update Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to December 2015 and January 2016 data.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (www.tewv.nhs.uk/nursestaffinginfo). The full monthly data set of day by day staffing for each of the 65 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

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

York and Selby localities are reported separately from this report and attached at appendix 13.

3. KEY ISSUES:

3.1 Safe Staffing Fill Rates

3.2 The daily nurse staffing information aggregated for the months of December 2015 and January 2016 is presented in Appendices 1, 2, 7 and 8 with locality information in Appendices 3 and 9.

The total number of inpatient rosters during the month of December 2015 increased to 66 from 65. This was due to the splitting out of Robin from Kingfisher/Heron/Robin to form a separate roster. The position in January 2016 equates to 66 and remains unchanged from the previous month of December 2015.

The month on month trend report shows an improvement in January 2016 with one of the four metrics showing as 'green'. Although the remaining trends show deterioration when compared to the month of December 2015 it is important to highlight that these figures are still within tolerance.

Month	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Nov-15	90.72	↑	118.47	↓	96.82	↓	114.52	↑
Dec-15	87.70	↓	114.20	↓	96.60	↓	113.30	↓
Jan-16	88.60	↑	114.00	↓	96.40	↓	112.00	↓

The numbers of wards reporting a fill rate of less than 89.9% in December 2015 and January 2016 are reporting as 47 which is an increase on previous reporting period of November 2015.

Month	January 2016	December 2015	November 2015	October 2015	September 2015	August 2015
No. of Red Wards	47	47	44	42	43	49

The majority of the red wards fall into the Registered Nurse on Day shifts category where there were 32 wards shown as red in January compared to 34 in November 2015.

A deterioration can be observed in Durham and Darlington and North Yorkshire when comparing January's data with December with the number of red wards increasing. Forensic services continue to have the highest number of red wards with 20 which is an improved position when compared to December. The table below shows the split across all localities over the last 6 months with the full detail available in appendix 3 and 9 of this report:

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

3.2.1 January 2016

The lowest staffing fill rate relates to Kingfisher/Heron who are reporting 41.8% for Registered Nurse on Day Shifts and 30.9% for Registered Nurses on Nights. They were identified as having the lowest fill rate in December 2015 for the first time. The breakdown since the split of the wards is as follows:

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

The ward has articulated that the low fill rates were in relation to sharing a registered nurse with Robin Ward. Heron ward closed on the 29th January 2016. Sickness and maternity leave were also attributable factors which meant staff were shared across rotas. Kingfisher is not open currently and patients are transferring from Heron this month in relation to the Transforming Care agenda. This reconfiguration should improve the roster position going forward.

The second lowest fill rate was observed by Robin who had a registered nurse fill rate on days at 37.4% and 34.4% for registered nurses on nights. Robin were identified as having one of the lowest fill rates in December 2015 for the first time. The breakdown since the split of the wards is as follows:

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

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

The third lowest fill rate was observed by Jay Ward who had a Registered Nurse fill rate on Days at 58.7%. The breakdown over the last 6 months is as follows:

	Jan-16	Dec-15	Nov-15	Oct-15	Sep-15	Aug-15
Jay Ward	58.7%	57.1%	62.8%	55.3%	80.2%	72.2%

The ward has articulated that the low fill rate was in relation to sickness and maternity cover. In addition they have advised that they have flexed their staffing to cover any shortfall, this is evident in the HCA fill rate for days reporting at 134.2%

There were 4 other wards that had low fill rates between 59.7% and 66.2%, as articulated below:

	Jan-16	Dec-15	Nov-15	Oct-15	Sept-15	Aug-15
The Orchards	59.7%	65.0%	100.0%	89.6%	120.0%	119.4%
Bedale Ward	61.1%	66.6%	71.5%	72.7%	71.8%	78.1%
Bilsdale	63.2%	77.9%	64.5%	68.0%	81.6%	63.6%
Wingfield	66.2%	74.1%	78.5%	81.2%	85.1%	91.7%

All of these were registered nurses on days with the exception of The Orchard whereby there low fill rate was related to registered nurses on nights.

It is also important to review the fill rates that exceed their budgeted establishment (shown in blue). During the month of January there were 39 metrics that had staffing in excess of their planned requirements to address patient care needs. This is a reduction when compared to December where there were 43.

Westerdale South saw the highest fill rate indicators during the month of January (293.2% and 208.3%). This is now the fifth month in a row they have been in this position. January fill rates are as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westerdale South	**89.1%**	**293.2%**	**100.3%**	**208.3%**

The ward has reported that throughout January the number of service users on enhanced observations did not fall below 3 and were at 4 on occasions requiring more staff to provide direct patient care.

The second highest fill rate indicator was in relation to Mallard Ward who had a Unregistered fill rate for night shifts of 238.1%. The January fill rate return is as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Mallard Ward	**83.3%**	**146.5%**	**105.2%**	**238.1%**

The ward has articulated that the staffing numbers for the ward is normally 6 on days, 3 on nights plus a twilight shift (4pm-midnight). During January two patients were receiving care at James Cook University Hospital (JCUH) with 2 and 3 staff respectively escorting them at all times. To facilitate exchange of staff during the night between Mallard ward and JCUH the twilight was altered to a night shift. This increased staffing numbers to 8 and 9 during the day and 5 and 6 when they were in-patients at JCUH. In addition to the

aforementioned, 1 member of qualified nursing staff is on long term sickness with another working off the ward.

The third highest fill rate indicator was in relation to Langley ward with 203.7% as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Langley	**70.3%**	**131.7%**	**101.9%**	**203.7%**

The ward has articulated that the high fill rates were in relation to extra staff required to undertake enhanced observations.

3.2.2 December 2015

The lowest fill rates were observed by Robin in December 2015. The Registered Nurse fill rate for Days was reported as 32.5% and the Registered Nurse fill rate for Nights was reported as 33.6%.

The ward has articulated that the low fill rates were in relation to the split of ward from Heron and having 1 qualified nurse covering. It is important to highlight that Kingfisher/Heron/Robin in November 2015 were identified as having the second lowest fil rate.

The second lowest fill rate was observed by Jay Ward who had a Registered Nurse fill rate on Days at 57.1%. The breakdown over the last 6 months is as follows:

	Dec-15	Nov-15	Oct-15	Sep-15	Aug-15	Jul-15
Jay Ward	57.1%	62.8%	55.3%	80.2%	72.2%	78.2%

The ward has articulated that the low fill rate was in relation to maternity leave high acuity and vacancies for registered nurses. They have also added that they have flexed their workforce between registered and unregistered staff to cover the shortfall. This is evident with the unregistered fill rate for days showing as 125.4%.

The third lowest staffing fill rate relates to Cedar (NY) who are reporting 57.6% for Registered Nurse on Night Shifts during December. Cedar (NY) held the second lowest fill rate in October and November reports. The breakdown over the last 6 months is as follows:

	Dec-15	Nov-15	Oct-15	Sep-15	Aug-15	Jul-15
Cedar Ward (NY)	57.6%	45.2%	56.6%	47.8%	54.2%	48.0%

The ward have articulated that the low fill rate was in relation to 1 qualified only working a night duty and the electronic roster is currently set up for 2 RN's to work nights. In addition they are also reporting sickness as a contributory factor.

There were 6 other wards that had low fill rates between 59.1% and 69.7%, interestingly all of these were in relation to RN Day Shifts as articulated below:

	Dec-15	Nov-15	Oct-15	Sept-15	Aug-15	Jul-15
Overdale Ward	59.1%	61.5%	64.2%	61.3%	68.0%	68.2%
The Orchards	65.0%	100.0%	89.6%	120.0%	119.4%	135.7%
Bedale	66.6%	71.5%	72.7%	71.8%	78.1%	71.6%
Thistle	67.5%	75.7%	80.5%	75.2%	70.0%	84.7%
Langley	67.9%	79.9%	71.8%	88.2%	75.8%	85.9%
Swift Ward	69.7%	87.5%	79.9%	81.2%	65.6%	72.0%

It is also important to review the fill rates that exceed their budgeted establishment (shown in blue). During the month of December there were 44 metrics that had staffing in excess of their planned requirements to address patient care. This is a reduction when compared to November where there were 45 and 51 in October 2015.

Westerdale South saw the highest fill rate indicators during the month of December (258.2% and 203.8%). Although this is the fifth month in a row the have been in this position the figures are an improvement when compared to November 2016 (306.2% and 228.8%). December data is as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westerdale South	**79.1%**	**258.2%**	**90.3%**	**203.8%**

The ward has reported that throughout December the number of service users on enhanced observations did not fall below 3 and therefore more staff were required to provide patient care and treatment.

The second highest fill rate indicator was in relation to Mallard Ward who had a Unregistered fill rate for night shifts of 215.8%. The December fill rate return is as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Mallard Ward	76.3%	158.0%	108.5%	215.8%

The ward has articulated that during December they had 2 patients in JCUH with 2 staff escorting them at all times. This increased their staffing numbers whilst they were in-patients.

The third highest fill rate indicator was in relation to Westwood Centre with 197.2% as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westwood Centre	106.5%	125.9%	109.6%	197.2%

Feedback from the ward was not available at the time of writing this report to advise of the reasons for over staffing the ward.

From those wards that had blue fill rate indicators during the reporting period the majority were unregistered day shifts.

3.3 Bank Usage

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

Appendices 6 and 12 highlights the usage of bank staffing, as a proportion of actual hours. These are 'RAG' rated independently of the overall fill rate.

Those wards using greater than 50% bank staffing to deliver their fill rates in December 2015 and January 2016 are identified below:

Locality	Ward	Bank Usage		Comments
		Jan-16	Dec-15	
Forensics	Mallard Ward	69%	53%	Significant increase in January when compared to December. Bank usage was only 40% in November
Forensics	Merlin Ward	60%	47%	Significant increase in January when compared to December. Bank usage was 50% in November
Teesside	Westerdale South	67%	68%	A slight reduction in January when compared to December. Bank usage was 78% in November.
Durham & Darlington	Picktree Ward	27%	51%	December's figure was only just over the 50% threshold for reporting. An improved position can be observed for January.

46 wards were reported as Amber (between 10 and 40%) in December 2015 and 45 wards in January 2016.

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

	January	December	November	October	September	August
Mallard Ward	69%	53%	40%	28%	30%	34%
Merlin	60%	47%	63%	62%	66%	66%
Westerdale South	67%	68%	91%	87%	74%	74%
Picktree Ward	27%	51%	55%	50%	41%	37%

3.4 Agency Usage

When considering staffing levels it is also important to consider the amount of agency worked within the reporting period. In December 2015 there was a total of 205,656.24 hours worked across the trust of which 236.00 were agency hours, equating to 0.11% of the total hours worked. In January 2016 there was a total of 207,123.64 hours worked across the trust of which 229.00 were agency hours, equating to 0.11% of the total hours worked.

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

Locality	Ward	Total Agency Hours (Jan-16)	Total Agency Hours (Dec-15)	Reason for using Agency
North Yorkshire	Cedar Ward	69.5	26.5	Service need
North Yorkshire	Rowan Ward	159.5	195.5	Sickness, annual leave
North Yorkshire	Springwood	0.0	60.0	Enhanced observations

It is positive to note that agency usage remains low within the Trust. It is important to continue to monitor this on an ongoing basis due to the potential risks that high agency working has on clinical areas and compliance with agency caps that the trust is required to report to Monitor on a monthly basis.

3.5 Quality Data Triangulation

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

3.5.1 January 2016

- There were 3 SUI's that occurred within the month of January 2016 from 3 different wards. One of these occurred on Wingfield who were identified earlier in relation to having a low staffing fill rate.
- There were 3 level 4 incidents that occurred in January, one of which occurred on Wingfield who have been identified as having a low staffing fill rate and an SUI. This incident is currently under investigation however two

staff were observing the patient who fell, therefore at this stage there does not appear to be a direct correlation to staffing levels.

- There were 10 level 3 incidents (self-harm) that occurred within the period none of which were relating to wards that have been identified to date within this report.
- There were 5 complaints that occurred within the reporting period none of which were relating to wards that have been identified to date within this report.
- There were 30 PALS related issues raised during January of which the following is of relevance:
  - 2 X Bilsdale who were identified as having a low fill rate
  - 2 X Cedar (NY) who were identified as having agency usage
  - 1 X Langley who were identified as having a high fill rate
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was Westwood with a total of 90 incidents requiring control and restraint (6 of which required the use of PRONE restraint). To date Westwood has not been highlighted within this report as having either a high or low staffing fill rate, bank or agency usage. However, they do continuingly feature as the highest user of control and restraint. This was discussed under the Force Reduction project update at the last Quality Assurance Committee and it was agreed to undertake a 'deep dive' review of practice on the ward to better understand this.

3.5.2 **December 2015**

- There were 7 SUI's that occurred within the reporting period from different wards. There were 3 SUI's that occurred within wards that have been identified as having a low fill rate during the month of December 2015 (Robin, Bedale and Thistle Wards).
- There were 2 level 4 incidents that occurred in December none of which were relating to wards that have been identified to date within this report.
- There were 8 level 3 incidents (self-harm) that occurred within the reporting period of which 1 occurred within Cedar (NY) who have been identified as having a low fill rate and agency usage.
- There were 7 complaints that occurred within the reporting period. The following is of relevance:
  - 1 X Bedale Ward who have been identified as having a low fill rate and an SUI
  - 1 X Langley who have been identified as having a low fill rate
  - 1 X Mallard Ward who has been identified as having a high fill rate and high bank usage.
- There were 39 PALS related issues raised during December of which the following is of relevance:
  - 2 X Thistle who have been identified as having a low fill rate and an SUI
  - 1 X Langley who have been identified as having a low fill rate and a complaint
  - 1 X Swift who have been identified as having a low fill rate

  - 1 X Mallard who have been identified as having a high fill rate, high bank usage and a complaint
  - 1 X Rowan Ward who have been identified as having agency usage.
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was Westwood with a total of 54 incidents requiring control and restraint (5 of which required the use of PRONE restraint). Westwood were also identified as having a high fill rate within the month of December.

3.6 Missed Breaks

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

A thorough analysis of the HealthRoster system has identified that there were 1,760 shifts in December 2015 and 1,512 shifts in January 2016 where unpaid breaks had not been taken. The majority of the shifts where breaks were not taken occurred on day shifts (822 shifts in total). This is a decrease of 15 shifts in January when compared to December (837 shifts in total).

The number of night shifts where breaks were not taken was 274 in December and 254 in January.

The highest number of shifts worked without a break can be observed within York and Selby and the lowest in Durham and Darlington.

It is difficult to draw any meaningful conclusions in relation to breaks not taken and staffing fill rates during day shifts. Interestingly, from those night shifts where a break was not taken the staffing fill rate is reporting mostly as 'green' and 1 ward showing 'blue' suggesting that missed breaks may not only occur as a result of staffing shortages.

It is not possible to highlight the reasons as to why breaks are not given due to this not being reported within the HealthRoster system. It is therefore not possible to separate whether this is due to clinical need or customary practice.

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

3.7 Incidents raised citing Staffing Levels

It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. Within the reporting period there were 32 incidents raised citing issues with staffing of which 26 were in relation to in-patient services and 6 were in relation to community based teams which would be considered out with this report.

The incidents citing staffing problems were from the following localities:

Locality	Dec-15	Jan-16
	No. of Incidents	No. of Incidents
North Yorkshire	1	1
Durham & Darlington	2	0
Teesside	5	1
Forensics	8	6
York and Selby	0	2

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 and inability to carry out key interventions and tasks.
- There were 2 incidents raised highlighting that there was no qualified nurse on duty. This related to a Forensic unit on the 7th December and a ward within Durham & Darlington on the 28th December.
- There were 2 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.
- Issues relating to carrying out enhanced observations due to low staffing levels

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

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

4. Other

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

- Test out NHS England evidence based staffing framework and tools for MH wards in agreed in-patient areas.
- To ensure above indicators are compliant with emerging NICE guidance or other DH documentation
- Set up a task and finish group for safe staffing

- Implement regular reporting and monitoring systems within services to enable timely and informed intervention to occur

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

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

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

5. IMPLICATIONS:

5.1 Compliance with the CQC Fundamental Standards:

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

- There was an improvement in January in relation to the month on month trend with 1 indicator showing as 'green' when compared to December. All other indicators are showing as 'red' although this is within acceptable tolerance.
- The number of wards showing as 'red' increased in December and remained at the same level in January both reporting at 47 (November there were 44 wards).
- North Yorkshire have the lowest number of red wards in both December (6) and January (8) whilst Forensic services have the highest number of red wards, 24 in December and 20 in January.
- The lowest fill rate in January related to Kingfisher/Heron as a result of sickness and maternity. In addition Kingfisher is not currently open and patients are transferring to Heron this month.
- The lowest fill rate in December related to Robin which followed the split from Kingfisher/Heron/Robin.
- The Highest fill rate was observed by Westerdale South in December and January with the unregistered shifts on days increasing in January from 258.2% (December) to 293.2% (January)
- In terms of the triangulation:
  - ***January 2016:***
    - Wingfield had a low fill rate as well as an SUI and a level 4 incident
    - Westerdale South had high fill rates and high bank usage
    - Mallard Ward had a high fill rate and high bank usage

- Westwood Centre continues to have the highest number of incidents involving control and restraint in particular the use of PRONE (6 episodes in January and 5 in December)

- ***December 2015:***
  - Robin had a low fill rate as well as an SUI
  - Cedar (NY) had a low fill rate and agency use in addition to a level 3 incident
  - Bedale Ward had a low fill rate as well as an SUI and a complaint
  - Thistle Ward had a low staffing fill rate as well as an SUI and 2 PALS related issues
  - Swift Ward had a low fill rate and PALS related issues
  - Mallard Ward had a high fill rate and bank usage in addition to a complaint and PALS related issues
  - Westwood Centre had the highest number of incidents involving control and restraint.

5.2 **Financial/Value for Money:**

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

5.3 **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.

5.4 **Equality and Diversity:**

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

5.5 **Other implications:**

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

6. RISKS:

The current lack of an evidence based tool for workforce planning and monitoring in mental health and learning disability nursing increases the risk that the publication of the workforce data will be compared to other Trust's data without appreciation of context. Information published on the Trust website will assist with provision of contextual information. NICE are expected to publish further guidance on evidence based approaches to staffing by the end of this year 2015

7. CONCLUSIONS:

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

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

It is difficult to draw any meaningful conclusions from the data presented within this report however a safe staffing task and finish group is being established to undertake ongoing analysis of factors affecting staffing and to enable staffing establishments to be safely met on a shift by shift basis. Progress will be reported to the board by exception through the safe staffing report.

8. RECOMMENDATIONS:

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

Emma Haimes
Head of Quality Data
February 2016

DECEMBER 2015 DATA

Appendix 1

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

				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
The Orchards (NY)	North Yorkshire	Adults	9	80.0%	112.4%	65.0%	173.9%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	13	102.2%	93.0%	104.7%	91.1%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	13	99.1%	99.9%	96.8%	98.4%
Bedale Ward	Teesside	Adults	10	66.6%	185.1%	100.8%	123.5%
Bilsdale Ward	Teesside	Adults	14	77.9%	136.2%	96.8%	113.1%
Birch Ward	Durham & Darlington	Adults	15	101.5%	95.5%	100.0%	130.0%
Bransdale Ward	Teesside	Adults	14	78.2%	125.3%	100.0%	98.4%
Cedar Ward	Durham & Darlington	Adults	10	100.3%	169.7%	100.0%	131.1%
Cedar Ward (NY)	North Yorkshire	Adults	18	73.9%	135.9%	57.6%	154.9%
Earlston House	Durham & Darlington	Adults	15	99.7%	96.7%	100.0%	100.0%
Elm Ward	Durham & Darlington	Adults	20	83.3%	135.0%	100.0%	121.0%
Farnham Ward	Durham & Darlington	Adults	20	97.7%	116.6%	103.2%	100.0%
Lincoln Ward	Teesside	Adults	20	100.2%	95.9%	92.8%	100.6%
Lustrum Vale	Teesside	Adults	20	75.2%	134.4%	100.3%	100.1%
Maple Ward	Durham & Darlington	Adults	17	88.8%	117.5%	90.3%	114.8%
Overdale Ward	Teesside	Adults	18	59.1%	150.1%	81.5%	116.4%
Park House	Teesside	Adults	14	96.5%	100.5%	100.6%	106.4%
Primrose Lodge	Durham & Darlington	Adults	15	78.6%	117.7%	100.0%	100.0%

Stockdale Ward	Teesside	Adults	18	95.4%	115.5%	100.6%	103.6%
Tunstall Ward	Durham & Darlington	Adults	20	93.8%	115.3%	93.4%	101.6%
Ward 15 Friarage	North Yorkshire	Adults	14	85.4%	114.7%	100.3%	98.7%
Willow Ward	Durham & Darlington	Adults	15	72.7%	149.4%	100.0%	100.0%
Baysdale	Teesside	CYPS	6	137.6%	87.5%	104.0%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	129.9%	109.0%	110.0%	110.0%
Newberry Centre	North Yorkshire	CYPS	14	82.9%	113.1%	105.8%	103.1%
The Evergreen Centre	North Yorkshire	CYPS	16	90.6%	112.3%	102.2%	100.2%
Westwood Centre	North Yorkshire	CYPS	12	106.5%	125.9%	109.6%	197.2%
Clover/Ivy	Forensics	Forensics LD	12	92.8%	110.7%	100.6%	137.1%
Eagle/Osprey	Forensics	Forensics LD	10	92.5%	92.6%	100.6%	101.6%
Harrier/Hawk	Forensics	Forensics LD	10	78.4%	116.2%	98.8%	111.4%
Kestrel/Kite.	Forensics	Forensics LD	16	75.6%	109.6%	101.1%	125.8%
Kingfisher/Heron	Forensics	Forensics LD	8	64.8%	86.6%	77.9%	103.2%
Robin	Forensics	Forensics LD	6	32.5%	88.8%	33.6%	105.7%
Langley Ward	Forensics	Forensics LD	10	67.8%	115.8%	102.2%	119.2%
Northdale Centre	Forensics	Forensics LD	6	81.5%	96.3%	101.9%	95.6%
Oakwood	Forensics	Forensics LD	8	91.8%	83.7%	100.0%	100.0%
Thistle	Forensics	Forensics LD	5	67.5%	100.9%	97.3%	96.8%
Brambling Ward	Forensics	Forensics MH	13	80.7%	106.7%	101.1%	105.6%
Fulmar Ward.	Forensics	Forensics MH	12	106.3%	84.9%	105.2%	97.5%
Jay Ward	Forensics	Forensics MH	5	57.1%	125.4%	95.0%	101.8%
Kirkdale Ward	Forensics	Forensics MH	16	82.0%	104.4%	101.7%	98.7%
Lark	Forensics	Forensics MH	15	79.7%	115.0%	104.9%	100.4%
Linnet Ward	Forensics	Forensics MH	17	80.2%	127.2%	104.4%	129.7%
Mallard Ward	Forensics	Forensics MH	16	76.3%	158.0%	108.5%	215.8%
Mandarin	Forensics	Forensics MH	16	100.7%	81.8%	101.7%	99.2%
Merlin	Forensics	Forensics MH	10	104.3%	148.9%	86.2%	155.4%

Newtondale Ward	Forensics	Forensics MH	20	91.5%	88.8%	93.7%	96.7%
Nightingale Ward	Forensics	Forensics MH	16	85.2%	103.7%	118.4%	103.7%
Sandpiper Ward	Forensics	Forensics MH	8	92.2%	97.8%	91.3%	105.0%
Swift Ward	Forensics	Forensics MH	10	69.7%	116.5%	103.2%	150.5%
Aysgarth	Teesside	LD	6	109.0%	153.7%	100.1%	100.0%
Bankfields Court Unit 2	Teesside	LD	5	120.4%	105.6%	100.0%	112.0%
Bankfields Court	Teesside	LD	12	89.5%	117.4%	94.6%	100.3%
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	99.0%	99.1%	100.0%	100.0%
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	98.5%	123.9%	100.3%	100.0%
Hamsterley Ward	Durham & Darlington	MHSOP	10	88.9%	135.0%	100.1%	100.0%
Oak Ward	Durham & Darlington	MHSOP	12	86.9%	90.7%	100.0%	103.3%
Picktree Ward.	Durham & Darlington	MHSOP	10	83.0%	148.1%	100.0%	121.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	91.7%	97.6%	100.0%	100.0%
Rowan Lea	North Yorkshire	MHSOP	20	101.4%	92.4%	122.5%	91.0%
Rowan Ward	North Yorkshire	MHSOP	12	101.0%	94.8%	125.5%	107.1%
Springwood Community Unit	North Yorkshire	MHSOP	14	102.1%	120.3%	114.1%	137.6%
Ward 14	North Yorkshire	MHSOP	9	94.1%	120.0%	104.2%	119.6%
Westerdale North	Teesside	MHSOP	18	107.4%	120.1%	100.8%	103.8%
Westerdale South	Teesside	MHSOP	14	79.1%	258.2%	90.3%	203.8%
Wingfield Ward	Teesside	MHSOP	9	74.1%	106.7%	92.7%	104.6%

Appendix 2

December	TRUSTWIDE DAILY POSITION –all wards	
	Difference between what was planned on roster and actually worked – RNs	Difference between what was planned on roster and actually worked – HCAs
1	-8%	12%
2	-4%	12%
3	-4%	11%
4	-11%	12%
5	-12%	10%
6	-8%	13%
7	-11%	8%
8	-8%	12%
9	-9%	13%
10	-9%	12%
11	-13%	14%
12	-10%	12%
13	-10%	14%
14	-10%	11%
15	-9%	14%
16	-9%	14%
17	-9%	14%
18	-14%	14%
19	-12%	12%
20	-11%	12%
21	-7%	12%
22	-8%	15%

23	-11%	17%
24	-13%	6%
25	-18%	4%
26	-13%	9%
27	-16%	10%
28	-16%	11%
29	-13%	11%
30	-11%	13%
31	8%	15%

Appendix 3

DURHAM & DARLINGTON LOCALITY REPORT - December 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Birch Ward	15	790.5	371.33	984	720	802.5	371.33	940.14	936	101.5%	100.0%	95.5%	130.0%
Elm Ward	20	893.33	372	720	744	744	372	972.17	900	83.3%	100.0%	135.0%	121.0%
Maple Ward	17	893.49	372	705.33	732	793.82	336	829	840	88.8%	90.3%	117.5%	114.8%
Farnham Ward	20	864	372	648.67	744	844.5	384	756.67	744	97.7%	103.2%	116.6%	100.0%
Tunstall Ward	20	905.34	365.32	696	730.68	849.25	341.32	802.59	742.01	93.8%	93.4%	115.3%	101.6%
Willow Ward	15	880.16	372	732	744	640.17	372	1093.5	744	72.7%	100.0%	149.4%	100.0%
Earlston House	15	910	372	744	744	906.84	372	719.5	744	99.7%	100.0%	96.7%	100.0%
Primrose Lodge	15	894	372	744	744	702.67	372	876	744	78.6%	100.0%	117.7%	100.0%
Holly Unit	4	251.4	190	427.48	190	326.46	209	465.83	209	129.9%	110.0%	109.0%	110.0%
Cedar Ward PICU	10	877	372	732	1080	880	372	1242.16	1416	100.3%	100.0%	169.7%	131.1%
Ceddesfeld Ward	10	902.3	372	687	744	888.42	373	850.99	744	98.5%	100.3%	123.9%	100.0%
Roseberry Wards	15	917.33	372	740.66	744	840.98	372	723	744	91.7%	100.0%	97.6%	100.0%
Oak Ward	12	892.17	372	744	720	775.17	372	674.49	744	86.9%	100.0%	90.7%	103.3%
Picktree Ward.	10	913.17	372	643.67	744	757.82	372	953.17	900.05	83.0%	100.0%	148.1%	121.0%
Hamsterley Ward	10	909.34	372	536.33	744	808	372.5	723.89	744	88.9%	100.1%	135.0%	100.0%
Bek, Ramsey, Talbot Wards	16	649.5	372	2586	1128	643	372	2562.17	1128	99.0%	100.0%	99.1%	100.0%

FORENSICS LOCALITY REPORT - December 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Lark	15	858.25	348.75	982	697.5	683.93	366	1129	700.5	79.7%	104.9%	115.0%	100.4%
Brambling Ward	13	870	348.75	991.75	697.5	702.5	352.75	1058	736.25	80.7%	101.1%	106.7%	105.6%
Fulmar Ward.	12	870	348.75	1302.25	695.75	925.1	367	1106.25	678.25	106.3%	105.2%	84.9%	97.5%
Jay Ward	5	859.25	348.75	1036.75	697.5	490.5	331.25	1299.75	709.75	57.1%	95.0%	125.4%	101.8%
Kirkdale Ward	16	783.75	348.75	1296.5	697.5	643	354.75	1353.5	688.25	82.0%	101.7%	104.4%	98.7%
Linnet Ward	17	858.4	348.75	1008.73	697.5	688.7	364	1283.29	905	80.2%	104.4%	127.2%	129.7%
Mallard Ward	16	858.98	348.75	1265.75	697.5	655.41	378.25	1999.5	1505.25	76.3%	108.5%	158.0%	215.8%
Mandarin	16	867.75	348.75	1016.25	697.5	874.25	354.75	831	692.25	100.7%	101.7%	81.8%	99.2%
Merlin	10	869	697.5	1046.25	697.5	906.25	601.5	1558.25	1084	104.3%	86.2%	148.9%	155.4%
Newtondale Ward	20	860.25	697.5	1622.25	681.5	787.25	653.5	1440.29	658.75	91.5%	93.7%	88.8%	96.7%
Nightingale Ward	16	869	348.75	1012.75	697.5	740.42	413	1050.25	723	85.2%	118.4%	103.7%	103.7%
Sandpiper Ward	8	866.75	690.58	1617.5	697.5	799.25	630.75	1582	732.25	92.2%	91.3%	97.8%	105.0%
Swift Ward	10	868.75	348.75	1301.25	697.5	605.75	360	1515.7	1049.92	69.7%	103.2%	116.5%	150.5%
Clover/Ivy	12	804.8	348.75	1892.75	697.5	747.1	350.75	2095.67	956.27	92.8%	100.6%	110.7%	137.1%
Eagle/Osprey	10	792.13	348.75	1638.75	686.75	732.38	350.75	1518.08	698	92.5%	100.6%	92.6%	101.6%
Harrier/Hawk	10	829.8	347	1882.25	697.5	650.88	342.75	2187.67	777.25	78.4%	98.8%	116.2%	111.4%
Kestrel/Kite.	16	788.34	348.75	2152.5	697.5	595.75	352.75	2358.1	877.5	75.6%	101.1%	109.6%	125.8%
Kingfisher/Heron	8	396.42	213.75	641.5	348.75	256.92	166.5	555.75	360	64.8%	77.9%	86.6%	103.2%
Robin	6	742.12	483.75	753	348.75	241.25	162.5	668.8	368.75	32.5%	33.6%	88.8%	105.7%
Northdale Centre	6	791.25	348.75	2092.38	1388.75	645.04	355.5	2014.39	1327.75	81.5%	101.9%	96.3%	95.6%

Oakwood	8	865.17	348.75	630	348.75	793.92	348.75	527	348.75	91.8%	100.0%	83.7%	100.0%
Thistle	5	803.41	348.75	1231.25	693.75	542.16	339.5	1242.75	671.75	67.5%	97.3%	100.9%	96.8%
Langley Ward	10	875.24	348.75	877.5	348.75	593.74	356.25	1016.27	415.75	67.8%	102.2%	115.8%	119.2%

NORTH YORKSHIRE LOCALITY REPORT - December 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Ayckbourn Unit Danby Ward	13	824	341	737.8	682	842	357	686	621	102.2%	104.7%	93.0%	91.1%
Ayckbourn Unit Esk Ward	13	1011.33	341	747.48	677	1001.81	330	746.5	666	99.1%	96.8%	99.9%	98.4%
Ward 15 Friarage	14	893.5	348.75	697.5	697.5	763.12	349.75	799.88	688.25	85.4%	100.3%	114.7%	98.7%
Cedar Ward (NY)	18	1089.3	685.25	973	696.5	804.67	394.5	1322	1078.75	73.9%	57.6%	135.9%	154.9%
The Orchards (NY)	9	896	720	372	372	717	467.98	418	646.98	80.0%	65.0%	112.4%	173.9%
Newberry Centre	14	1125	285	1189.98	579.5	933.11	301.5	1345.32	597.25	82.9%	105.8%	113.1%	103.1%
Westwood Centre	12	1167	391	1590	690	1242.5	428.5	2002.52	1360.5	106.5%	109.6%	125.9%	197.2%
The Evergreen Centre	16	1462.58	356.5	1383.16	851.33	1324.7	364.25	1553.19	853.33	90.6%	102.2%	112.3%	100.2%
Rowan Lea	20	1065.34	372	1329.52	1107.01	1080.58	455.74	1228.56	1007.78	101.4%	122.5%	92.4%	91.0%
Rowan Ward	12	1089	372	734	744.75	1100.25	466.75	695.5	797.5	101.0%	125.5%	94.8%	107.1%
Springwood Community Unit	14	975	348.75	930	697.5	995.34	398	1118.43	960	102.1%	114.1%	120.3%	137.6%
Ward 14	9	835.58	348.75	607.5	697.5	786.08	363.25	728.76	834.25	94.1%	104.2%	120.0%	119.6%

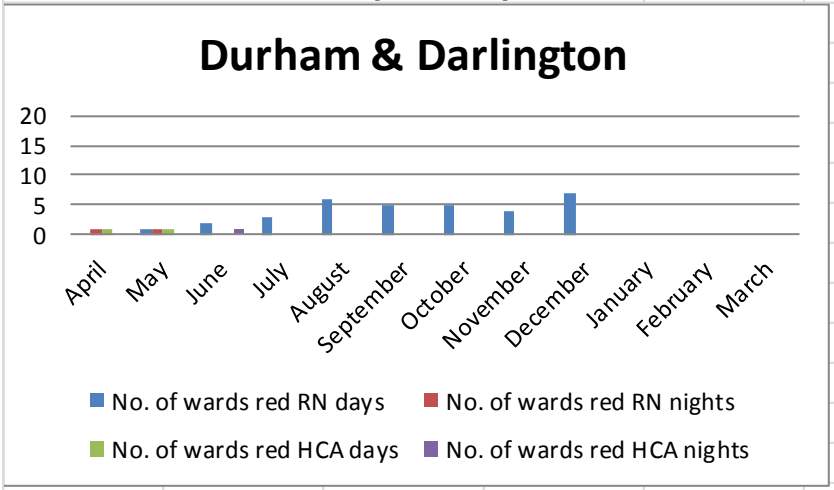
TEESSIDE LOCALITY REPORT - December 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Bedale Ward	10	870.5	356.5	713	1069.5	579.5	359.5	1320	1321	66.6%	100.8%	185.1%	123.5%
Bilsdale Ward	14	816.5	356.5	701.5	701.5	636	345	955.2	793.5	77.9%	96.8%	136.2%	113.1%
Bransdale Ward	14	840.5	356.5	713	713	657.5	356.5	893.2	701.5	78.2%	100.0%	125.3%	98.4%
Lincoln Ward	20	807.3	387.5	1205.48	713	809.08	359.5	1156.5	717	100.2%	92.8%	95.9%	100.6%
Lustrum Vale	20	1016.25	356.5	699.5	713	764.4	357.5	940.45	714	75.2%	100.3%	134.4%	100.1%
Overdale Ward	18	825.5	356.5	849.5	713	488.25	290.7	1275	830	59.1%	81.5%	150.1%	116.4%
Park House	14	713.48	356.5	712	701.5	688.73	358.5	715.5	746.5	96.5%	100.6%	100.5%	106.4%
Stockdale Ward	18	788	356.5	847.5	701.5	751.5	358.5	979	727	95.4%	100.6%	115.5%	103.6%
Baysdale	6	515.09	301.59	791.07	602.91	708.98	313.75	691.84	603.16	137.6%	104.0%	87.5%	100.0%
Westerdale North	18	849.25	356.5	707.25	713	911.75	359.5	849.25	740	107.4%	100.8%	120.1%	103.8%
Westerdale South	14	787.5	356.5	729.74	632.5	623.05	322	1884.43	1289	79.1%	90.3%	258.2%	203.8%
Wingfield Ward	9	830.5	379.5	614	713	615.25	351.75	655	745.5	74.1%	92.7%	106.7%	104.6%
Aysgarth	6	471.5	270	710.5	270	514	270.25	1092.25	270	109.0%	100.1%	153.7%	100.0%
Bankfields Court Unit 2	5	453.5	270	888.49	270	546.17	270	938.17	302.5	120.4%	100.0%	105.6%	112.0%
Bankfields Court	12	1477.17	744	3744.67	2231	1322.75	703.67	4395.16	2237.99	89.5%	94.6%	117.4%	100.3%

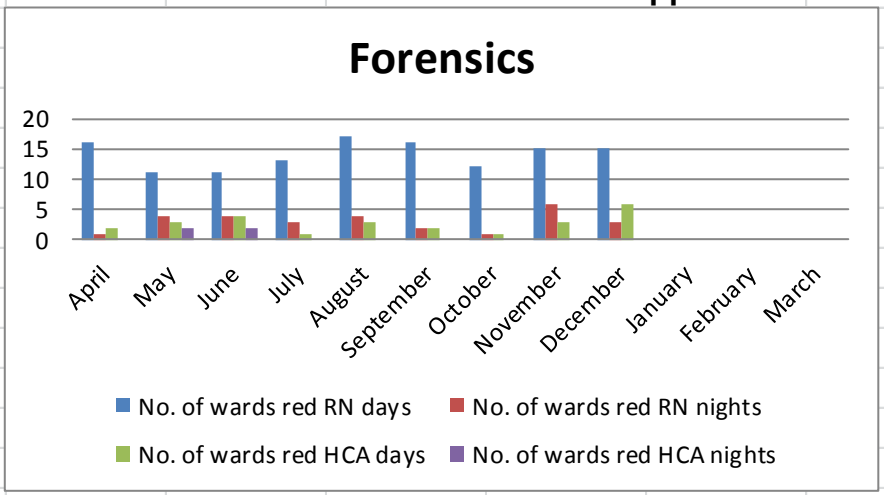
Appendix 4

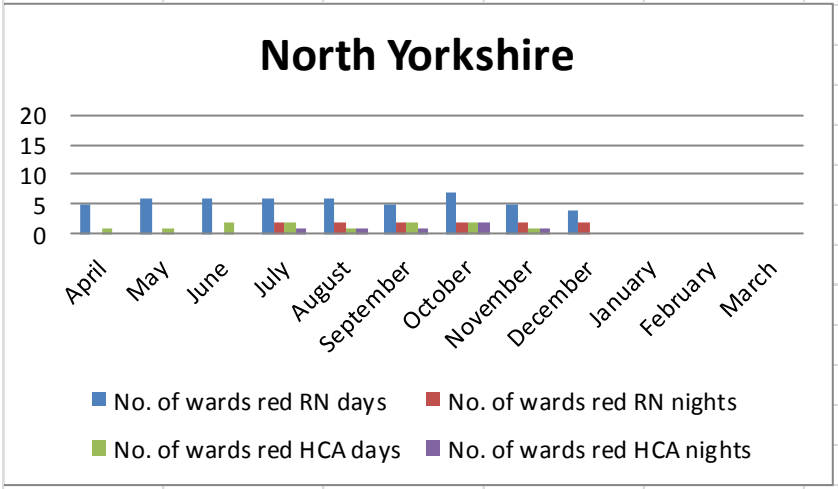
TEWV TOTAL (Excluding York and Selby) - Month on Month Trend

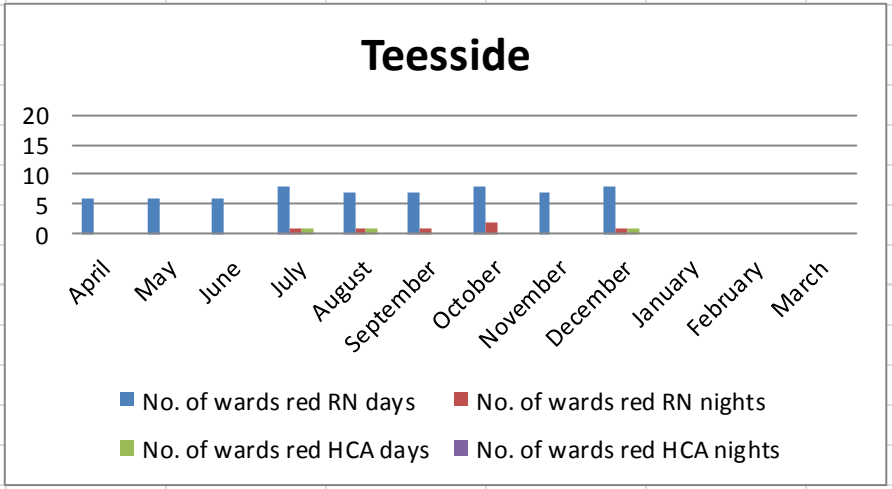
Month	Actual Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
May-14	65.90		86.20		96.30		99.90	
Jun-14	94.87	↑	109.00	↑	101.23	↑	113.00	↑
Jul-14	90.72	↓	111.00	↑	99.68	↓	111.00	↓
Aug-14	86.14	↓	107.00	↓	99.58	↓	109.00	↓
Sep-14	93.08	↑	105.27	↓	99.66	↑	109.43	↑
Oct-14	92.76	↓	108.82	↑	99.09	↓	108.67	↓
Nov-14	92.04	↓	109.45	↑	99.41	↑	108.98	↑
Dec-14	90.79	↓	102.47	↓	98.22	↓	107.13	↓
Jan-15	93.61	↑	107.32	↑	100.95	↑	110.20	↑
Feb-15	92.65	↓	107.14	↓	102.52	↑	109.17	↓
Mar-15	91.99	↓	106.64	↓	100.62	↓	110.48	↑
Apr-15	93.12	↑	111.42	↑	101.19	↑	111.20	↑
May-15	93.00	↓	110.34	↓	102.27	↑	110.09	↓
Jun-15	93.12	↑	109.50	↓	100.62	↓	112.27	↑
Jul-15	90.80	↓	114.10	↑	99.40	↓	115.30	↑
Aug-15	87.90	↓	112.60	↓	98.10	↓	110.10	↓
Sep-15	90.3	↑	113.6	↑	98.20	↑	112.6	↑
Oct-15	89.8	↓	119.0	↑	99.01	↑	113.8	↑
Nov-15	90.72	↑	118.47	↓	96.82	↓	114.52	↑
Dec-15	87.70	↓	114.20	↓	96.60	↓	113.30	↓

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









Appendix 6

Scored Fill Rate compared to Quality Indicators - DECEMBER 2015					Bank Usage Vs Actual Hours			Totals for Quality Indicators						Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total score	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Aysgarth	Teesside	LD	6	9	2146.5	451	21%									
Tunstall Ward	Durham & Darlington	AMH	20	10	2735.17	118.66	4%						1	0	1	1
Westerdale South	Teesside	MHSOP	14	12	4118.48	2812.85	68%									
Earlston House	Durham & Darlington	AMH	15	8	2742.34	332.5	12%									
Bankfields Court Unit 2	Teesside	LD	5	9	2056.84	496.2	24%									
Holly Unit	Durham & Darlington	CAMHS	4	9	1210.29	14.17	1%									
Lincoln Ward	Teesside	AMH	20	7	3042.08	156	5%									
Westerdale North	Teesside	MHSOP	18	9	2860.5	242	8%						7	0	11	11
Westwood Centre	North Yorkshire	CAMHS Tier 4	12	9	5034.02	1314.5	26%						54	5	97	102
Farnham Ward	Durham & Darlington	AMH	20	11	2729.17	72	3%	1	1				3	0	3	3
Hamsterley Ward	Durham & Darlington	MHSOP	10	13	2648.39	155.67	6%									
Mallard Ward	Forensics	FMH	16	13	4538.41	2414.75	53%				1	1	2	0	3	3
Rowan Ward	North Yorkshire	MHSOP	12	8	3060	440	14%					1	2	0	3	3
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	11	2856.41	286.83	10%						2	0	3	3
Elm Ward	Durham & Darlington	AMH	20	13	2988.17	684	23%			1		3				
Stockdale Ward	Teesside	AMH	18	11	2816	616.5	22%					1	2	0	3	3
Northdale Centre	Forensics	FMH	6	11	4342.68	724.68	17%					1	3	0	7	7
Bedale Ward	Teesside	AMH	10	13	3580	1074.5	30%	1			1		14	2	23	25
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	9	4705.17	80.17	2%						1	0	1	1

Brambling Ward	Forensics	FMH	13	13	2849.5	1161.75	41%						4	0	6	6
Bransdale Ward	Teesside	AMH	14	12	2608.7	1067.5	41%			1		1	1	0	2	2
Lustrum Vale	Teesside	AMH	20	13	2776.35	628	23%					1				
Bilsdale Ward	Teesside	AMH	14	12	2729.7	747.5	27%									
Birch Ward	Durham & Darlington	AMH	15	8	3049.97	492	16%									
Cedar Ward (NY)	North Yorkshire	AMH	18	11	3599.92	577	16%			1			5	1	8	9
Eagle/Osprey	Forensics	FLD	10	10	3299.21	320.5	10%									
Maple Ward	Durham & Darlington	AMH	17	12	2798.82	552	20%			1		1	1	0	1	1
Picktree Ward.	Durham & Darlington	MHSOP	10	13	2983.04	1531.64	51%						5	1	11	12
Primrose Lodge	Durham & Darlington	AMH	15	13	2694.67	444	16%									
Newberry Centre	North Yorkshire	CAMHS Tier 4	14	13	3177.18	406.68	13%						1	0	1	1
The Evergreen Centre	North Yorkshire	CAMHS Tier 4	16	11	4095.47	873.42	21%						12	0	18	18
Ward 14	North Yorkshire	MHSOP	9	11	2712.34	130.75	5%						11	1	26	27
Willow Ward	Durham & Darlington	AMH	15	13	2849.67	596.66	21%						1	0	2	2
Baysdale	Teesside	CAMHS	6	10	2317.73	58	3%						2	0	2	2
Langley Ward	Forensics	FLD	10	13	2382.01	456.5	19%				1	1				
Merlin	Forensics	FMH	10	10	4150	1960.25	47%						6	1	11	12
Oak Ward	Durham & Darlington	MHSOP	12	12	2565.66	173.65	7%									
Oakwood	Forensics	FLD	8	12	2018.42	154.25	8%	1	1							
Bankfields Court	Teesside	LD	12	12	8659.57	950.35	11%						19	1	27	28
Park House	Teesside	AMH	14	11	2509.23	397.5	16%									
Cedar Ward	Durham & Darlington	AMH	10	9	3910.16	1728.16	44%					2	11	1	14	15
Fulmar Ward.	Forensics	FMH	12	9	3076.6	304.75	10%			1		1	4	1	5	6
Jay Ward	Forensics	FMH	5	12	2831.25	750.25	26%						2	0	2	2
Kingfisher/Heron	Forensics	FLD	8	9	1339.17	353.5	26%									
Robin	Forensics	FLD	6	9	1441.3	371		1								
Nightingale Ward	Forensics	FMH	16	13	2926.67	510.25	17%					2				

Sandpiper Ward	Forensics	FMH	8	9	3744.25	448.75	12%	1			1		23	2	48	50
Springwood Community Unit	North Yorkshire	MHSOP	14	9	3471.77	510	15%						11	1	21	22
Thistle	Forensics	FLD	5	11	2796.16	674.75	24%	1				2	1	0	1	1
Ward 15 Friarage	North Yorkshire	AMH	14	12	2601	524.5	20%			1		1	7	0	12	12
Overdale Ward	Teesside	AMH	18	11	2883.95	385	13%						1	0	1	1
Linnet Ward	Forensics	FMH	17	13	3240.99	1351.41	42%					3				
Swift Ward	Forensics	FMH	10	13	3531.37	1115.84	32%					1	18	3	30	33
Ayckbourn Unit Esk Ward	North Yorkshire	AMH	13	7	2744.31	78	3%				2	5	6	0	11	11
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	13	7	2506	409	16%									
Clover/Ivy	Forensics	FLD	12	11	4149.79	1196.12	29%			3		4	3	0	4	4
Kirkdale Ward	Forensics	FMH	16	12	3039.5	687.25	23%									
Roseberry Wards	Durham & Darlington	MHSOP	15	10	2679.98	250.32	9%									
Lark	Forensics	FMH	15	13	2879.43	705.5	25%					3				
Wingfield Ward	Teesside	MHSOP	9	12	2367.5	90.5	4%									
Kestrel/Kite.	Forensics	FLD	16	13	4184.1	1665.34	40%					2				
The Orchards (NY)	North Yorkshire	AMH	9	8	2249.96	192	9%									
Mandarin	Forensics	FMH	16	10	2752.25	516.5	19%					2				
Rowan Lea	North Yorkshire	MHSOP	20	7	3772.66	458.44	12%						8	0	16	16
Newtondale Ward	Forensics	FMH	20	10	3539.79	516.58	15%				1					
Harrier/Hawk	Forensics	FLD	10	12	3958.55	679.25	17%	1					4	0	5	5

JANUARY 2016 DATA

Appendix 7

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN January							
				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
The Orchards (NY)	North Yorkshire	Adults	10	82.4%	100.1%	59.7%	180.4%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	13	96.5%	104.5%	99.7%	98.8%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	13	96.8%	98.2%	103.2%	98.4%
Bedale Ward	Teesside	Adults	10	61.1%	166.7%	100.0%	106.5%
Bilsdale Ward	Teesside	Adults	14	63.2%	150.8%	80.6%	100.1%
Birch Ward	Durham & Darlington	Adults	15	88.9%	104.5%	100.0%	100.0%
Bransdale Ward	Teesside	Adults	14	71.7%	138.4%	106.5%	96.9%
Cedar Ward	Durham & Darlington	Adults	10	100.4%	121.0%	103.6%	102.2%
Cedar Ward (NY)	North Yorkshire	Adults	18	77.7%	124.7%	88.0%	113.9%
Earlston House	Durham & Darlington	Adults	15	99.4%	101.5%	100.0%	100.8%
Elm Ward	Durham & Darlington	Adults	20	85.5%	123.9%	100.0%	114.5%
Farnham Ward	Durham & Darlington	Adults	20	100.6%	106.6%	96.8%	106.8%
Lincoln Ward	Teesside	Adults	20	109.9%	95.8%	96.4%	110.0%
Lustrum Vale	Teesside	Adults	20	73.8%	133.9%	100.0%	101.6%
Maple Ward	Durham & Darlington	Adults	17	89.2%	101.9%	93.5%	106.5%
Overdale Ward	Teesside	Adults	18	71.9%	153.9%	97.1%	109.7%
Park House	Teesside	Adults	14	94.9%	104.1%	100.0%	101.3%
Primrose Lodge	Durham & Darlington	Adults	15	73.8%	108.1%	100.0%	100.0%
Stockdale Ward	Teesside	Adults	18	84.9%	125.1%	100.0%	103.4%
Tunstall Ward	Durham & Darlington	Adults	20	96.3%	108.2%	100.0%	98.4%

Ward 15 Friarage	North Yorkshire	Adults	14	82.9%	108.1%	97.5%	100.0%
Willow Ward	Durham & Darlington	Adults	15	85.6%	130.6%	100.0%	100.0%
Baysdale	Teesside	CYPS	6	122.1%	98.3%	103.4%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	126.2%	102.7%	100.1%	100.6%
Newberry Centre	North Yorkshire	CYPS	14	77.1%	124.0%	102.0%	100.7%
The Evergreen Centre	North Yorkshire	CYPS	16	90.6%	117.3%	102.2%	101.3%
Westwood Centre	North Yorkshire	CYPS	12	104.6%	122.5%	108.5%	158.4%
Clover/Ivy	Forensics	Forensics LD	12	104.5%	100.4%	106.7%	142.7%
Eagle/Osprey	Forensics	Forensics LD	10	90.5%	90.9%	100.0%	100.0%
Harrier/Hawk	Forensics	Forensics LD	10	76.6%	117.9%	100.9%	105.1%
Kestrel/Kite.	Forensics	Forensics LD	16	84.4%	114.7%	97.3%	151.6%
Kingfisher/Heron	Forensics	Forensics LD	4	41.8%	83.0%	30.9%	106.4%
Robin	Forensics	Forensics LD	6	37.4%	85.1%	34.4%	129.0%
Langley Ward	Forensics	Forensics LD	10	70.3%	131.7%	101.9%	203.7%
Northdale Centre	Forensics	Forensics LD	12	94.8%	89.3%	100.4%	99.0%
Oakwood	Forensics	Forensics LD	8	83.5%	148.8%	100.1%	100.5%
Thistle	Forensics	Forensics LD	5	73.6%	115.6%	101.1%	95.2%
Brambling Ward	Forensics	Forensics MH	13	86.2%	109.4%	103.8%	112.5%
Fulmar Ward.	Forensics	Forensics MH	12	105.9%	81.0%	107.0%	98.0%
Jay Ward	Forensics	Forensics MH	5	58.7%	134.2%	101.3%	122.2%
Kirkdale Ward	Forensics	Forensics MH	16	91.2%	100.9%	78.0%	90.9%
Lark	Forensics	Forensics MH	15	90.8%	102.9%	93.5%	101.6%
Linnet Ward	Forensics	Forensics MH	17	102.6%	144.3%	107.6%	144.3%
Mallard Ward	Forensics	Forensics MH	16	83.3%	146.5%	105.2%	238.1%
Mandarin	Forensics	Forensics MH	16	109.9%	87.7%	100.6%	100.0%
Merlin	Forensics	Forensics MH	10	114.1%	150.6%	99.3%	227.4%
Newtondale Ward	Forensics	Forensics MH	20	93.9%	97.0%	89.0%	93.5%
Nightingale Ward	Forensics	Forensics MH	16	92.8%	108.1%	101.1%	100.1%

Sandpiper Ward	Forensics	Forensics MH	8	102.3%	112.5%	85.3%	143.2%
Swift Ward	Forensics	Forensics MH	10	90.2%	99.5%	94.1%	98.4%
Aysgarth	Teesside	LD	6	107.3%	146.3%	100.0%	104.3%
Bankfields Court Unit 2	Teesside	LD	5	132.7%	96.0%	100.6%	109.7%
Bankfields Court	Teesside	LD	19	84.2%	118.5%	99.8%	100.0%
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	107.0%	80.2%	106.5%	73.9%
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	98.8%	131.4%	100.0%	100.0%
Hamsterley Ward	Durham & Darlington	MHSOP	10	92.7%	127.3%	100.0%	100.0%
Oak Ward	Durham & Darlington	MHSOP	12	88.6%	92.6%	100.4%	100.0%
Picktree Ward.	Durham & Darlington	MHSOP	10	82.1%	136.5%	100.4%	100.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	98.3%	101.2%	100.0%	100.2%
Rowan Lea	North Yorkshire	MHSOP	20	93.7%	109.6%	108.5%	112.5%
Rowan Ward	North Yorkshire	MHSOP	12	100.9%	102.6%	115.7%	103.0%
Springwood Community Unit	North Yorkshire	MHSOP	14	89.0%	92.0%	106.5%	116.2%
Ward 14	North Yorkshire	MHSOP	9	84.5%	119.2%	113.8%	105.6%
Westerdale North	Teesside	MHSOP	18	99.9%	131.8%	100.6%	112.1%
Westerdale South	Teesside	MHSOP	14	89.1%	293.2%	100.3%	208.3%
Wingfield Ward	Teesside	MHSOP	12	66.2%	113.6%	98.9%	106.7%

Appendix 8

January	TRUSTWIDE DAILY POSITION –all wards	
	Difference between what was planned on roster and actually worked – RNs	Difference between what was planned on roster and actually worked – HCAs
1	-22%	9%
2	-12%	10%
3	-11%	12%
4	-12%	9%
5	-11%	9%
6	-11%	13%
7	-11%	11%
8	-10%	12%
9	-12%	12%
10	-15%	16%
11	-12%	10%
12	-8%	13%
13	-9%	13%
14	-7%	10%
15	-12%	15%
16	-11%	14%
17	-12%	16%
18	-10%	11%
19	-8%	12%
20	-7%	11%
21	-9%	11%
22	-8%	10%
23	-8%	13%

24	-9%	16%
25	-8%	12%
26	-9%	13%
27	-11%	13%
28	-9%	11%
29	-9%	10%
30	-10%	10%
31	6%	19%

Appendix 9

DURHAM & DARLINGTON LOCALITY REPORT - January 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Birch Ward	15	798	372	1062	744	709.7	372	1110	744	88.9%	100.0%	104.5%	100.0%
Elm Ward	20	886.5	372	732	744	758	372	907.16	852	85.5%	100.0%	123.9%	114.5%
Maple Ward	17	883.83	372	731	744	788.5	348	744.99	792	89.2%	93.5%	101.9%	106.5%
Farnham Ward	20	813	372	732	708	817.67	360	780	756	100.6%	96.8%	106.6%	106.8%
Tunstall Ward	20	887.16	370.33	744.5	740.67	854.25	370.33	805.58	728.67	96.3%	100.0%	108.2%	98.4%
Willow Ward	15	748.5	372	744	744	640.5	372	972	744	85.6%	100.0%	130.6%	100.0%
Earlston House	15	865.5	372	735.33	744	860.67	372	746	749.67	99.4%	100.0%	101.5%	100.8%
Primrose Lodge	15	894	372	744	744	660	372	804	744	73.8%	100.0%	108.1%	100.0%
Holly Unit	4	240.57	199.5	452.28	199.5	303.62	199.75	464.5	200.75	126.2%	100.1%	102.7%	100.6%
Cedar Ward PICU	10	847	336	720	1116	850.5	348	870.99	1140	100.4%	103.6%	121.0%	102.2%
Ceddesfeld Ward	10	901.5	372	658.5	744	890.5	372	865.5	744	98.8%	100.0%	131.4%	100.0%
Roseberry Wards	15	891.68	372	737.33	744	876.92	372	746.33	745.33	98.3%	100.0%	101.2%	100.2%
Oak Ward	12	868.17	372	744	744	769.34	373.33	689	744	88.6%	100.4%	92.6%	100.0%
Picktree Ward.	10	894.17	372	585.67	744	734.17	373.34	799.68	744	82.1%	100.4%	136.5%	100.0%
Hamsterley Ward	10	901.5	372	543.17	744	836	372	691.41	744	92.7%	100.0%	127.3%	100.0%
Bek, Ramsey, Talbot Wards	16	595.5	372	2412	1562.5	637.34	396	1934.67	1154.5	107.0%	106.5%	80.2%	73.9%

FORENSICS LOCALITY REPORT - January 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Lark	15	841	348.75	958.5	697.5	763.75	326.25	986.5	708.75	90.8%	93.5%	102.9%	101.6%
Brambling Ward	13	855	348.75	1001.75	697.5	737.25	362	1096	784.75	86.2%	103.8%	109.4%	112.5%
Fulmar Ward.	12	854.5	348.75	1282.5	688.93	905.33	373.25	1039	675	105.9%	107.0%	81.0%	98.0%
Jay Ward	5	834.73	345.25	998.7	697.5	489.62	349.75	1340.55	852	58.7%	101.3%	134.2%	122.2%
Kirkdale Ward	16	815.25	348.75	1251.5	697.5	743.5	272	1262.25	634.08	91.2%	78.0%	100.9%	90.9%
Linnet Ward	17	857.5	348.75	999.98	697.5	879.38	375.25	1442.87	1006.25	102.6%	107.6%	144.3%	144.3%
Mallard Ward	16	849.75	348.75	1265.75	690.5	707.5	366.75	1854.25	1643.98	83.3%	105.2%	146.5%	238.1%
Mandarin	16	844.25	348.75	997.75	697.5	927.5	350.75	875	697.5	109.9%	100.6%	87.7%	100.0%
Merlin	10	848	697.5	1215	697.5	967.83	692.48	1830	1586.25	114.1%	99.3%	150.6%	227.4%
Newtondale Ward	20	852	697.5	1614.93	697.5	799.75	620.75	1566.47	652.5	93.9%	89.0%	97.0%	93.5%
Nightingale Ward	16	852.5	348.75	990.5	697.5	791	352.75	1070.75	698.5	92.8%	101.1%	108.1%	100.1%
Sandpiper Ward	8	851.25	690.5	1606.63	697.5	870.75	589	1807.38	998.48	102.3%	85.3%	112.5%	143.2%
Swift Ward	10	855	348.75	1282.5	697.5	770.88	328.25	1276.25	686.25	90.2%	94.1%	99.5%	98.4%
Clover/Ivy	12	768	348.75	1915.32	697.5	802.85	372.13	1922.75	995.5	104.5%	106.7%	100.4%	142.7%
Eagle/Osprey	10	783	348.75	1609.31	697.5	709	348.75	1462.72	697.25	90.5%	100.0%	90.9%	100.0%
Harrier/Hawk	10	770.25	348.75	1928.75	697.5	590.25	351.75	2274	732.75	76.6%	100.9%	117.9%	105.1%
Kestrel/Kite.	16	806.75	348.75	2173.75	697.5	680.55	339.5	2494.29	1057.5	84.4%	97.3%	114.7%	151.6%
Kingfisher/Heron	4	499.88	112.5	717.83	348.75	208.75	34.75	595.5	371	41.8%	30.9%	83.0%	106.4%
Robin	6	832.75	697.5	826.75	348.75	311.75	240.25	703.5	450	37.4%	34.4%	85.1%	129.0%
Northdale Centre	12	820.8	348.75	2091.25	1395	778.42	350	1866.87	1380.5	94.8%	100.4%	89.3%	99.0%
Oakwood	8	859.5	348.75	348.75	348.75	717.5	349.25	519	350.5	83.5%	100.1%	148.8%	100.5%
Thistle	5	785.73	348.75	1220.5	697.5	578.23	352.75	1411.05	663.75	73.6%	101.1%	115.6%	95.2%

Langley Ward	10	851.83	348.75	853	348.75	598.5	355.25	1123.25	710.5	70.3%	101.9%	131.7%	203.7%

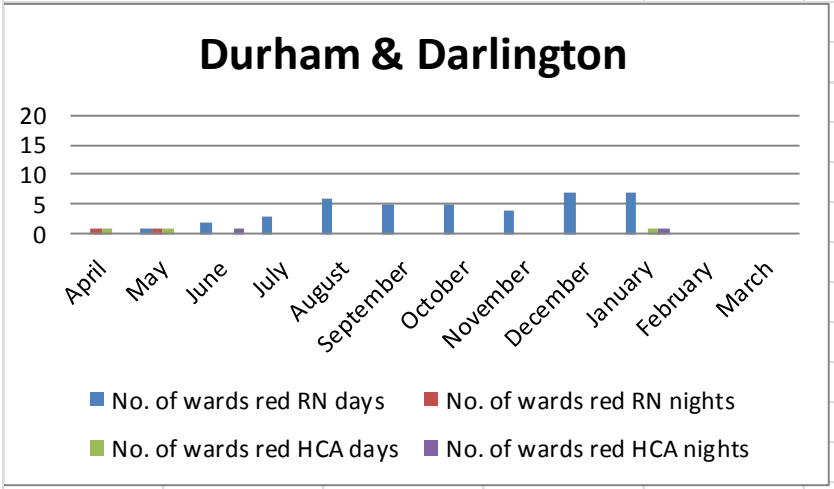
NORTH YORKSHIRE LOCALITY REPORT - January 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Ayckbourn Unit Danby Ward	13	810	341	747.33	682	782	340	781.33	674	96.5%	99.7%	104.5%	98.8%
Ayckbourn Unit Esk Ward	13	1041.83	341	745.5	682	1009	352	732	671	96.8%	103.2%	98.2%	98.4%
Ward 15 Friarage	14	832.5	348.75	697.5	697.5	690.18	340.17	753.68	697.5	82.9%	97.5%	108.1%	100.0%
Cedar Ward (NY)	18	1065.33	440.75	987.8	900	827.42	387.83	1231.5	1025.25	77.7%	88.0%	124.7%	113.9%
The Orchards (NY)	10	901.5	744	372	372	742.5	444.5	372.25	670.98	82.4%	59.7%	100.1%	180.4%
Newberry Centre	14	1313.67	294.5	1284.96	589	1012.78	300.5	1593.87	593.25	77.1%	102.0%	124.0%	100.7%
Westwood Centre	12	1110.5	379.5	1572.5	690	1161.5	411.75	1926.5	1092.75	104.6%	108.5%	122.5%	158.4%
The Evergreen Centre	16	1727.75	356.5	1403.25	1046.5	1566	364.5	1646	1060	90.6%	102.2%	117.3%	101.3%
Rowan Lea	20	1006.12	365.07	1330.98	1092.84	942.96	396.25	1458.34	1228.96	93.7%	108.5%	109.6%	112.5%
Rowan Ward	12	1055	372	744	744	1064.93	430.5	763.5	766	100.9%	115.7%	102.6%	103.0%
Springwood Community Unit	14	990	348.75	930	697.5	881.42	371.25	855.59	810.5	89.0%	106.5%	92.0%	116.2%
Ward 14	9	938	348.75	562.5	697.5	792.5	396.75	670.5	736.75	84.5%	113.8%	119.2%	105.6%

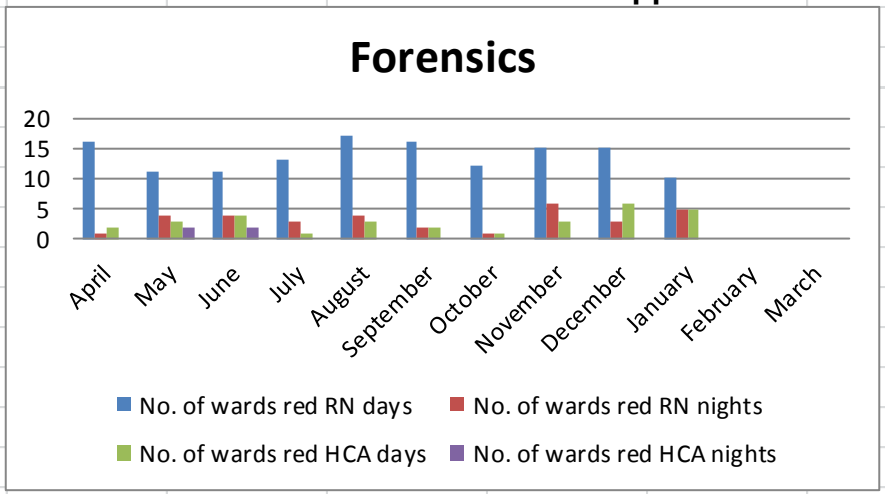
TEESSIDE LOCALITY REPORT - January 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Bedale Ward	10	859	356.5	711	1069.5	525	356.5	1185	1139.5	61.1%	100.0%	166.7%	106.5%
Bilsdale Ward	14	822.96	356.5	701.5	690	520.41	287.5	1058	691	63.2%	80.6%	150.8%	100.1%
Bransdale Ward	14	845	356.5	713	713	605.5	379.5	986.45	691	71.7%	106.5%	138.4%	96.9%
Lincoln Ward	20	840.6	387.5	1198.8	713	923.6	373.5	1148.5	784	109.9%	96.4%	95.8%	110.0%
Lustrum Vale	20	1065	356.5	713	713	785.5	356.5	954.5	724.5	73.8%	100.0%	133.9%	101.6%
Overdale Ward	18	818	356.5	840	713	588	346	1292.5	782	71.9%	97.1%	153.9%	109.7%
Park House	14	737.5	356.5	701.5	701.5	700	356.5	730	710.88	94.9%	100.0%	104.1%	101.3%
Stockdale Ward	18	830.5	356.5	750.5	713	704.75	356.5	939.1	737	84.9%	100.0%	125.1%	103.4%
Baysdale	6	533.85	346.27	918.25	692.23	652.09	358.18	902.76	692.23	122.1%	103.4%	98.3%	100.0%
Westerdale North	18	849.25	356.5	713	713	848	358.5	939.75	799.5	99.9%	100.6%	131.8%	112.1%
Westerdale South	14	870.75	356.5	711.58	701.5	776	357.5	2086.56	1461.5	89.1%	100.3%	293.2%	208.3%
Wingfield Ward	12	836.5	366.5	633.5	713	554	362.5	719.5	760.5	66.2%	98.9%	113.6%	106.7%
Aysgarth	6	511.5	310	834.5	300	549	310	1220.59	313	107.3%	100.0%	146.3%	104.3%
Bankfields Court Unit 2	5	502.5	310	1031.3	310	666.94	312	990.51	340	132.7%	100.6%	96.0%	109.7%
Bankfields Court	19	1483.67	744	3713.49	2232	1249.92	742.16	4399.72	2232	84.2%	99.8%	118.5%	100.0%

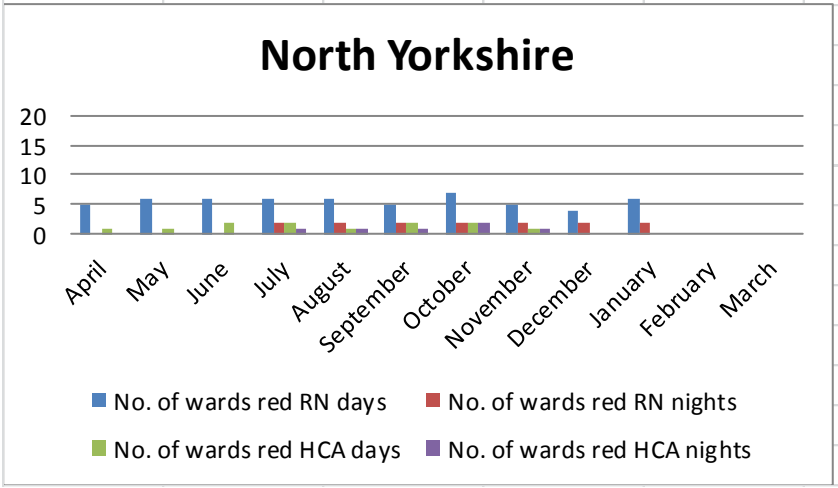
TEWV TOTAL (Excluding York and Selby) - Month on Month Trend **Appendix 10**

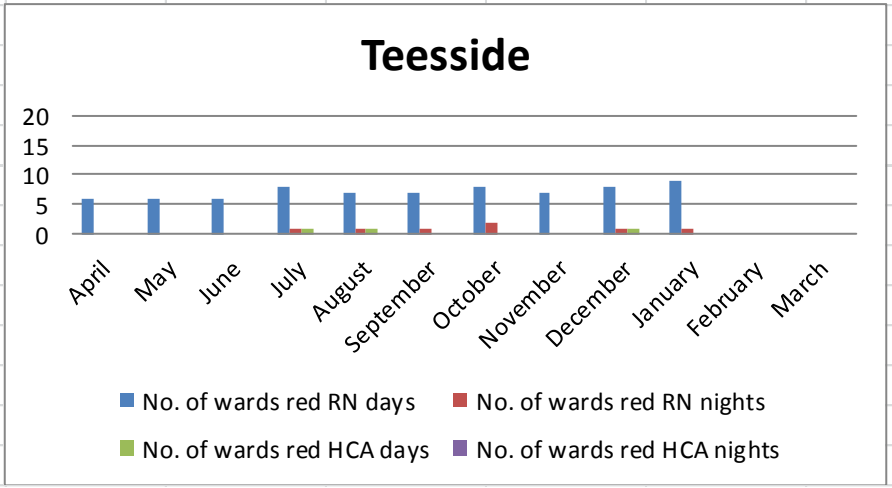
Month	Actual Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
May-14	65.90		86.20		96.30		99.90	
Jun-14	94.87	↑	109.00	↑	101.23	↑	113.00	↑
Jul-14	90.72	↓	111.00	↑	99.68	↓	111.00	↓
Aug-14	86.14	↓	107.00	↓	99.58	↓	109.00	↓
Sep-14	93.08	↑	105.27	↓	99.66	↑	109.43	↑
Oct-14	92.76	↓	108.82	↑	99.09	↓	108.67	↓
Nov-14	92.04	↓	109.45	↑	99.41	↑	108.98	↑
Dec-14	90.79	↓	102.47	↓	98.22	↓	107.13	↓
Jan-15	93.61	↑	107.32	↑	100.95	↑	110.20	↑
Feb-15	92.65	↓	107.14	↓	102.52	↑	109.17	↓
Mar-15	91.99	↓	106.64	↓	100.62	↓	110.48	↑
Apr-15	93.12	↑	111.42	↑	101.19	↑	111.20	↑
May-15	93.00	↓	110.34	↓	102.27	↑	110.09	↓
Jun-15	93.12	↑	109.50	↓	100.62	↓	112.27	↑
Jul-15	90.80	↓	114.10	↑	99.40	↓	115.30	↑
Aug-15	87.90	↓	112.60	↓	98.10	↓	110.10	↓
Sep-15	90.3	↑	113.6	↑	98.20	↑	112.6	↑
Oct-15	89.8	↓	119.0	↑	99.01	↑	113.8	↑
Nov-15	90.72	↑	118.47	↓	96.82	↓	114.52	↑
Dec-15	87.70	↓	114.20	↓	96.60	↓	113.30	↓
Jan-16	88.60	↑	114.00	↓	96.40	↓	112.00	↓

Number of Red Wards by Locality **Appendix 11**









Appendix 12

Scored Fill Rate compared to Quality Indicators - JANUARY 2016					Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total score	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Aysgarth	Teesside	LD	6	9	2392.59	401.5	17%						1	0	3	3
Tunstall Ward	Durham & Darlington	AMH	20	8	2758.83	24	1%					1				
Westerdale South	Teesside	MHSOP	14	9	4681.56	3130.08	67%						1	0	2	2
Earlston House	Durham & Darlington	AMH	15	8	2728.34	262.5	10%									
Bankfields Court Unit 2	Teesside	LD	5	9	2309.45	500.2	22%									
Holly Unit	Durham & Darlington	CAMHS	4	9	1168.62	0	0%					1				
Lincoln Ward	Teesside	AMH	20	8	3229.6	332.5	10%									
Westerdale North	Teesside	MHSOP	18	9	2945.75	262	9%	1	1			1	4	0	8	8
Westwood Centre	North Yorkshire	CAMHS Tier 4	12	10	4592.5	1663	36%			2			90	6	145	151
Farnham Ward	Durham & Darlington	AMH	20	8	2713.67	264	10%						4	0	7	7
Hamsterley Ward	Durham & Darlington	MHSOP	10	9	2643.41	344.84	13%					1				
Mallard Ward	Forensics	FMH	16	9	4572.48	3171.25	69%									
Rowan Ward	North Yorkshire	MHSOP	12	8	3024.93	621	21%						1	0	1	1
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	9	2872	290.66	10%						3	0	3	3
Elm Ward	Durham & Darlington	AMH	20	8	2889.16	488.84	17%			1		1	1	0	1	1
Stockdale Ward	Teesside	AMH	18	8	2737.35	680.5	25%					1	2	0	6	6
Northdale Centre	Forensics	FMH	12	7	4375.79	937	21%									
Bedale Ward	Teesside	AMH	10	8	3206	989	31%						2	0	3	3
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	6	4122.51	180.51	4%						4	1	5	6

Brambling Ward	Forensics	FMH	13	7	2980	1361.25	46%						14	0	25	25
Bransdale Ward	Teesside	AMH	14	8	2662.45	1270.75	48%				1		3	0	7	7
Lustrum Vale	Teesside	AMH	20	8	2821	715	25%					1	1	0	1	1
Bilsdale Ward	Teesside	AMH	14	7	2556.91	1000.5	39%					2				
Birch Ward	Durham & Darlington	AMH	15	7	2935.7	288	10%									
Cedar Ward (NY)	North Yorkshire	AMH	18	7	3472	911.5	26%					2				
Eagle/Osprey	Forensics	FLD	10	8	3217.72	419.59	13%									
Maple Ward	Durham & Darlington	AMH	17	7	2673.49	666.99	25%				1		4	0	5	5
Picktree Ward.	Durham & Darlington	MHSOP	10	8	2651.19	723.14	27%						9	1	13	14
Primrose Lodge	Durham & Darlington	AMH	15	7	2580	336	13%									
Newberry Centre	North Yorkshire	CAMHS Tier 4	14	8	3500.4	184.87	5%			2			10	1	18	19
The Evergreen Centre	North Yorkshire	CAMHS Tier 4	16	8	4636.5	667	14%			1			26	5	52	57
Ward 14	North Yorkshire	MHSOP	9	5	2596.5	26	1%					1	4	0	7	7
Willow Ward	Durham & Darlington	AMH	15	8	2728.5	246	9%					1	1	0	4	4
Baysdale	Teesside	CAMHS	6	9	2605.26	111.95	4%					1				
Langley Ward	Forensics	FLD	10	9	2787.5	1162	42%					1				
Merlin	Forensics	FMH	10	10	5076.56	3054.25	60%						4	0	9	9
Oak Ward	Durham & Darlington	MHSOP	12	7	2575.67	268	10%									
Oakwood	Forensics	FLD	8	8	1936.25	245.5	13%									
Bankfields Court	Teesside	LD	19	7	8623.8	724.85	8%						20	0	27	27
Park House	Teesside	AMH	14	8	2497.38	448.26	18%						1	0	1	1
Cedar Ward	Durham & Darlington	AMH	10	9	3209.49	580.99	18%					2	7	0	10	10
Fulmar Ward.	Forensics	FMH	12	7	2992.58	337.5	11%	1	1							
Jay Ward	Forensics	FMH	5	9	3031.92	1397.25	46%						2	1	5	6
Kingfisher/Heron	Forensics	FLD	4	5	1210	400.75	33%						1	0	2	2
Robin	Forensics	FLD	6	6	1705.5	525.5	31%									
Nightingale Ward	Forensics	FMH	16	8	2913	284.25	10%									

Sandpiper Ward	Forensics	FMH	8	8	4265.61	1787.25	42%			1		1	43	5	71	76
Springwood Community Unit	North Yorkshire	MHSOP	14	7	2918.76	441.58	15%						14	1	27	28
Thistle	Forensics	FLD	5	7	3005.78	939.22	31%						11	0	18	18
Ward 15 Friarage	North Yorkshire	AMH	14	7	2481.53	262.25	11%						1	0	1	1
Overdale Ward	Teesside	AMH	18	8	3008.5	904	30%						1	0	1	1
Linnet Ward	Forensics	FMH	17	10	3703.75	1679.25	45%					2	5	1	10	11
Swift Ward	Forensics	FMH	10	8	3061.63	448.5	15%						1	0	1	1
Ayckbourn Unit Esk Ward	North Yorkshire	AMH	13	8	2764	168	6%				2		8	2	11	13
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	13	8	2577.33	542.83	21%									
Clover/Ivy	Forensics	FLD	12	9	4093.23	773	19%			3		2	1	0	3	3
Kirkdale Ward	Forensics	FMH	16	7	2911.83	607.5	21%					1	1	0	1	1
Roseberry Wards	Durham & Darlington	MHSOP	15	8	2740.58	492.5	18%									
Lark	Forensics	FMH	15	8	2785.25	537.5	19%									
Wingfield Ward	Teesside	MHSOP	12	7	2396.5	385	16%	1	1				1	0	1	1
Kestrel/Kite.	Forensics	FLD	16	8	4571.84	2306	50%					3				
The Orchards (NY)	North Yorkshire	AMH	10	7	2230.23	71	3%									
Mandarin	Forensics	FMH	16	7	2850.75	257.25	9%					2				
Rowan Lea	North Yorkshire	MHSOP	20	8	4026.51	654.97	16%						4	0	8	8
Newtondale Ward	Forensics	FMH	20	7	3639.47	589.75	16%				1		1	0	2	2
Harrier/Hawk	Forensics	FLD	10	7	3948.75	527.25	13%					1				

YORK AND SELBY DATA DECEMBER 2015 AND JANARY 2016

Appendix 13

YORK AND SELBY SAFE STAFFING REPORT

Introduction:

The total number of rosters during the period of December 2015 and January 2016 for York and Selby equates to 7.

Month on Month Trend:

The month on month trend report shows an improving picture with all 4 of the metrics showing as 'green' in December and only 1 'red' indicator in January, as shown below:

Month	Actual Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Oct-15	89.29	-	101.00	-	112.99	-	104.68	-
Nov-15	83.55	↓	91.27	↓	85.65	↓	101.89	↓
Dec-15	84.50	↑	91.40	↑	91.60	↑	107.40	↑
Jan-16	78.60	↓	96.40	↑	91.80	↑	112.70	↑

Red Fill Rate Indicators:

The position in December and January was that there were 11 of the metrics that had fill rates of less than 89.9% (shown as red) across both staff groups for all shifts. This is an increase when compared to October as illustrated below:

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

The majority of the red indicators fall into the Registered Nurse on Day shifts category where there were 5 wards shown as red in January 2016 and December 2015. The split is as follows:

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

January 2016 Staffing Fill Rates:

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

	Jan-16	Dec-15	Nov-15	Oct-15
Meadowfields	48.9%	68.9%	63.5%	71.3%

The ward has articulated that the low fill rate is in relation to:

- Maternity leave
- Short term sickness
- Vacancies (funded for 8.0WTE but actually have 5.4WTE)
- Some RN shifts were covered by adjusting the skill mix

The second lowest fill rate was observed by Recovery Unit Acomb who had a Registered Nurse on nights fill rate of 50%. The breakdown over the last 4 months is as follows:

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

The ward has articulated that the low fill rate is in relation to:

- Sickness and maternity
- Not enough RN's on the establishment to cover the requirement of 2 trained nurses on each night shift.
- 2 RN's on secondment
- Vacancies
- 14 HCA shifts lost due to study leave.

The third lowest fill rate was observed by Peppermill and Worsley Court with a fill rate of 77.1% on unregistered nurse days (Peppermill) and registered nurse on nights (Worsley Court):

	Jan-16	Dec-15	Nov-15	Oct-15
Peppermill	77.1%	79.7%	101.8%	102.5%
Worsley Court	77.1%	91.5%	0%	145.8%

Peppermill have articulated that the low fill rate is in relation to:

- Ward occupancy was gradually reduced for patients which meant a reduction in the requirement of staff as part of the closure plans.
- A minimum of 3 staff per shift was maintained until the ward closed on 11th January 2016 with any extra staff being sent to cover other wards in York and Selby.

Worsley Court have articulated that the low fill rate was in relation to:

- Vacancies, maternity leave and sickness were the main reasons
- Increase in the number of patients requiring enhanced observations.

There were 4 wards that had staffing in excess of their budgeted establishments (shown as 'blue') as articulated below:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Meadowfields	**48.9%**	**85.1%**	**220.0%**	**98.4%**
Peppermill	**100.5%**	**77.1%**	**103.9%**	**131.8%**
Worsley Court	**79.0%**	**110.9%**	**77.1%**	**149.0%**
Cherry Tree	**87.0%**	**135.0%**	**112.2%**	**118.3%**

The following have been provided as an explanation for the additional staffing:

- Peppermill – covering of shifts on other wards
- Worsley Court – enhanced observations
- Cherry Tree – enhanced observations and honouring of shift patterns for some staff who came from Peppermill

December 2015 Staffing Fill Rates:

The lowest fill rate was observed by Whitehorse View who had a Registered Nurse days fill rate of 58.2%. The breakdown over the last 3 months is as follows:

	Dec-15	Nov-15	Oct-15
Whitehorse View	58.2%	83%	90.5%

The ward has articulated that the low fill rate is in relation to:

- The rates reflect low occupancy on the ward resulting in less staff being required

The second lowest fill rate was observed by Meadowfields who had a Registered Nurse day fill rate of 68.9%. The breakdown over the last 3 months is as follows:

	Dec-15	Nov-15	Oct-15
Meadowfields	68.9%	63.5%	71.3%

The ward has articulated that the low fill rate is in relation to:

- Reduced occupancy therefore less staff were required
- Highlighted that RN on day shifts are particularly difficult to fill and a limited bank

The third lowest fill rate was observed by Recovery Unit Acomb who had a Registered Nurse day fill rate of 70%. The breakdown over the last 3 months is as follows:

	Dec-15	Nov-15	Oct-15
Recovery Unit Acomb	70%	88.7%	98.2%

The ward has articulated that the low fill rate is in relation to:

- A number of RN shifts were vacant due to sickness over December
- Maternity leave and secondment were also sighted

There were 2 wards who had staffing in excess of their budgeted establishment as shown below:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Oak Rise	**124.2%**	**83.4%**	**106.4%**	**96.6%**
Worsley Court	**109.5%**	**101.4%**	**91.5%**	**146.0%**

The wards have offered the following explanations:

- Oak Rise have advised that the additional staffing was used to cover vacancies ensuring that the numbers did not fall below the minimum requirements for each shift.
- Worsley court has experienced high activity over December with an increase in patient need and high levels of observations / enhanced engagement with two service users on within eye sight levels of observations. The additional staff was to ensure the safety of the patients and staff on the ward.

Bank Usage:

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

	January 2016			December 2015		
	Total Hours Worked	**Bank Usage (Hours)**	**Bank %**	**Total Hours Worked**	**Bank Usage (Hours)**	**Bank %**
Meadowfields	3065.5	859	28%	2932.02	679.5	23%
Oak Rise	2897.8	629.75	22%	2917.82	333.5	11%
Peppermill Court	1317.5	46	3%	3362	122	4%
Recovery Unit Acomb	2848.34	335.5	12%	2832.08	125.5	4%
White Horse View	2965	128.5	4%	2897.25	10.5	0%
Worsley Court	3521.5	119	3%	3410	198.5	6%
Cherry Tree House	4416.5	706	16%	4169.5	498	12%

The highest user of bank is Meadowfields in both January and December.

Agency Usage:

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

	Dec-15			Jan-16		
	Agency Usage (Hours)	Total Hours Worked	Agency %	Agency Usage (Hours)	Total Hours Worked	Agency %
Meadowfields	83.00	3065.50	2.71	166.00	2932.02	5.66
Oak Rise	10.45	2897.80	0.36	0.00	2917.82	0.00
Peppermill Court	418.00	1317.50	31.73	44.00	3362.00	1.31
Recovery Unit Acomb	99.00	2848.34	3.48	0.00	2832.08	0.00
White Horse View	0.00	2965.00	0.00	0.00	2897.25	0.00
Worsley Court	648.00	3521.50	18.40	415.50	3410.00	12.18
Cherry Tree House	814.00	4416.50	18.43	621.50	4169.50	14.91

The highest user of agency was Peppermill Court in December and Cherry Tree House in January.

Quality Data Triangulation:

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

- During December there were no quality metrics flagged for all wards or teams within York and Selby
- In January 2016 Recovery Unit Acomb had a PALS related issue in addition to a low fill rate and an 'amber' rating for bank.

In Conclusion

The following is of relevance:

- The month on month trend showed an improving picture in December with all indicators showing 'green'. A slight deterioration in January can be observed with 1 of the 4 indicators turning 'red'.
- The number of red wards has increased from 10 in November to 11 in December and January
- In January Meadowfields had the lowest fill rate whilst Whitehorse had the lowest in December.
- In January 4 wards had staffing in excess of their budgeted establishment which was an increase when compared to December where there were 2.
- Bank usage is reporting as 'green' and 'amber' in December and January
- Peppermill Court had the highest agency usage in December with 31.73% and Cherry Tree had the highest in January with 14.91%
- In turning to the triangulation there was 1 PALS related issue identified in January relating to the Recovery Unit Acomb. They also had a low fill rate and showed 'amber' for bank usage.

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

				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Meadowfields	York and Selby	MHSOP	18	68.9%	85.3%	105.0%	95.2%
Oak Rise	York and Selby	LD	8	124.2%	83.4%	106.4%	96.6%
Peppermill Court	York and Selby	MHSOP	14	78.1%	79.7%	94.2%	101.2%
Recovery Unit Acomb	York and Selby	Adults	16	70.0%	87.4%	75.8%	90.3%
White Horse View	York and Selby	LD	8	58.2%	99.0%	95.4%	102.0%
Worsley Court	York and Selby	MHSOP	14	109.5%	101.4%	91.5%	146.0%
Cherry Tree House	York and Selby	MHSOP	16	87.9%	102.9%	89.3%	115.7%

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 31 DAYS IN January							
				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Meadowfields	York and Selby	MHSOP	18	48.9%	85.1%	220.0%	98.4%
Oak Rise	York and Selby	LD	8	112.4%	94.0%	100.0%	100.0%
Peppermill Court	York and Selby	MHSOP	14	100.5%	77.1%	103.9%	131.8%
Recovery Unit Acomb	York and Selby	Adults	16	80.4%	77.3%	50.0%	100.0%
White Horse View	York and Selby	LD	8	79.7%	88.0%	100.0%	100.0%
Worsley Court	York and Selby	MHSOP	14	79.0%	110.9%	77.1%	149.0%
Cherry Tree House	York and Selby	MHSOP	16	87.0%	135.0%	112.2%	118.3%

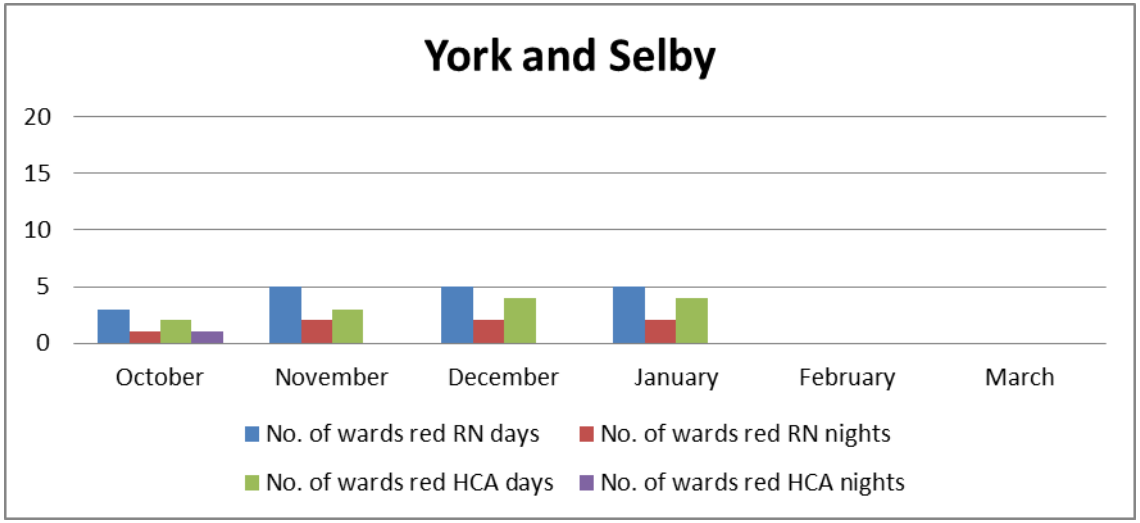
YORK AND SELBY LOCALITY REPORT - December 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Meadowfields	18	1066.5	341	1395	682	735.26	358	1189.76	649	68.9%	105.0%	85.3%	95.2%
Oak Rise	8	928.25	333.25	918	667.5	1152.56	354.7	765.81	644.75	124.2%	106.4%	83.4%	96.6%
Peppermill Court	14	930	667	1627.5	701.5	726.5	628	1297.5	710	78.1%	94.2%	79.7%	101.2%
Recovery Unit Acomb	16	930	682	1200	682	650.58	517	1048.5	616	70.0%	75.8%	87.4%	90.3%
White Horse View	8	926	326.75	1393.5	653.5	539.25	311.75	1379.75	666.5	58.2%	95.4%	99.0%	102.0%
Worsley Court	14	795	341	1215	682	870.5	312	1231.5	996	109.5%	91.5%	101.4%	146.0%
Cherry Tree House	16	997.5	682	1458	1023	877	608.75	1500.25	1183.5	87.9%	89.3%	102.9%	115.7%

YORK AND SELBY LOCALITY REPORT - January 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Meadowfields	18	1664	110	1574	682	813	242	1339.5	671	48.9%	220.0%	85.1%	98.4%
Oak Rise	8	926.5	333.25	912.75	665.25	1041.77	333.25	857.53	665.25	112.4%	100.0%	94.0%	100.0%
Peppermill Court	14	330	241.5	577.5	253	331.5	251	445.5	333.5	100.5%	103.9%	77.1%	131.8%
Recovery Unit Acomb	16	930	682	1395	682	747.59	341	1077.75	682	80.4%	50.0%	77.3%	100.0%
White Horse View	8	930	333.25	1391	666.5	741.25	333.25	1224	666.5	79.7%	100.0%	88.0%	100.0%
Worsley Court	14	922.5	341	1365	682	729	263	1513.5	1016	79.0%	77.1%	110.9%	149.0%
Cherry Tree House	16	915	539	1292.5	1023	796.5	605	1745.5	1210.5	87.0%	112.2%	135.0%	118.3%

YORK & SELBY TOTAL - Month on Month Trend

Month	Actual Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Oct-15	89.29	-	101.0	-	112.99	-	104.68	-
Nov-15	83.55	↓	91.27	↓	85.65	↓	101.89	↓
Dec-15	84.50	↑	91.40	↑	91.60	↑	107.40	↑
Jan-16	78.60	↓	96.40	↑	91.80	↑	112.70	↑

Number of Red Wards – York and Selby



Quality Indicators

Scored Fill Rate compared to Quality Indicators - DECEMBER 2015					Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total score	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI (TAKEN FROM IIC)	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Meadowfields	York & Selby	MHSOP	18	10	2932.02	679.5	23%									
Oak Rise	York & Selby	LD	8	9	2917.82	333.5	11%									
Peppermill Court	York & Selby	MHSOP	14	10	3362	122	4%									
Recovery Unit Acomb	York & Selby	Adults	16	8	2832.08	125.5	4%									
White Horse View	York & Selby	LD	8	12	2897.25	10.5	0%									
Worsley Court	York & Selby	MHSOP	14	8	3410	198.5	6%									
Cherry Tree House	York & Selby	MHSOP	16	11	4169.5	498	12%									
Scored Fill Rate compared to Quality Indicators – JANUARY 2016																
Meadowfields	York & Selby	MHSOP	18	7	3065.5	859	28%									
Oak Rise	York & Selby	LD	8	8	2897.8	629.75	22%									
Peppermill Court	York & Selby	MHSOP	14	4	1317.5	46	3%									
Recovery Unit Acomb	York & Selby	Adults	16	5	2848.34	335.5	12%					1				
White Horse View	York & Selby	LD	8	6	2965	128.5	4%									
Worsley Court	York & Selby	MHSOP	14	7	3521.5	119	3%									
Cherry Tree House	York & Selby	MHSOP	16	9	4416.5	706	16%									

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 23 February 2016**
TITLE:	**To consider the report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 3, 2015-16.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 23 February 2016**
TITLE:	**To consider the report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

1.1 To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 3, 2015-16; through consideration of the work of the Mental Health Legislation Committee, which is a Standing Committee of the Board.

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

At the meeting held on 25th January 2016

3.1 The minutes of the Committee meeting held on 26th October 2015 were reviewed and, other than one minor amendment, agreed as an accurate record. (See Appendix 2 for information).

3.2 It was noted from the summary report for CQC MHA inspections that there were 16 visits in the quarter. Of the 16 visits, reports had been received for 15 of them and the report for Acomb Garth was awaited. There were three visits where no issues were identified. There were no significant issues identified in relation to the MHA or MCA specifically but a recurring theme in a number of reports was the unavailability of the report from the Local Authority Approved Mental Health Professional (AMHP) within the MHA record.

3.3 The Section 136 report was presented. In total there were 186 uses of section 136 across the whole Trust area (a slight decrease from 188 in the previous quarter) of which 170 (91%) were brought to a MHBPOS, an increase from 84% in the previous quarter. Cleveland Police use of section 136 has decreased by approximately 29% compared with the previous quarter; whilst those taken to a Trust place of safety in North Yorkshire shows a significant increase of approximately 69%; although the 136 suite in Bootham Park Hospital is now open, as there were only 2 section 136s in the last quarter, this would not account for this increase.

In terms of Street Triage activity there were 146 contacts in the quarter in Teesside, of which 3 resulted in the use of section 136, and in Scarborough there were 130 contacts of which 2 resulted in the use of section 136.

Within the Crisis Assessment Suite at Roseberry Park activity continues to be significant though has reduced to 481 assessments undertaken in the quarter

compared to 597 in the previous quarter (this does not include those assessed subject to section 136). The numbers attending 'voluntarily' with the police and not subject to section 136 continues to be high and far exceeds the number subject to section 136 – in the quarter there were 160 attending voluntarily with the police compared to 54 brought subject to section 136. Of the total 481 assessments 100, approximately 21%, were discharged without mental health follow up or sign-posting to other services.

3.4 There is no seclusion report for this quarter as we are awaiting the production of a report by the Information Team to enable the extraction of the data from Paris since the recording of seclusion became part of the electronic care record and no longer a manual record.

3.5 The Discharge from Detention Report was presented. This report focusses on discharge from detention by either the First Tier Tribunal or the Associate Hospital Managers. There were 178 Hospital Managers reviews held, compared to 152 in the previous quarter, and 1 patient was discharged this quarter. The number of FTTs cannot be provided for this quarter due to reporting issues. Of the FTTs held the Tribunal ordered 7 absolute discharges (6 of which were subject to section 2), 1 conditional discharge and 1 deferred discharge**.** Two of the patients absolutely discharged patients had the same RC but different named nurses and care coordinators. One of these patients remained informally, was re-detained 7 weeks later and discharged by the RC 4 weeks after that. The other was discharged from hospital immediately and at 6 weeks point had not been re-detained.

3.6 The Department of Health response to the Law Commissions MCA and Deprivation of Liberty Safeguards consultation was provided for information. It was noted that a re-drafted version will be produced, possibly by the summer of this year.

3.7 The draft report from Audit North around Mental Health Act compliance was shared. The report demonstrates significant assurance and there were no recommendations.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:**
No new implications.

4.3 **Legal and Constitutional (including the NHS Constitution):**
Non-compliance with the CQC regulatory framework for the Mental Health Act and Mental Capacity Act and DoLS and/or non-compliance with the MHA or MCA itself would have serious consequences for the organisation and place the organisation at risk of breach of the conditions of the Independent Regulators or potential litigation.

4.4 **Equality and Diversity:**
No new implications.

4.4 **Other implications:**
In terms of York and Selby the administration of the MHA and the Paris care record in use in the York and Selby locality for the MHA are potential areas of concern until at least March when it is anticipated that the Paris version will align with what is available across the rest of the Trust.

5. RISKS:
The MHA issues identified in York and Selby which have been rectified may give rise to legal challenge from the affected service users or their legal representatives. Whilst the issues arose prior to our involvement, we allowed a period of time for York and Selby to attempt to locate missing information and from the period of our identification of the issues to the ending of the MHA use for those service users for whom we could not satisfy ourselves of the continued legality of their section, TEWV may hold a level of accountability.

6. CONCLUSIONS:
At their meeting in January 2016, the MHL Committee received reports and evidence for assurance on all elements of the Mental Health Act administration and implementation, demonstrating compliance with CQC regulatory requirements. This assurance is externally supported by the feedback from the CQC Mental Health Act inspections and the report form Audit North and also from the Trust CQC inspection in January.

7. RECOMMENDATIONS:

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

Author: Mel Wilkinson
Title: Head of Mental Health Legislation

Background Papers:
Appendix 1 – Background Information
Appendix 2 – Approved minutes of the 26th October 2015 MHL Committee Meeting

Appendix 1

Background Information

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

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

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

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

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

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 26 OCTOBER 2015 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 11.00AM.

Present:
Dr H Griffiths, Non-Executive Director
Mr R Simpson, Non-Executive Director, (Chairman of the Committee)
Mr B Kilmurray, Chief Operating Officer
Dr N Land, Medical Director
Mrs E Moody, Director of Nursing and Governance
Ms J Clark, Public Governor
Mr K Marsden, Public governor

In Attendance:
Mrs L Bessant, Chairman of the Trust
Ms P Griffin, Mental Health Legislation Advisor
Mrs J Illingworth, Director of Quality Governance
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation

Apologies: There were no apologies for absence.

15/27 MINUTES

Agreed – *That the minutes of the last meeting held on 27July 2015 be approved as a correct record and signed by the Chairman.*

15/28 ACTION LOG

The Committee updated the Action log taking into account the relevant reports provided to the meeting.

15/11 "Review of leaflets already in distribution in the Trust and report back to the next MHLC meeting".

Completed

15/17 "Terms of reference to be updated to include the new Director of Nursing and Governance".

Completed

15/20 "CQC Feedback Summary Report – further discussion required around the evidence of recording capacity assessments at the October MHLC meeting". This was covered under minute 15/34 .

15/21 "MHA performance reports – look into the bed occupancy on Bilsdale showing 20/14 beds on 31.1.15 and 20/14 beds on Lustram Vale on 31.3.15".

Mr Kilmurray confirmed that this was an error in the report and should have read "14/20 beds".

Completed

15/21(1) MHA Performance Reports – check the validity of the statistics – spike of 34 individuals
subject to section 126 taken to Roseberry Park in June 2015, compared to 17 in May 2015.

The data had been incorrect in this report and the statistics had been amended for this quarter.

Completed

15/21(2) "CAS team staff to request information on whether voluntary attenders who returned
home received follow up and include in future reports".

Completed

15/21(3) Force Reduction Group to receive the Seclusion Report from MHLC for consideration".

Miss Wilkinson confirmed that she had been invited to attend the Force Reduction Group meetings going forward.

Completed

15/24 "Delirium in the Acute Hospital – raise the issue of patients that may be in an Acute Trust
setting thought to be deprived of liberty with Executive peers".

Completed

15/29 CARE QUALITY COMMISSION (CQC) FEEDBACK SUMMARY REPORT: 1 July 2015 to 30 September 2015

The Committee considered and noted the Care Quality Commission (MHA) visit feedback summary report for the period 1 July 2015 to 30 September 2015.

Arising from the report it was noted that:

(1) The CQC had undertaken 13 MHA visits to the Trust, of which 10 had been summarised in the report, with 1 received last week and 2 outstanding.
(2) Action plans were in place for the 25 issues raised.

Following discussion it was noted that:

(a) It would be helpful to show the Ward areas against the number of actions outlined in the action plan.

Action: Mrs E Moody

(b) That the responses to matters following issues raised and actions taken were not seen by the MHLC and it would be useful once the CQC mock inspections were re-launched to look at perception issues.
(c) The number of CQC visits had previously dropped a little, however since the reconfiguration within the CQC had increased to the numbers more usual for the Trust.

(d) The first CQC visit had taken place at York last week.
(e) The issue around the seclusion room not being safe and secure had been rectified.
(f) There were ongoing discussions with the CQC about the appropriate signage for CCTV in patient areas, which the Trust did not believe should be on every door in recovery areas.

15/30 MHA PERFORMANCE REPORTS

The Committee considered and noted the Admissions, Changes and Detention Themes Report.

Arising from the report it was highlighted that:

(1) The report had been shortened, removing the in-depth information around the use of the Mental Health Act on a locality at service level. This would go directly to the relevant services.
(2) The impact of the Cheshire West Judgement had impacted on the number of people who were now defined as being deprived of liberty.
This had resulted in a significant increase in the number of people in care homes with their deprivation of liberty authorised by a Supervisory Body and being made subject to a Standard Authorisation under DoLS.
(3) It was anticipated that the majority of patients in Trust wards identified of being deprived of liberty would meet the criteria for detention under the MHA.
(4) It was interesting to note the significant dip in December 2014 in the number of patients subject to section 2 at the end of the month in the past 2 years. This was discussed and the possible various reasons, which included an increase in community support to enable people to be discharged home for New Year, families 'managing' to keep people at home during the Christmas holidays and then seeking assistance in the New Year.
It was not felt to indicate that people were being discharged purely because it was New Year, who would not have been discharged otherwise.

On this matter it was felt that this pattern should be discussed further with Senior Medical Staff colleagues, Modern Matrons and Ward Managers.

Action: Mrs E Moody

Following discussion it was noted that the HSCIC Report into the use of the MHA nationally was now available. This would be reviewed and any relevant issues or anomalies brought back to the next MHLC meeting.

Action: Miss M Wilkinson

The Committee considered and noted the Section 136 Report.

Arising from the report it was noted that:

(1) The number of individuals brought to Roseberry Park continued to be significantly higher than other areas of the Trust.
(2) There were issues with collation of the data for this report as there were varying methods being used.
(3) The report had been produced without September 2015 figures from Cleveland Police, which had been unavailable.

Following discussion it was noted that:

(a) Patients presenting to Cleveland Police with a mental health issue and for a crime were being detained using Section136.
(b) There were high numbers of people without any follow up after being detained on Section 136 within the Cleveland Police area. This appeared to be quite often due to people being picked up whilst intoxicated, with suspected mental health issues, who when sober did not require follow up. Some training and collaborative work had been undertaken with Cleveland Police to try to reduce the use of Section 136.
(c) It would be more effective for street triage to operate 24 hours a day, however through the Crisis Care Concordat there would potentially be an opportunity for a Crisis Worker to be placed in the control room to provide expertise.
Discussions around funding for street triage would continue with Commissioners and an update would be brought back to the next MHLC meeting.

Action: Mr B Kilmurray

The Committee considered and noted the Discharges from Detention Report.

Arising from the report it was noted that:

(1) There were occasions when a patient had been discharged from detention, despite the opposite view from the clinical team.
(2) There were 152 Hospital Managers reviews held and 1 patient had been discharged.
(3) There were 153 FTTs held in quarter 2 compared to 140 in quarter 1. The Tribunal ordered 10 absolute discharges (4 of which were patients subject to a CTO) 2 conditional discharges and 1 deferred discharge. All of the discharges were from Adult Services and the 2 conditional discharges from Forensic mental health.

Following discussion it was noted that:

(a) There had been no patients re-detained after being discharged against the clinical team's view at the point of report writing.
(b) In terms of FFTs this equated to an approximate 8.5% discharge rate and the Committee had asked, if possible, for a comparison to be provided against either national statistics or comparable providers.

Action: Miss M Wilkinson

15/31 CODE OF PRACTICE UPDATE – IMPLEMENTATION PLAN

The Committee considered and noted the action plan on the Code of Practice Update.

It was highlighted from the action plan that:

(1) Most of the actions had been completed.
(2) All MHA policies had been updated and ratified and were available on InTouch.
(3) Policy Leads had been contacted for updates on non MHA policies.
(4) The 2 hour briefing sessions for staff had not been undertaken due to capacity issues within the MHL department. However, all wards and teams had been provided with a copy of the Code of Practice and all MHA and MCA training had been updated to incorporate the changes. In terms of the 2 hour briefings it was questionable how many staff this would capture as 2 hours would only allow for an awareness raising session.

15/32 MHA UPDATE FOR YORK AND SELBY

The Committee noted a verbal update around the MHA and MCA status for York & Selby, post 1 October 2015.

Miss Wilkinson highlighted the following:

(1) Issues had been highlighted around missing documentation and some instances of inadequate documentation for some patients subject to the MHA.
(2) This had been fully investigated and staff within LYPFT had been supported in order to try and locate missing documentation. This related to a number of patients initially, however this number had reduced.
The CQC would be notified in due course of these issues.
(3) This matter had been escalated to the Director of Nursing at Leeds.
(4) Each individual patient issue had been raised with legal services to ensure the correct decision would be made for each patient.
(5) Meeting rooms for tribunals were being identified in the community off site from Bootham Park.

15/33 DEPRIVIATION OF LIBERTY SAFEGUARDS CONSULTATION

The Committee noted the consultation on the Deprivation of Liberty Safeguards which had been undertaken by the Law Commission.

Highlighted from the consultation it was noted that:

(1) The Cheshire West judgement had further highlighted that the DoLS legislation was not fit for purpose.
The Law Commission had set out proposals to change the legislation, together with an attempt to focus not solely on Article 5 issues alone, but to include a much greater consideration of Article 8 rights. This broadening within the legislation aspired to provide significant safeguards for the most vulnerable in society, however there would be resource implications attached to these changes.
(2) The document had been circulated and comments and views had been incorporated into the consultation document.

Following discussion it was noted that:

(a) The comments provided by Mr Barkley, (page 20, paragraph 1), would be amended to read " From a hospital provider perspective….and from the perspective of families this may well be seen as having a negative impact due to the funding of aftercare…".
Action: Miss M Wilkinson

(b) The consultation document would be presented to the Board of Directors on 27 October 2015.
The overall timescales for implementation of these changes, should they be passed through parliament was not anticipated to conclude until around 2020.

15/34 RECORDING OF CAPACITY ASSESSMENTS

The Committee noted a verbal update from Dr Land around the changes to recording capacity assessments.

It was noted that:

(1) There would be a change in practice to recording the capacity assessment carried out at the first administration of medication for mental disorder for a detained patient. The usual practice had involved printing off the entry and placing it with the drug Kardex, to enable it to be easily located by the CQC.

The new process would mean that the entry would be made on the MHA tab only within Paris and clearly identified as a capacity assessment, which would enable it to be easily located. If needed the location of the entry could be aided by reference to the date that the medication had been first administered to assist with the date when this entry should have been made. A long run in period for this change had been agreed with a date set for April 2016.

(2) This change to practice would go to Modern Matrons, via Mrs Moody and it would be added to the mock CQC visit template.

Action: Mrs E Moody/Mrs J Illingworth

15/35 AMHP AVAILABILITY – DURHAM COUNCIL

Miss Wilkinson notified the Committee that there had been more recent issues in Durham since the reduction in AMHP services.

Mr Kilmurray confirmed that this had been escalated to the Local Authority where discussions would take place.

15/36 POLICY - INTER-AGENCY SECTION 117 MENTAL HEALTH ACT 1983

The Committee considered a draft policy document setting out the requirements around section 117.

It was noted that the document had been sent to Local Authorities and CCGs for the addition of their appendices setting out local implementation guidance, however no responses had been received.

Following discussion it was agreed that this document was more of a reference and guidance statement, which would now go to the Clinical Leaders Board and then EMT for ratification.

15/37 POLICY - MENTAL CAPACITY ACT 2005 POLICY

The Committee considered and noted the Mental Capacity Act 2005 policy which had been reviewed in light of the changes to the MHA code of practice. The policy had been re-drafted into a new format.

Following discussion it was highlighted that:

(1) Within the MHL Department there would be a fixed term appointment for someone to lead on the Mental Capacity Act.

15/36 ANY OTHER BUSINESS

The Committee noted and discussed issues raised by Mrs Clarke, Public Governor.

(1) At a recent approved Mental Health Professional training event concerns had been raised around the number of last minute applications to amend from a Section 2 to a Section 3 with a lack of time to complete the consultation process.
(2) It was queried whether this should be monitored by the Trust.

Following discussion it was noted that:

(a) This was something that the Trust was aware of and there were measures in place to prevent this happening.
Miss Wilkinson confirmed that the responsible clinician would, under due process, be contacted around 5 days before the section 2 expiry date.
(b) It was unclear if these concerns were raised by members of this Trust or from another Trust.
(c) This would be something that could be followed up by the social worker involved in the patient care.

The Committee noted the following:

(1) The published British National Formulary (BNF) would be changing and all drug categories would be removed.
(2) The first non-medical approved clinician had commenced working in IP services at Roseberry Park.

The meeting concluded at 1.10pm

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Richard Simpson
Chairman – Mental Health Legislation Committee
26 October 2015

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**17th February 2016**
TITLE:	**Nicotine Management and Smoking Cessation Project**
REPORT OF:	**Dr. Nick Land**
REPORT FOR:	**Assurance**

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

Executive Summary:

This report will provide progress to date with regards to the nicotine management and smoking cessation project. Progress against key milestones is identified below and all areas are currently green as we approach the 'go-live' date for the Trust to go smokefree on 9th March 2016.

Also included are the future proposals for continuation of the project post March to ensure continuous improvement and quality of service delivery. The 2016/17 business case has been approved at EMT but is now awaiting approval of funding. Should the funding be approved, the project will continue for an additional year to further embed being smoke free within inpatients, support the role out to community services whilst also supporting the prisons to go smoke free.

Recommendations:

The Board are asked to receive and comment on this report on the progress made against the Nicotine Management and Smoking Cessation project and its plans for the coming year.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**23rd February 2016**
TITLE:	**Nicotine Management and Smoking Cessation Project**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this paper is to provide an update to the Board of Directors on progress against the 2015-2016 Business Case for the Nicotine Management and Smoking Cessation Project.

1.2 Also under consideration is the 2016-2017 Business Case proposal to further embed the smoke free agenda within inpatient services and the role out to community services.

1.3 The 2016-2017 Business Case also identifies the proposal for the Trust to provide project management support to the North of England Prison services to enable them to initially reduce smoking rates with a view to go completely smoke free from 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Business Case contains the key elements to support the implementation of the NICE PH48 "Smoking cessation in secondary care" guidance. The Project Plan includes comprehensive details of progress to date and future objectives to support the delivery of the project.

2.2 This report provides information on progress on whether actions due for completion during Quarter 3 (Q3)-Quarter4 (Q4) 2015/16 have been completed (green) or not (red, or grey if this is due to an external factor or Board/EMT decision).

2.3 The Quarter 3-4 monitoring is against the original milestones set out in the Project Plan included in the Business Case.

3. KEY ISSUES:

Progress against milestones due to be delivered by 9th March 2016

3.1 Table 1 below shows the active milestones which had been delivered as planned within Q3-Q4 2015/16. Some of the individual milestones will be on-going throughout Q1-Q4 2016/17 and these are identified with an * as appropriate.

3.2 With the embedding of the smoke free agenda within all TEWV inpatient services, service users in our care will be supported to remain smoke free whilst receiving behavioural support and nicotine management. This would further enhance the work already being undertaken within inpatient areas and promote future sustainability of nicotine management services and support.

The roll out to community services will ensure a seamless pathway of support is available to service users on discharge. Community staff will be trained to support the smoke free agenda over the longer term, ensuring service users are informed of appropriate smoking cessation services available in primary care, and offered referral directly into these services.

The Trust would also offer Project Management support to the North of England Prisons, with a view to them initially reducing smoking rates between March 2016/17, and then looking to become completely smoke free by March 2018. The Trust will be taking part in an exercise that mirrors work already taking place in "early adopter" sites within prisons nationally.

Table 1 – Milestones to be completed by Q3-Q4 2015/16

Strategic Goal	Green	Red	Grey
Carry out a full review of the Nicotine Management Policy	✓		
Implement the Trusts standards on nicotine management as per the new/revised approved policy	✓		
Completion of Level 1 and Level 2 frontline staff training in smoking cessation and nicotine management	✓*		
Updating of the Guidance on stop smoking products	✓		
Finalise the development of Information leaflets for service users carers and staff	✓		
Develop a robust smoke free communications plan and communicate Trustwide	✓		
Complete a benchmarking exercise to identify the numbers of staff who smoke within the Trust	✓*		
Develop an implementation plan to support staff to stop smoking	✓		
Identify services to host clinics to support staff to stop smoking	✓		
Advertise and promote Stoptober across the Trust	✓*		
2016/17			
Identify appropriate training packages for role out to community services	✓		
Identify appropriate trainers to deliver training to community staff	✓		
Inclusion of smoking question in Trust FFT-June 2016	✓		
FFT taking place-June 2016	✓		
Make available the information sheets and pathways to support drug dosage adjustments as appropriate within Community services	✓*		
Provide project management support for the prisons to reduce smoking with a view to becoming completely smoke free by 2018	✓		

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The project complies with the relevant CQC fundamental standards.

4.2 **Financial/Value for Money:** There will be an increase in the cost of pharmacotherapies for those service users wishing to stop smoking but as identified by the World Health Organisation "The additional expense is justified on purely cost–effectiveness grounds"[1].

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust obtained legal advice which raised no legal or constitutional implications associated with this paper to date.

4.4 **Equality and Diversity:** There were no identified negative impacts on any of the protected characteristic groups.

4.5 **Other implications:** None.

5. RISKS:

5.1 **Quality:** There are currently no identified risks to patient safety or patient experience with the implementation of a smoke free Trust.

5.2 **Financial:** Due to the increase in the cost of pharmacotherapies for those service users wishing to stop smoking there is a financial risk due to the uncertainty of individual service users use of nicotine products.

6. CONCLUSIONS:

6.1 All of the active milestones for Quarter 3 and Quarter 4, identified within the Project Plan have been delivered as planned.

6.2 Staff training is ongoing across the trust and will continue post March 2016 to further embed nicotine management and smoking cessation support both for inpatient and community services.

6.3 The Business case for 2016-2017 is available to the Board for further discussion regarding the future planned actions required to further progress smoking cessation and nicotine management work within the Trust and identified prison services.

7. RECOMMENDATIONS:

7.1 The Board are asked to receive and comment on this report on the progress made against the Nicotine Management and Smoking Cessation project and its plans for the coming year.

Lesley Colley
Nicotine Management and Smoking Cessation Project Manager

Background Papers:

1. *The world health report 2002: reducing the risks, promoting healthy life* -Geneva, World Health Organization, 2002

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23 February 2016**
TITLE:	**Finance Report for Period 1 April 2015 to 31 January 2016**
REPORT OF:	**Colin Martin, Director of Finance**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 January 2016 is a surplus of £4,610k, which is equivalent to 1.8% of turnover. The financial position is £540k behind plan largely due to the impairment of Trust properties being £1,287k above plan. Excluding impairments the Trust is ahead of plan by £747k.

Identified Cash Releasing Efficiency Savings at 31 January 2016 are in line with plan.

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

The Financial Sustainability Risk Rating for the Trust is 4 for the period ending 31 January 2016.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**23 February 2016**
TITLE:	**Finance Report for Period 1 April 2015 to 31 January 2016**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2015 to 31 January 2016.

2. BACKGROUND INFORMATION

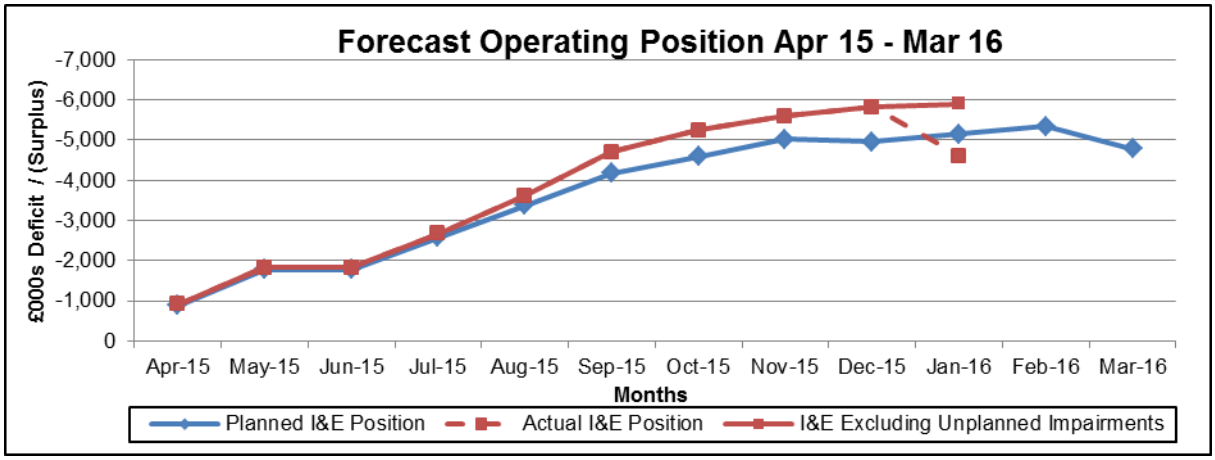
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

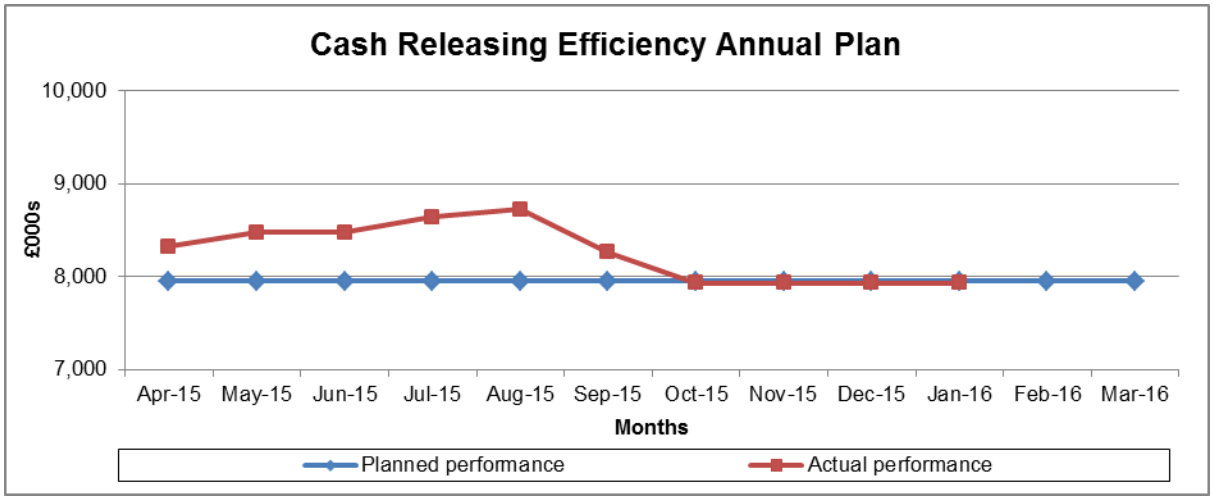
The financial position shows a surplus of £4,610k for the period 1 April 2015 to 31 January 2016, representing 1.8% of the Trust's turnover and is £540k behind plan. This is largely due to a planned impairment of Trust property being £1,287k higher than anticipated. Excluding impairments the Trust is ahead of plan by £747k.

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

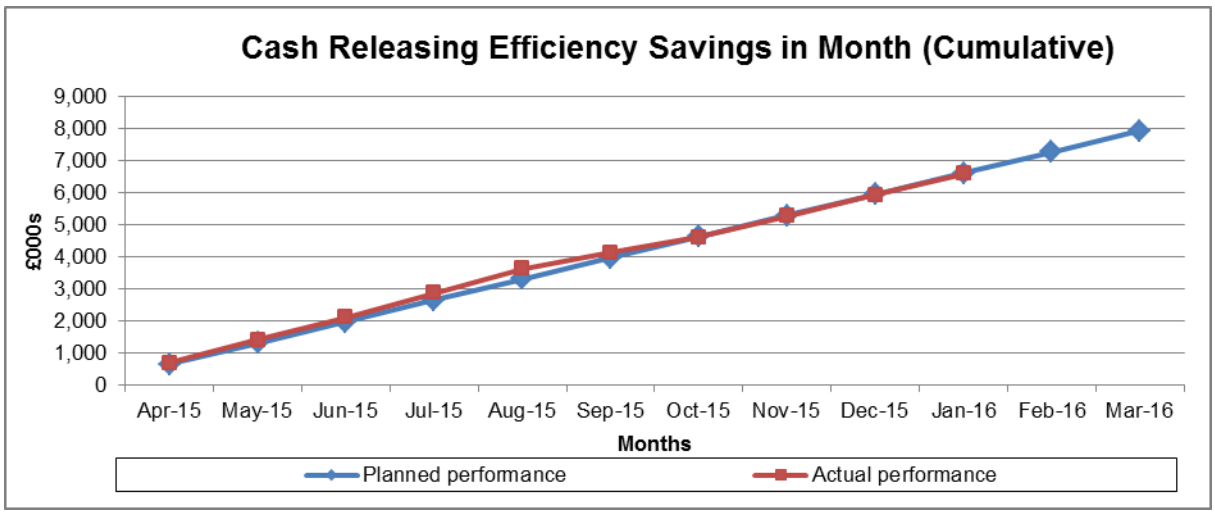


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 January 2016 is £7,930k. The reduction in September and October was due to some schemes being deferred to 2016/17. At this stage it is not anticipated that there will be any further material changes against the CRES plan in 15/16.

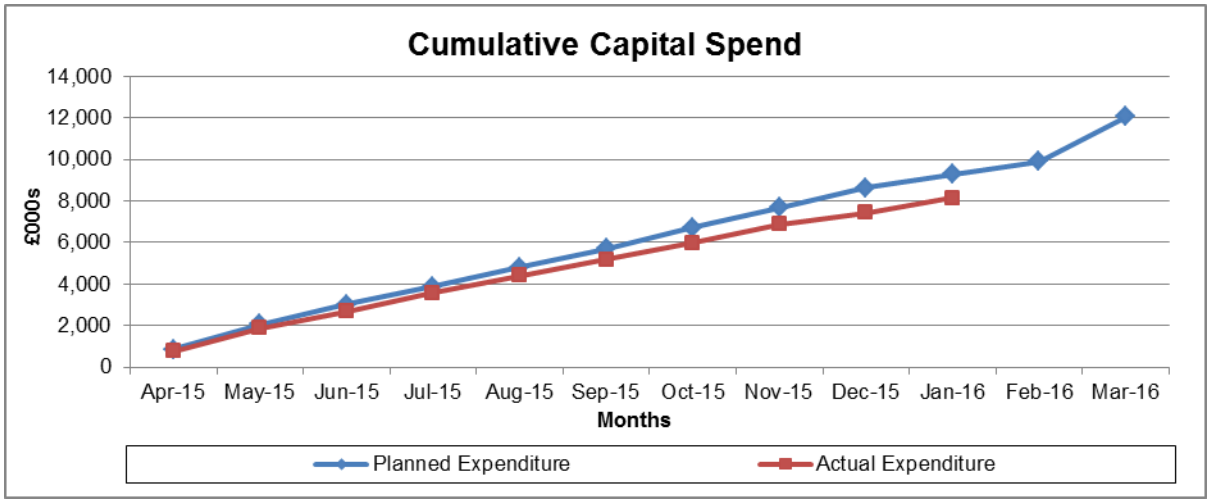


The monthly profile for CRES identified by Localities is shown below.



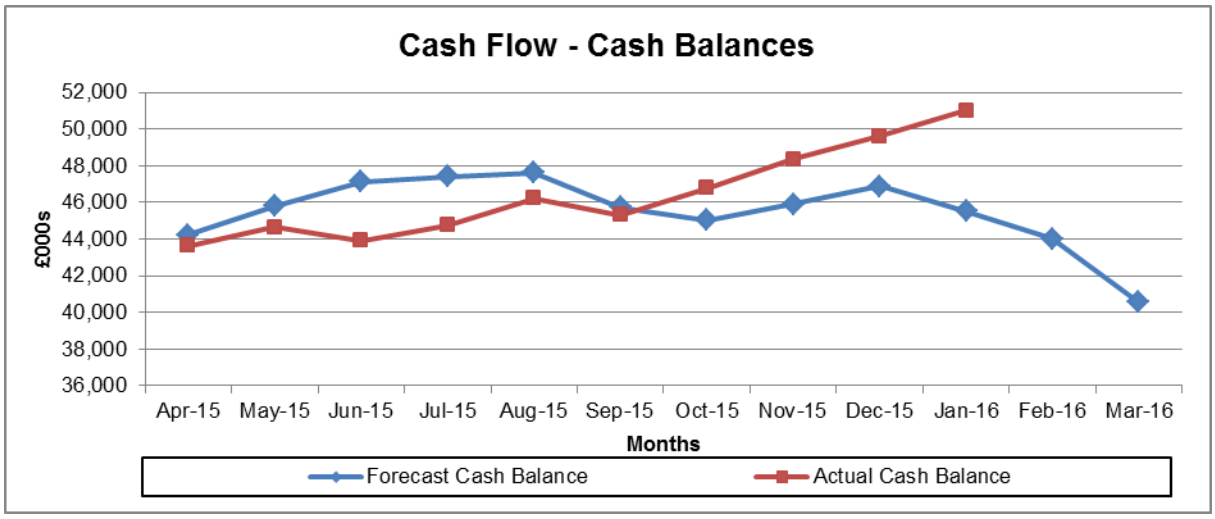
3.3 Capital Programme

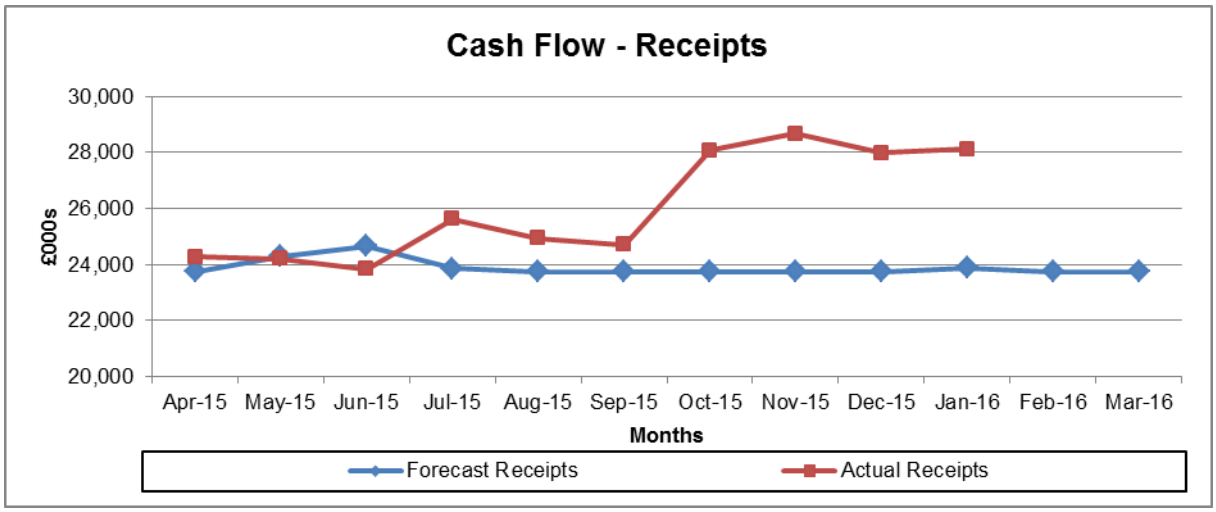
Capital expenditure to 31 January 2016 is £8,139k, and is behind plan and is forecast to be 80% of plan at the financial year end due to the planned deferral of schemes into 2016/17.

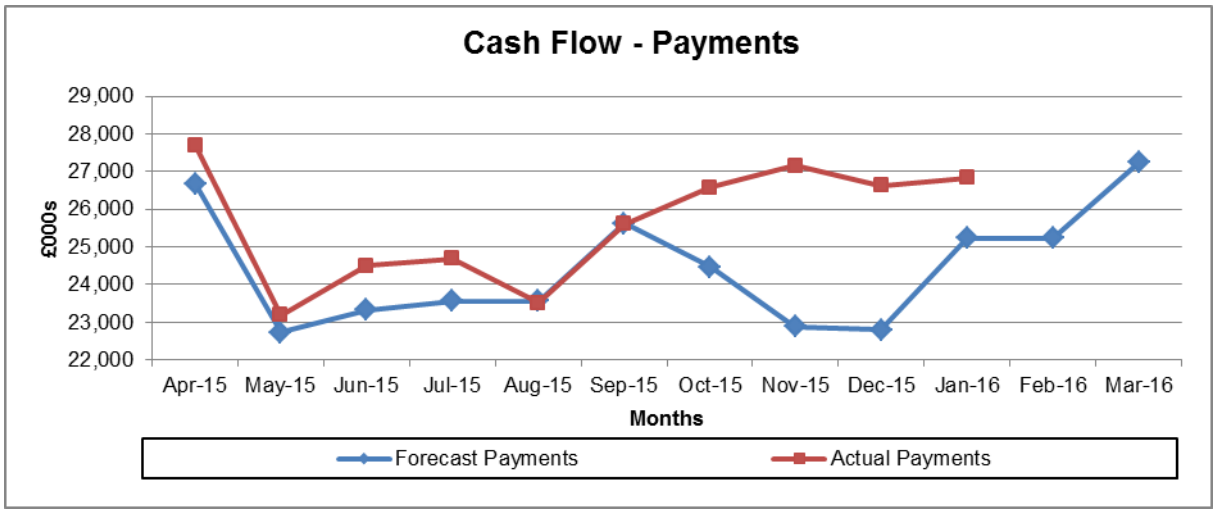


3.4 Cash Flow

Total cash at 31 January 2016 is £51,016k 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.





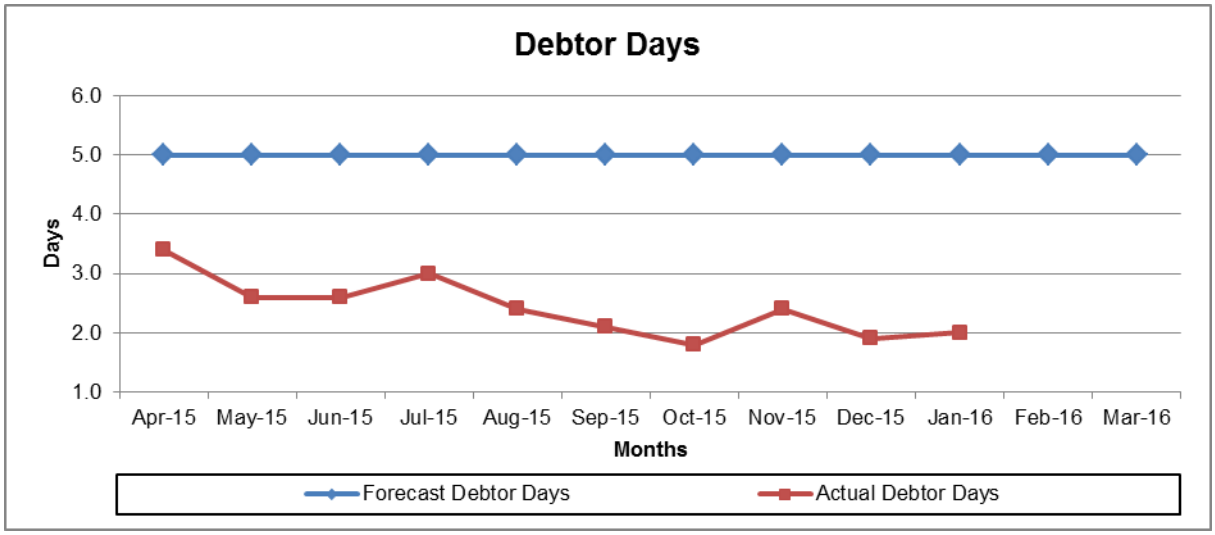


The increase within receipts and payments from October 2015 is due to additional revenue streams related to the York and Selby locality.

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

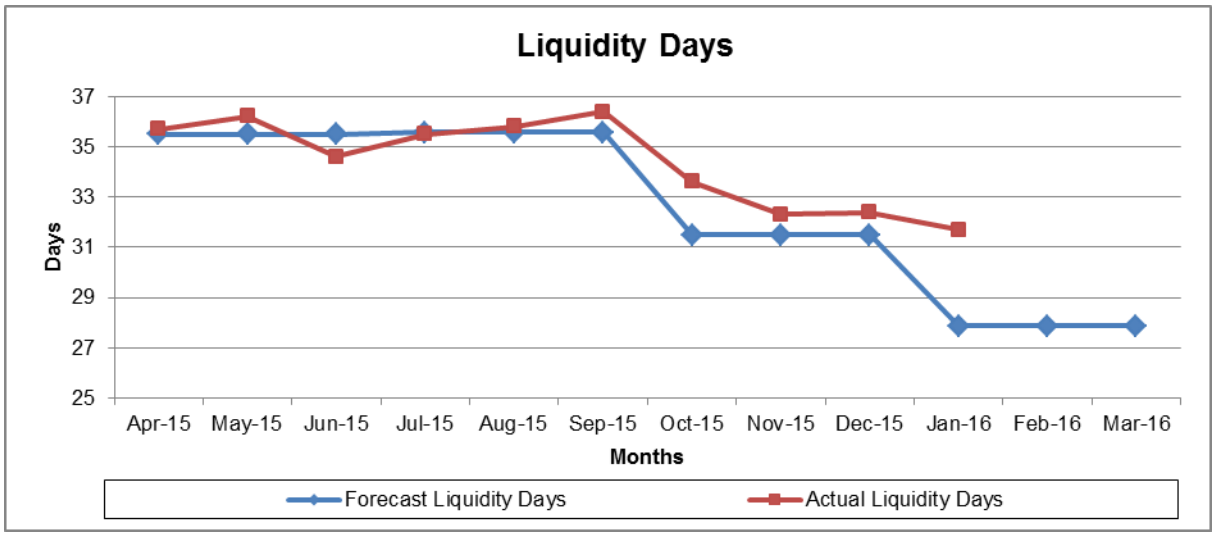
Working Capital ratios for period to 31 January 2016 were:

- Debtor Days of 2.0 days
- Liquidity of 31.7 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 76.18%
  Non NHS 30 Days – 97.42%



The Trust had a debtors' target of 5.0 days and actual performance of 2.0 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.



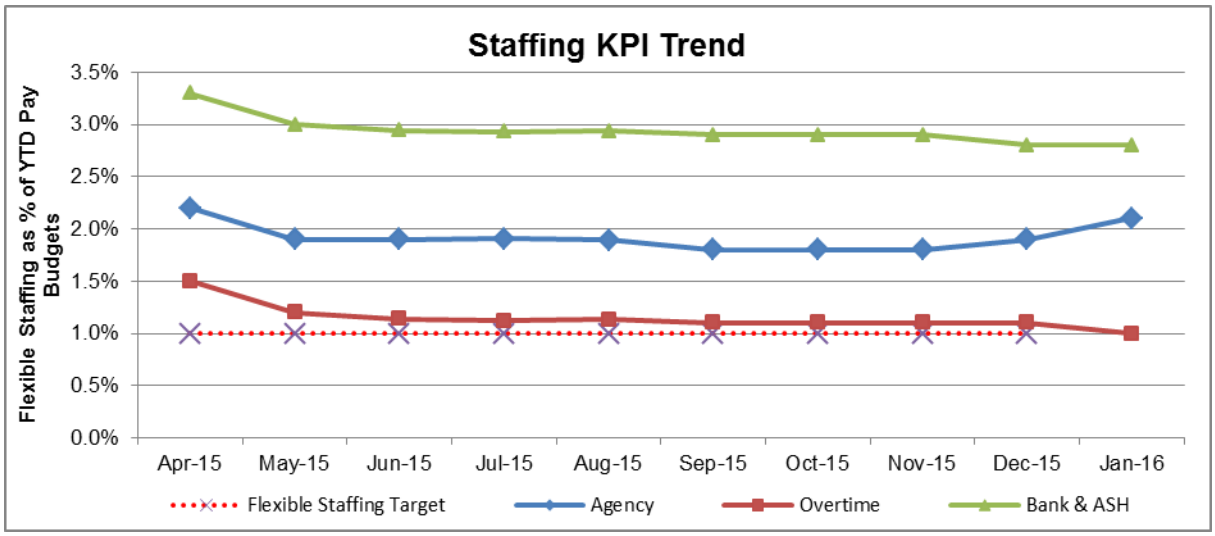
3.5 Financial Drivers

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

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

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 January 2016 the tolerance for Bank and ASH is 3.8% of pay budgets.

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



Additional staffing expenditure is 5.9% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (46%), enhanced observations (16%) and sickness (16%).

3.6 Monitor Risk Ratings and Indicators

3.6.1 The Financial Sustainability Risk Rating was assessed as 4 at 31 January 2016, and is in line with the restated planned risk rating.

3.6.2 Capital service capacity rating assesses the level of operating surplus generated, to ensure a Trust is able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.43x (can cover debt payments due 1.43 times), which is in line with plan and rated as a 2.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 31.7 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 2.9% and is rated as a 4.

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

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

- Capital service cover - to reduce to a 1 a surplus decrease of £2,293k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £24,377k is required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £4,776k is required.
- Variance from plan – to reduce to a 3 an operating surplus decrease of £834k is required.

Financial Sustainability Risk Rating at 31 January 2016

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

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service Cover	1.43x	2	1.36x	2	
Liquidity	31.7 days	4	27.9 days	4	
I&E Margin	2.9%	4	2.4%	4	
Variance from plan	0.5%	4	0%	4	
Overall Financial Sustainability Risk Rating		**4.00**			

3.6.7 7.8% of total receivables (£172k) are over 90 days past their due date. This is above the 5% finance risk tolerance set by Monitor, but is not a cause for concern as negotiations are ongoing to resolve.

3.6.8 3.5% of total payables invoices (£368k) held for payment are over 90 days past their due date. This is below the 5% finance risk tolerance set by Monitor.

3.6.9 The cash balance at 31 January 2016 is £51,016k and represents 67.2 days of annualised operating expenses.

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

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

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 January 2016 is a surplus of £4,610k, which is equivalent to 1.8% of turnover and is marginally ahead of plan after impairments.

6.2 Identified Cash Releasing Efficiency Savings at 31 January 2016 are in line with plan.

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

6.3 The Financial Sustainability Risk Rating for the Trust is 4 for the period ending 31 January 2016.

7. RECOMMENDATIONS:

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

Colin Martin
Director of Finance

Item 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd February 2016**
TITLE:	**Board Dashboard as at 30th January 2016**
REPORT OF:	**Sharon Pickering, Director of Planning & Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to provide the latest performance for the Board Dashboard as at 30th January 2016 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. A separate appendix covering the York and Selby Locality is attached in Appendix B.

In terms of the Trust (excluding the York and Selby Locality) 11 of the 24 (46%) indicators are being reported as red in January 2016 which is an improvement on the position in December when 13 (54%) of the indicators were red. Of those, 3 are showing an improving trend over the last 3 months. In terms of the York and Selby Locality report 7 of the 11 (64%) of the indicators reported are showing as red which is a deterioration of 1 compared to December..

The key risks continue to be:

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

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

MEETING OF:	**Board of Directors**
DATE:	**23rd February 2016**
TITLE:	**Board Dashboard as at 30th January 2016**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 30th January 2016 in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 The key issues are as follows:

- This report includes the following 4 Appendices:
  - The usual Dashboard report produced from the IIC in Appendix A. For all but the three staffing indicators this does not include data relating to the York and Selby (Please see item regarding Out of Locality below)
  - A separate dashboard for the locality of York and Selby is included within Appendix B where the information is available. This will be produced until the services in York and Selby move over to the Trust's PARIS system in April 2016
  - The Data Quality Scorecard is included in Appendix C. This does not include an assessment of the data quality relating to the York and Selby locality. As agreed this will be undertaken at the start of 2016/17 when the services transfer to the Trusts PARIS system.
- For the Trust (excluding the York and Selby Locality) 11 of the 24 (43%) indicators are being reported as red in January 2016 which is an improvement of 2 on the position in December 2015. Of those11, 3 are showing an improving trend over the last 3 months. In terms of the York and Selby report 7 of the 11 (64%) indicators reported are showing as red which is one more than the previous month.

The key risks are as follows:

- Access - Both waiting time targets (KPIs 1 & 2) continue to show an underperformance as at the end of January with a further deterioration on the position reported for 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 continuing to develop a further action plan to improve the position where possible. Teesside and North Yorkshire CYP services are implementing existing action plans.
- Early Intervention in Psychosis – whilst the dashboard shows that this target is being met this is based on an internal definition due to the delay in the publication of the national guidance. Further guidance was published in January however this is not the final guidance which was expected at the beginning of February. The performance for January

under the guidance that has been published is slightly below the target. Once the final guidance is published we will start to report using this. Work has been taking place with the services to ensure that recording of activity supports reporting against the current guidance. There is therefore a risk that until the agreed method of recording has become embedded that we will report an underperformance against this target.

- Psychological Therapies

  Whilst we are meeting the two waiting time targets (KPI 4 and 5) we continue to be below target for Access (KPI 6) and Recovery (KPI 7). In terms of the Access target there has been an improvement on the December position and the overall trend is one of improvement. The position continues to be higher than the same point in previous years. It should be noted that all three localities within North Yorkshire are achieving the access target which is a significant achievement. In terms of There has also been a significant improvement in the York and Selby locality during January.

  In terms of Recovery the overall Trust figure is impacted on by the recovery rates being achieved in the Teesside service. Whilst the other localities are not achieving target the overall position should improve when we stop delivering this service in Teesside. A number of the CCG areas are achieving target but Darlington and Scarborough and Ryedale are significantly below target. Focused work with individual members of staff in Darlington in taking place to address the underperformance

- Out of Locality Admissions (OoL) (KPI 12) The figures included with the dashboard incorrectly include 1 OoL admission out of 22 admissions of patients from the York and Selby locality. The position for TEWV excluding York and Selby is 17.14%. Whilst still over target this in an improvement on the December position and the second month of improvement following the peak in November. A report has now been received from the University of York following the work commissioned by the Chief Executive. This identified that addressing Length of Stay (rather than the admissions rate) would have the greatest impact on the OoL rate.
- Appraisal (KPI 19) – Performance is under target for the Trust (including York & Selby Locality) as a whole and has remained broadly the same as the figure reported for December. The Trust figures excluding York & Selby Locality slightly improves to 83.62% which is similar to the December position of 83.77%. Development work has started to enhance the HR information available via the IIC to support more proactive performance management.

2.2 **Appendix D** 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

	January 2016				April 2015 To January 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	98.00%	81.41%			98.00%	82.52%		98.00%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	82.79%			98.00%	86.53%		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%	64.58%			50.00%	71.87%		50.00%
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	87.72%			75.00%	83.85%		75.00%
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	97.09%			95.00%	94.53%		95.00%
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	15.00%	14.10%			15.00%	13.36%		15.00%
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	46.65%			50.00%	46.07%		50.00%
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	95.00%	96.43%			95.00%	97.10%		95.00%
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.27%			95.00%	97.83%		95.00%
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.92%			98.00%	98.92%		98.00%
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	90.62%			85.00%	89.94%		85.00%

Trust Dashboard Summary for TRUST

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

	January 2016				April 2015 To January 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	15.93%			15.00%	16.66%		15.00%
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	23.61%			15.00%	24.62%		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)	18.00	21.00			175.00	222.00		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	200.50			146.00	121.00		146.00
16) Percentage of appointments cancelled by the Trust	0.67%	1.17%			0.67%	1.07%		0.67%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.59			10.00	12.78		12.00
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	77.78%			75.00%	74.47%		75.00%

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

	January 2016				April 2015 To January 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	83.55%			95.00%	83.55%		95.00%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.78%			95.00%	88.78%		95.00%
21) Percentage Sickness Absence Rate (month behind)	4.50%	5.20%			4.50%	4.62%		4.50%

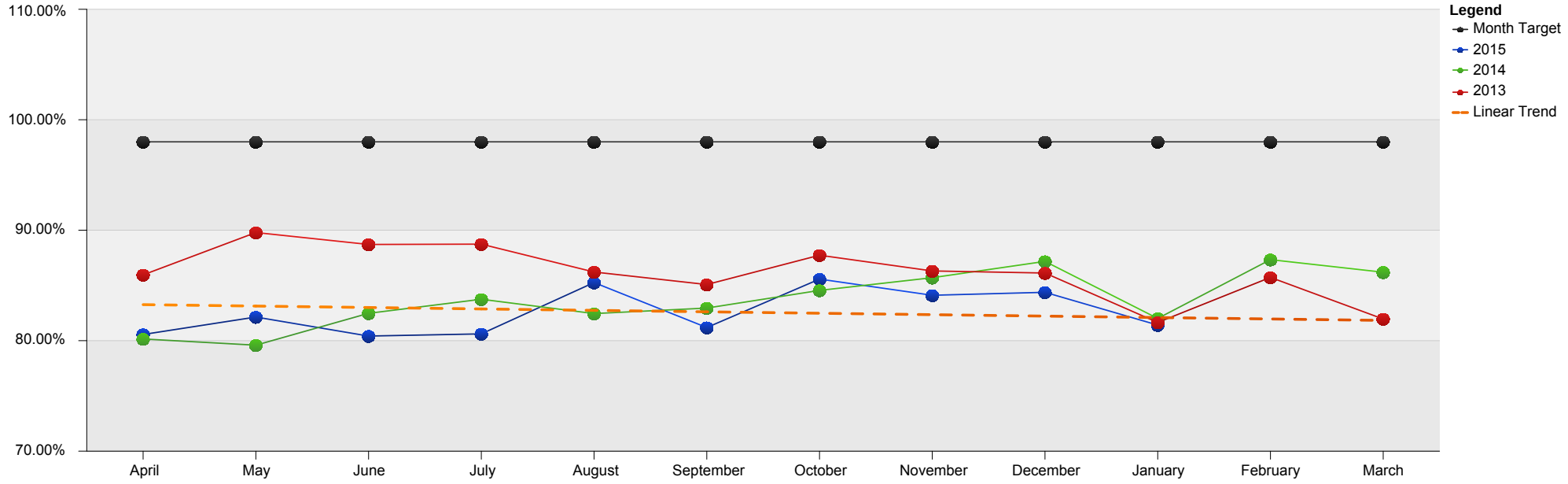
Trust Dashboard Summary for TRUST

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

	January 2016				April 2015 To January 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00			0.00	0.00		0.00
23) Total number of External Referrals into the Trust Services	5,939.00	6,783.00			58,627.00	64,442.00		69,931.00
24) Delivery of our financial plan (I and E)	-192,700.00	1,210,000.00			-5,149,700.00	-4,610,000.00		-4,784,000.00

Trust Dashboard Graphs for TRUST

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



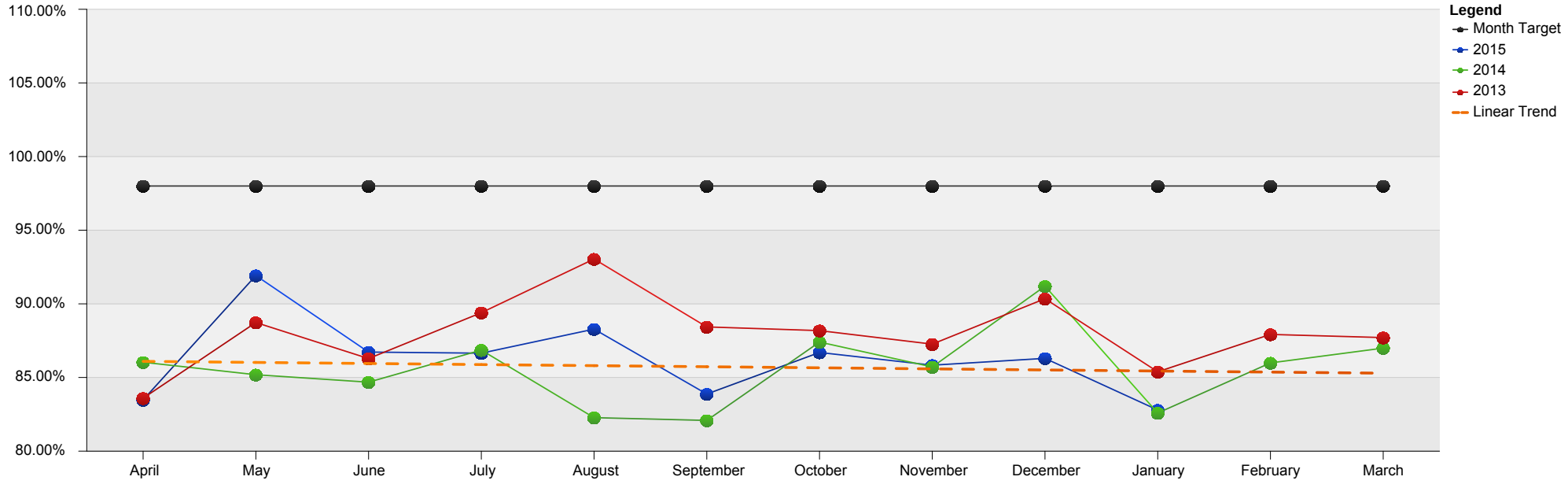
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	81.41%	82.52%	75.95%	77.92%	88.55%	89.55%	73.56%	74.85%	99.69%	99.84%		

Narrative

The Trust position January 2016 is 81.41%, which relates to 706 patients out of 3798 who had waited longer than 4 weeks for a first appointment. This is 16.59% below target, and a deterioration on December 2015 performance. The Trust position for the financial year to date is 82.52%, which is 15.48% below target.The specific areas of concern are:• Durham & Darlington CYP at 33.67% (130 of 196 patients) and AMH at 74.80% (124 of 492 patients). Within CYP, staff vacancies and sickness continue to impact on waiting times. In AMH there continues to be capacity issues within access teams; due to staff sickness• Teesside CYP at 63.46% (76 of 208 patients). The deterioration is due to vacancies and sickness. Recruitment has now taken place. The service are on track to achieve the target by March 2016.• North Yorkshire MHSOP at 73.37% (86 of 323 patients), CYP at 58.91% (53 of 559 patients). There has been a range of staffing issues including sickness and maternity leave in both teams. Plans are in place to address this. Based on past performance and January's performance, it is highly unlikely that we will achieve the annual target of 98%. The annual outturn for 2014/15 was 83.73%.

Trust Dashboard Graphs for TRUST

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



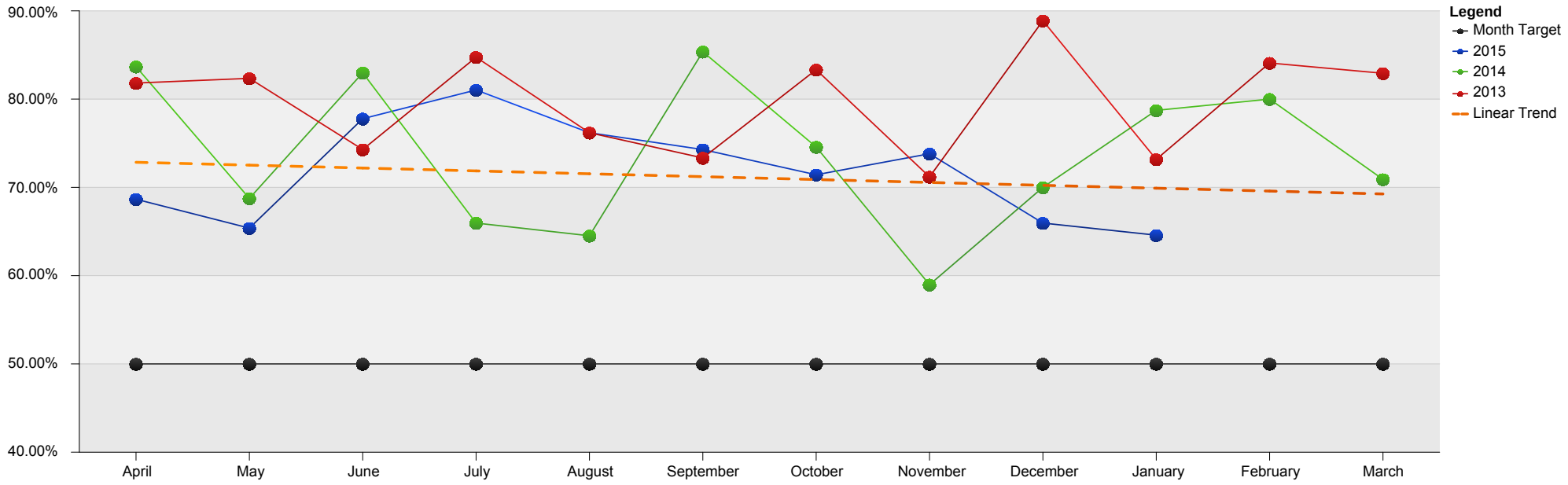
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	82.79%	86.53%	74.72%	80.90%	88.99%	92.15%	84.33%	89.20%	73.33%	53.62%		

Narrative

The Trust position for January 2016 is 82.79%, which relates to 381 patients out of 2214 that were not seen within 4 weeks of an internal referral. This is 15.21% below target and a deterioration on December performance. The Trust position for the financial year to date is 86.53%, which is 11.47% below target.The specific areas of concern are:• Durham & Darlington CYP at 50.93% (106 of 216 patients)• North Yorkshire LD at 50% (4 of 8 patients)• Tees CYP at 61.08% (65 of 167 patients)Based on past performance and January's performance, it is extremely unlikely that we will achieve the annual target of 98%. The annual outturn for 2014/15 was 85.79%.

Trust Dashboard Graphs for TRUST

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

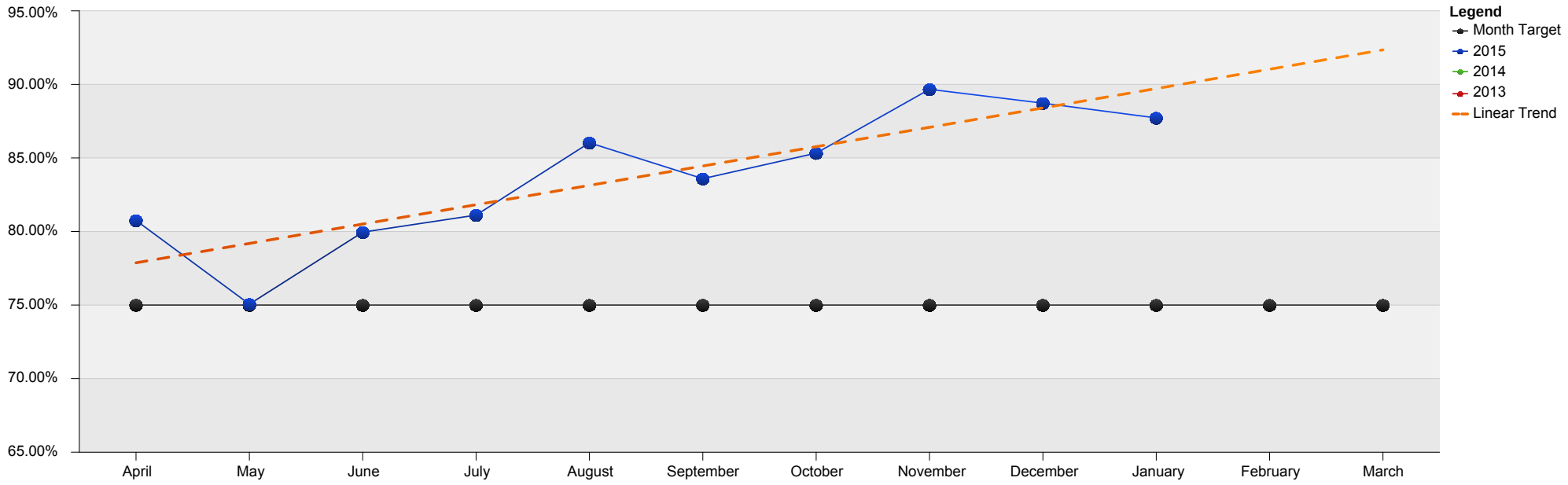


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	64.58%	71.87%	63.64%	62.23%	69.57%	80.47%	33.33%	71.43%	NA	NA		

Narrative
The Trust position for January 2016 is 64.58%, which relates to 17 patients out of 48 that were not treated within 2 weeks of referral. This is 14.58% above target but a deterioration on December 2015 performance. All localities with the exception of North Yorkshire (33.33%) are achieving target. In North Yorkshire assessment capacity continues to be impacted by vacancies, recruitment is underway and these will be filled by the end of March. The Trust position for the financial year to date is 71.87%, which is 21.87% above target. Based on past performance and January'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.



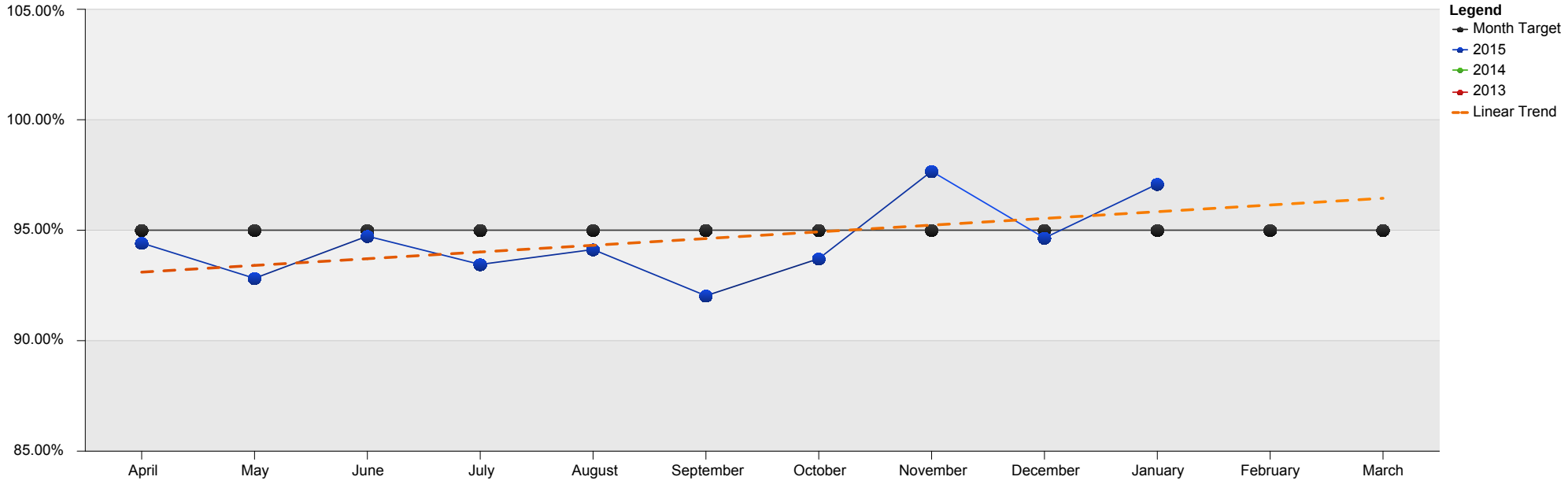
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	87.72%	83.85%	97.88%	98.43%	42.31%	55.59%	89.74%	75.06%	NA	NA		

Narrative

The Trust position for January 2016 is 87.72%, which relates to 118 patients out of 961 that were not treated within 6 weeks of referral. This is 12.72% above target but a deterioration on December 2015 performance. The Trust position for the financial year to date is 83.85%, which is 8.85% above target.Both Durham & Darlington (97.88%) and North Yorkshire (89.74%) report above target. Teesside reports significantly below target at 42.31% and a deterioration on December performance. The service are continuing to manage the close down of the service with as limited impact on targets as possible.Based on past performance, it is anticipated that we will achieve the annual target of 75%.Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

Trust Dashboard Graphs for TRUST

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

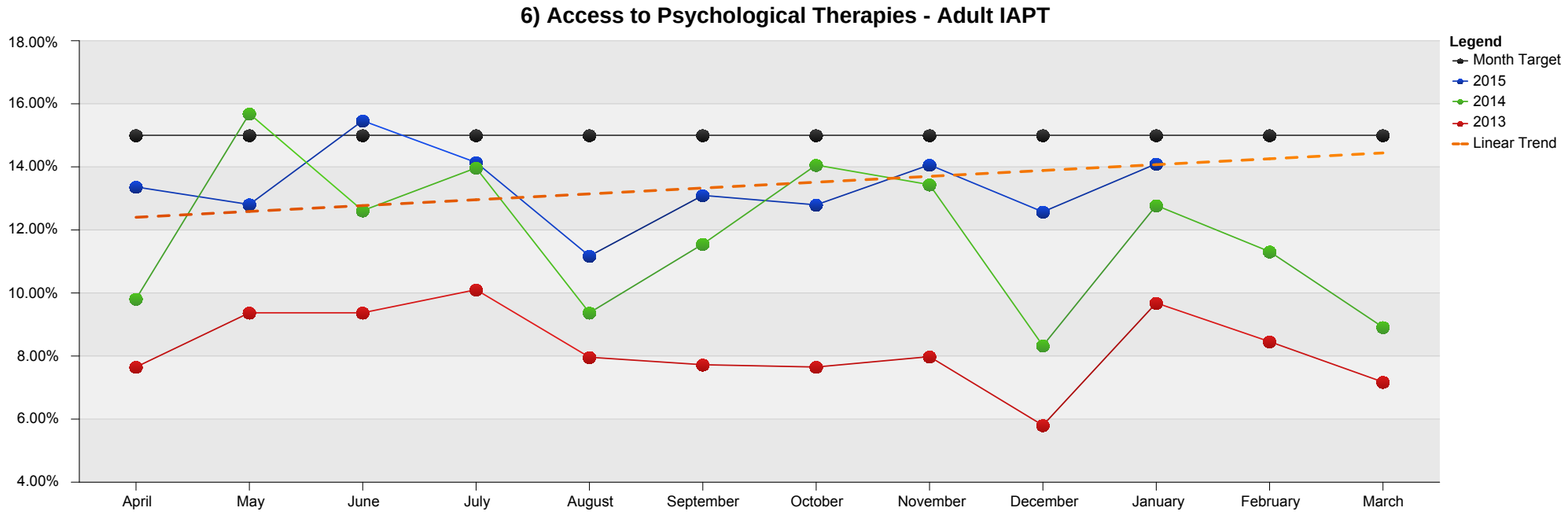


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	97.09%	94.53%	100.00%	99.82%	90.00%	80.68%	95.19%	93.21%	NA	NA		

Narrative

The Trust position for January 2016 is 97.09%, which relates to 28 patients out of 961 that were not treated within 18 weeks of referral. This is 2.09% above target and an improvement on December 2015 performance. Both Durham & Darlington (100%) and North Yorkshire (95.19%) are achieving target. Teesside reports 90% which is impacting on the overall Trust position. The Trust position for the financial year to date is 94.53%, which is 0.47% below target. Based on past performance during the 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

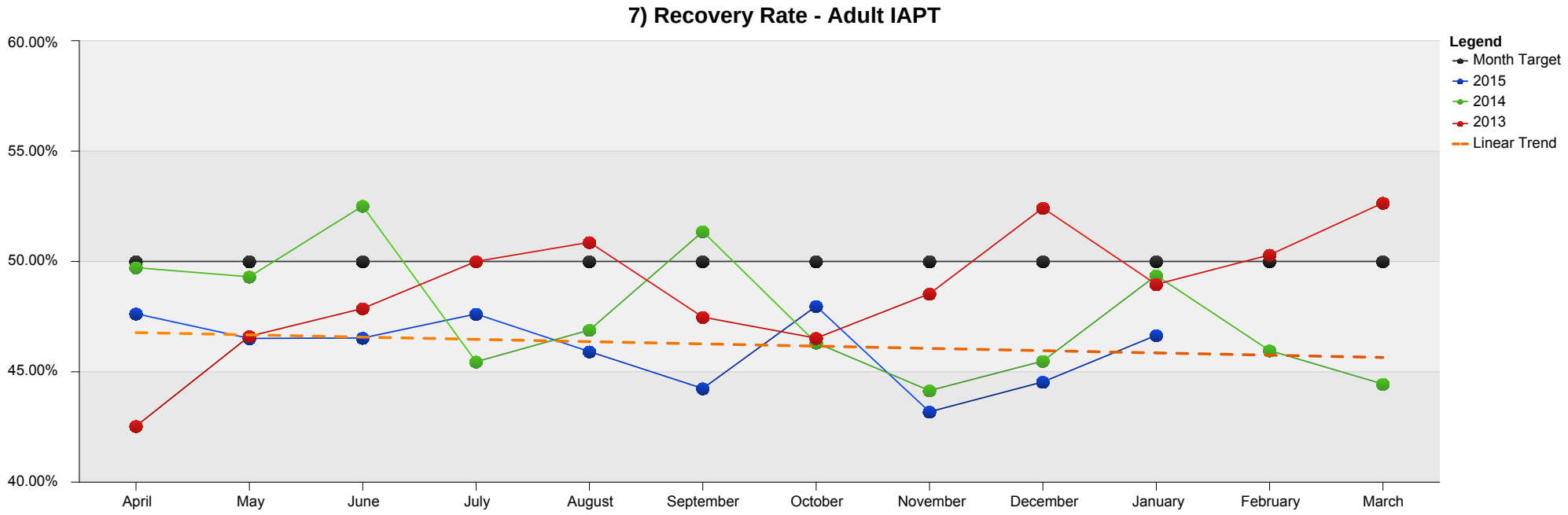


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	14.10%	13.36%	13.00%	12.58%	NA	NA	15.80%	14.56%	NA	NA		

Narrative

The Trust position for January 2016 is 14.10% which equates to 1268 people entering treatment from 8996 of the general population. This is 0.9% below the target of 15% and an improvement on December 2015 performance. The Trust position for the financial year to date is 13.36%, which is 1.64% below target. North Durham CCG (13.10%), DDES CCG (13.28%) and Darlington CCG (11.91%) are below target. There remains a high number of referrals for step 2a treatment. Team Managers have a direct allocation model in place to improve efficiency whilst managing waiting lists. Scarborough & Ryedale CCG (15.89%), Hambleton, Richmondshire & Whitby CCG (16.40%) and Harrogate & Rural CCG (15.47%) are above target. Vale of York CCG (13.25%) although significantly improved are below target. Whilst there has been an increasing trend this year, there remains a risk that we will not achieve the annual target of 15%, unless further action is taken.The annual outturn for 2014/15 was 11.82%.

Trust Dashboard Graphs for TRUST



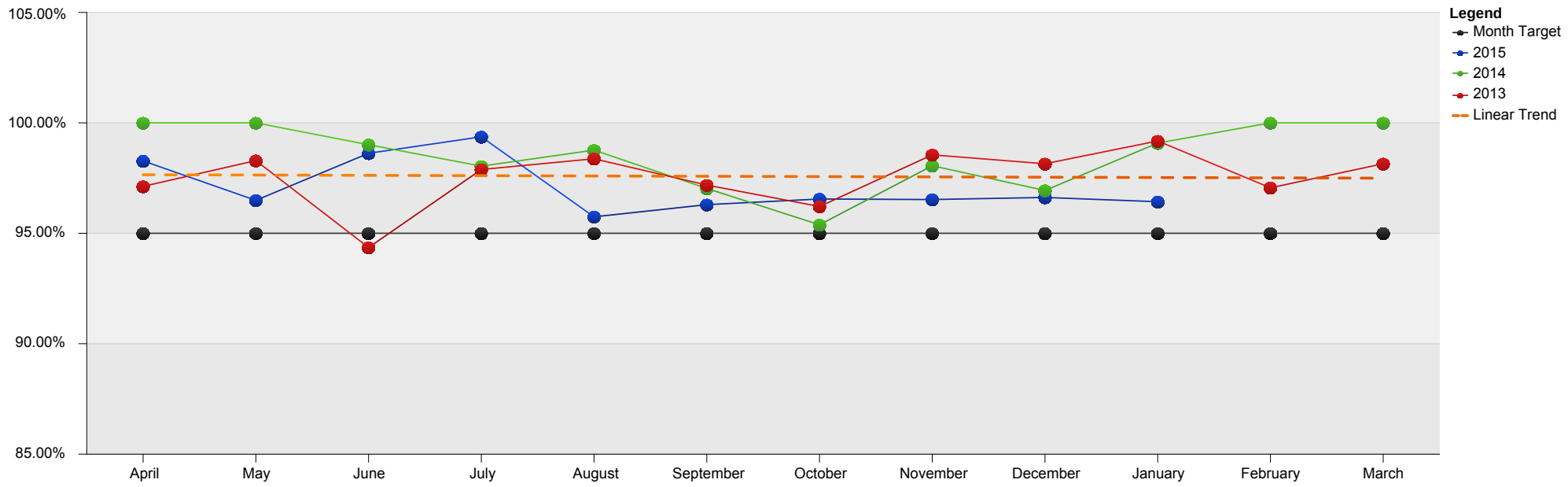
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	46.65%	46.07%	47.94%	45.41%	37.80%	44.37%	48.41%	48.14%	NA	NA		

Narrative

The Trust position for January 2016 is 46.65%, with 478 people out of 896 not achieving recovery. This is 3.35% below the target of 50% but an improvement on December performance. All localities are failing to achieve target. The Trust position for the financial year to date is 46.07%, which is 3.93% below target.North Durham CCG (51.94%) and DDES CCG (47.03%) have reported improvements in performance, whilst Darlington CCG (39.74%) has reported a deterioration. An action plan has been developed and focused work is underway in Darlington to look at individuals performance and share best practice across therapists. Hartlepool and Stockton CCG (33.33%) and South Tees CCG (39.77%) report deteriorations in performance. The action plan concerning recovery, which is agreed with commissioners, is being implemented. Harrogate & Rural CCG (53.06%) and Hambleton, Richmondshire & Whitby CCG (50.02%) have reported an improvement, whilst and Scarborough & Ryedale CCG (39.51%) have reported a deterioration. Although January 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

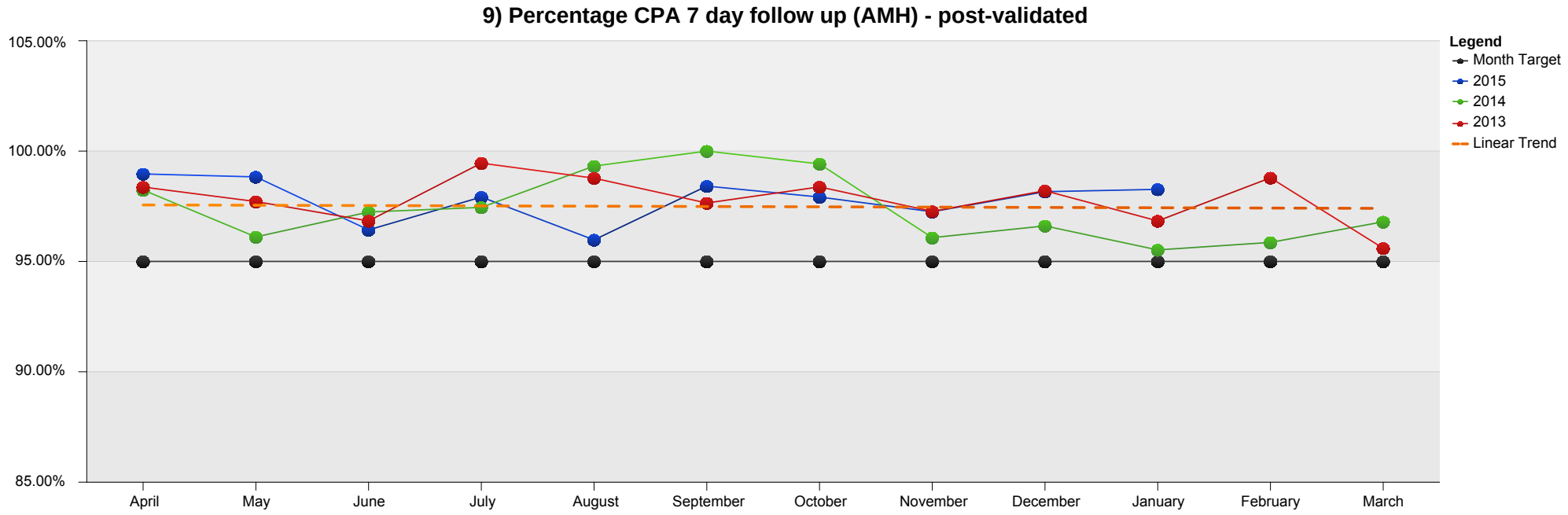
8) People seen by Crisis Services before admission - post-validated



	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	96.43%	97.10%	94.44%	96.07%	97.18%	97.34%	97.67%	97.95%	NA	NA		

Narrative
The Trust post validated position for January 2016 is 96.43%, which relates to 6 patients out of 168 that were not seen by a Crisis Home Treatment Team prior to admission. This is 1.43% above the target but a slight deterioration on December's performance. The Trust post validated position for the financial year to date is 97.10%, which is 2.11% above target.Based on current and past performance, it is anticipated that we will achieve the annual target of 95%.The annual outturn for 2014/15 was 98.42%.

Trust Dashboard Graphs for TRUST

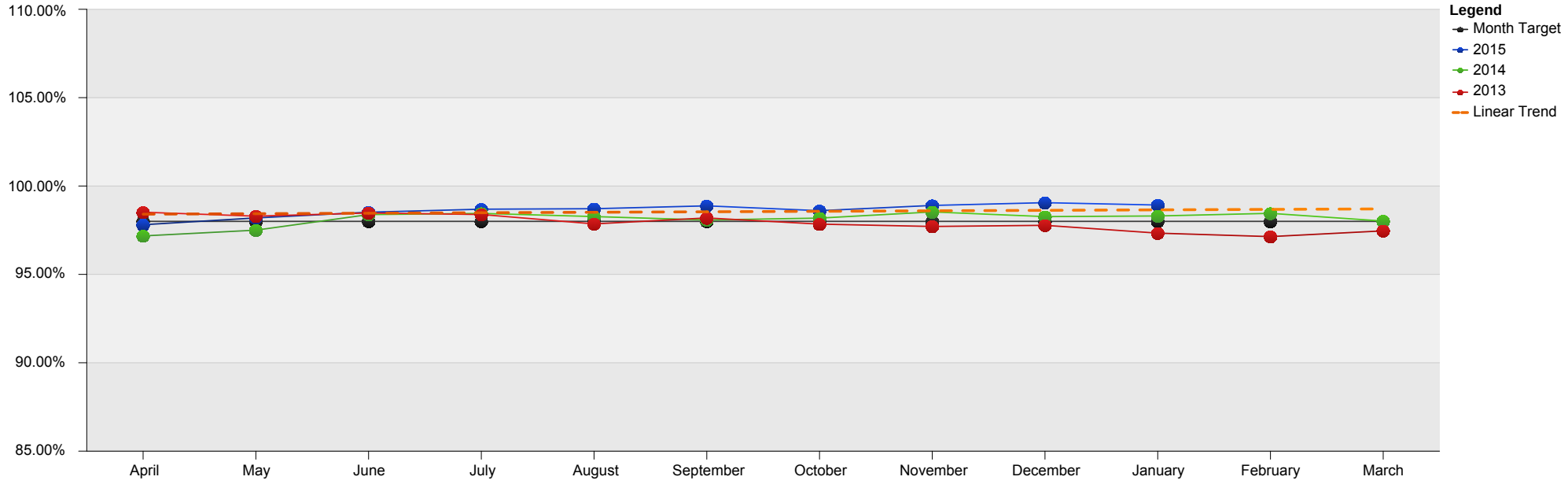


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) Percentage CPA 7 day follow up (AMH) - post-validated	98.27%	97.83%	98.33%	98.16%	97.44%	98.18%	100.00%	96.54%	NA	NA		

Narrative
The Trust post validated position for January 2016 is 98.27% which relates to 3 patients out of 173 that were not followed up within 7 days of discharge. This is 3.27% above the target and a slight improvement on December performance. The Trust post validated position for the financial year to date is 97.83%, which is 2.83% 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)



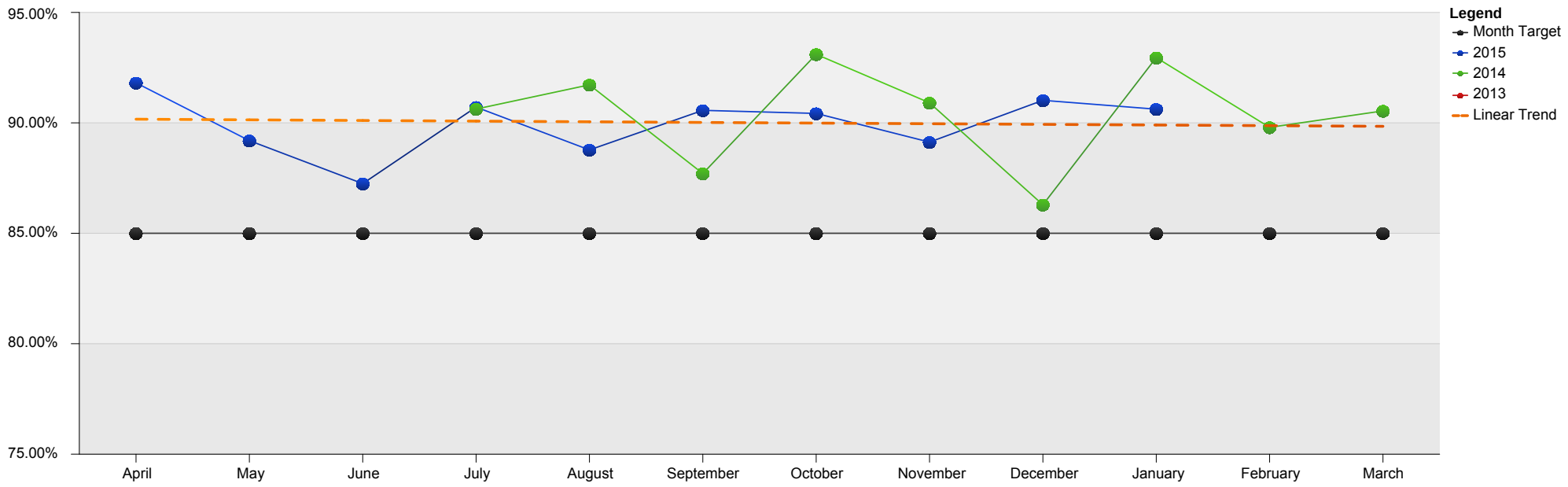
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.92%	98.92%	98.85%	98.85%	99.77%	99.77%	97.90%	97.90%	100.00%	100.00%		

Narrative

The Trust position for January 2016 is 98.92% which relates to 43 patients out of 3993 that had not had a formal review documented within 12 months. This is 3.92% above the Monitor target of 95%, 0.92% above the Trust target of 98% and a slight improvement on December's performance. All localities are achieving target with the exception of North Yorkshire who are 0.10% 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)

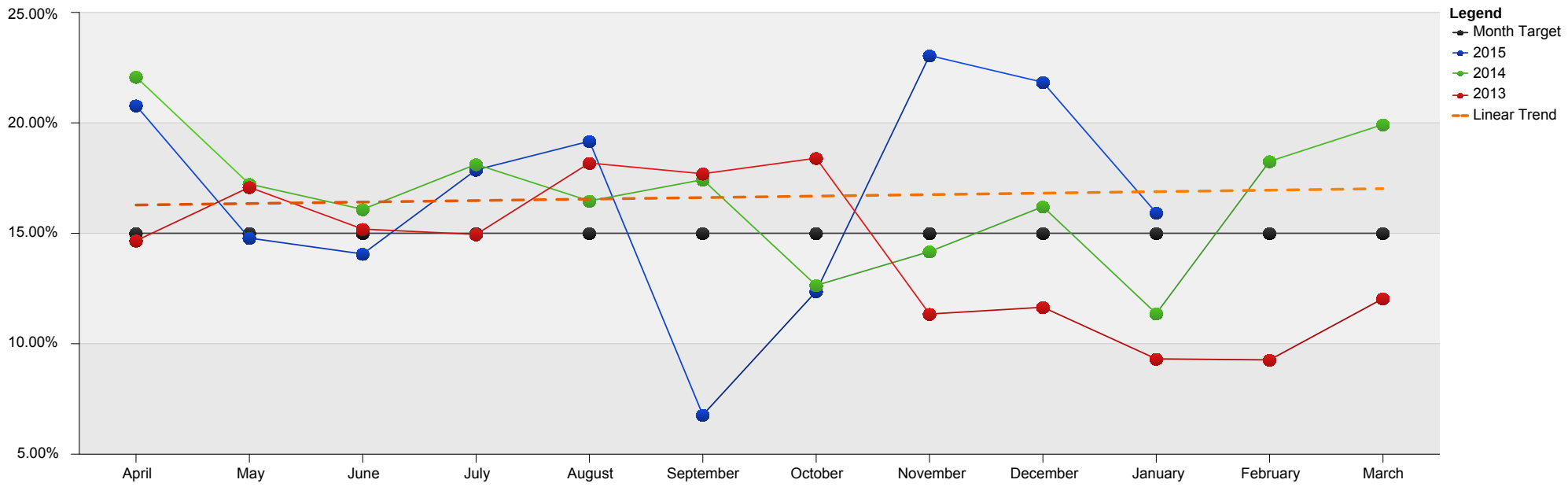


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	90.62%	89.94%	87.95%	89.22%	93.13%	91.12%	87.83%	87.75%	100.00%	91.84%		

Narrative
The position reported in January 2016 relates to December performance. The Trust position for December 2015 is 90.62%, which relates to 50 patients out of 533 that stated they have not been involved in the development of their care plan. This is 5.62% above the target of 85% but a slight deterioration on the performance reported for November. The Trust position for the financial year to date is 89.94%, which is 4.94% 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



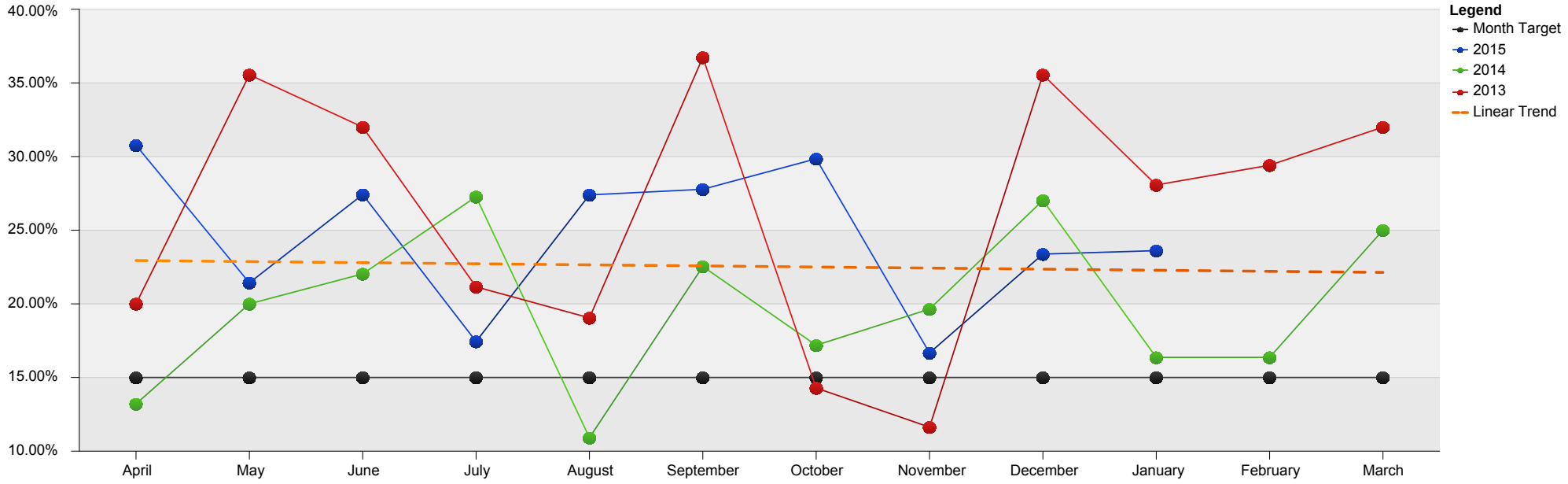
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.93%	16.66%	19.35%	17.17%	13.33%	10.80%	19.67%	25.31%	NA	NA	3.85%	6.59%

Narrative

Please note: - This indicator has included York and Selby locality in error. The Trust position without York & Selby is 17.14% which is 2.14% above target but an improvement on the position reported in December. York & Selby had 1 patient out of 26 admitted out of locality. This will be corrected in next month's report. Durham and Darlington (19.35%) and North Yorkshire (19.67%) are below target. Tees are reporting 13.33%. The Trust position for the financial year to date is 16.66%, which is 1.66% over target.Of the 43 patients admitted to an 'out of locality' bed, all were due to no beds being available at their local hospital (AMH 30, MHSOP 13). The localities continue to investigate ways in which they can reduce OOL admissions.Although there is an improvement on the December 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)



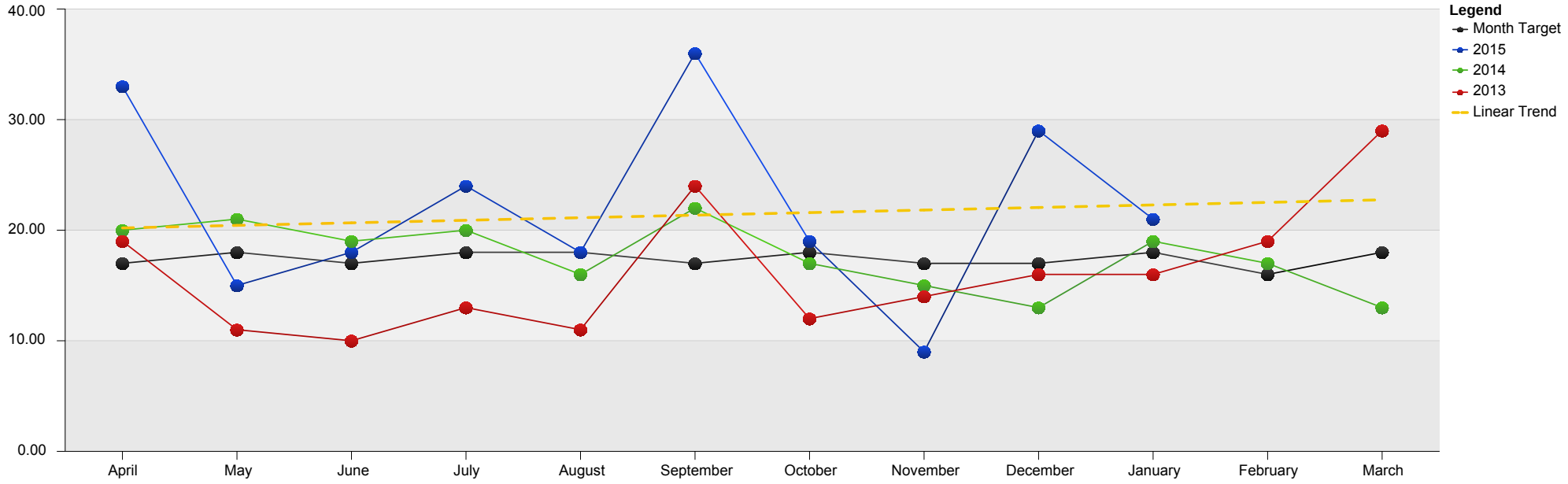
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	23.61%	24.62%	24.00%	23.08%	22.22%	22.71%	26.32%	28.44%	NA	NA		

Narrative

The Trust position for January 2016 is 23.61%, which relates to 17 patients out of 72 that were readmitted within 30 days. This is 8.61% above the target of 15% and a slight deterioration on the position reported in December. The Trust position for the financial year to date is 24.62%, which is 9.62% above target.All of the 17 readmissions were spread across the three localities and were within AMH Services:• 6 (24%) were within Durham & Darlington • 6 (22.22%) were within Teesside.• 5 (26.32%) 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 which will be reported to QUAC and Board in April. 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)

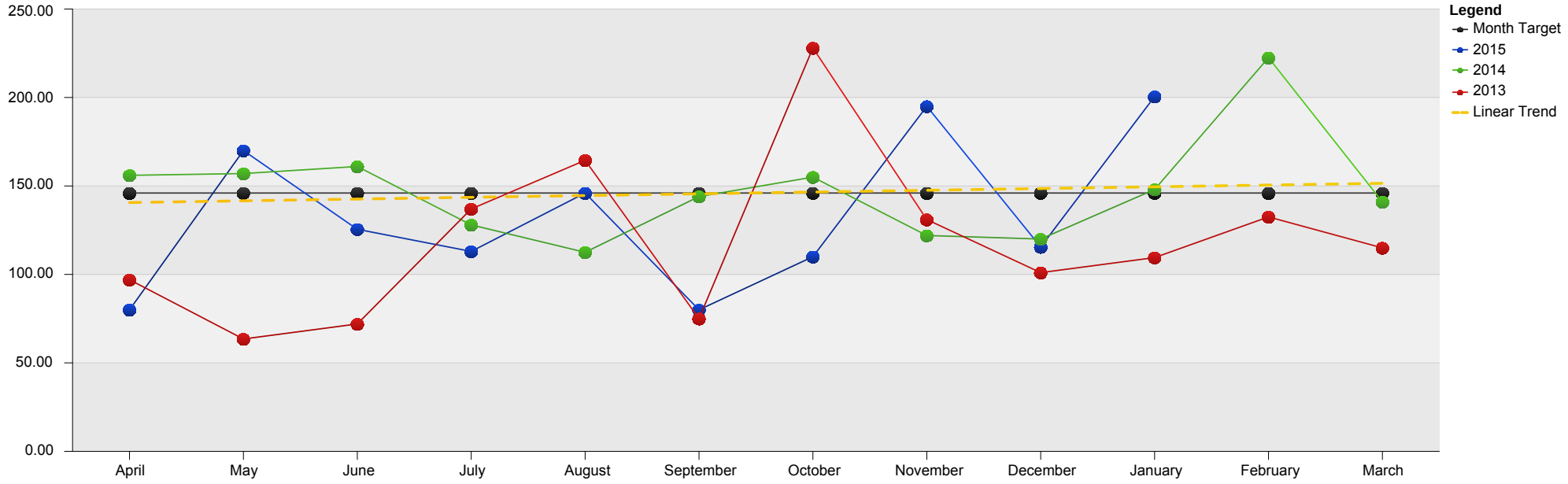


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	21.00	222.00	5.00	76.00	11.00	70.00	4.00	75.00	NA	NA		

Narrative
The Trust position for January 2016 is 21, which is 3 above the target of 18 and an improvement on the position reported in December. Only Teesside are over target. The Trust position for the financial year to date is 222, which is 47 above target.Of the 21 patients• 5 (17.86%) were within Durham & Darlington (AMH)• 11 (39.28%) were within Teesside (AMH)• 4 (14.28%) were within North Yorkshire (3 AMH, 1 MHSOP)• 1 (4.76%) unknown locality – this is under investigationThe 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

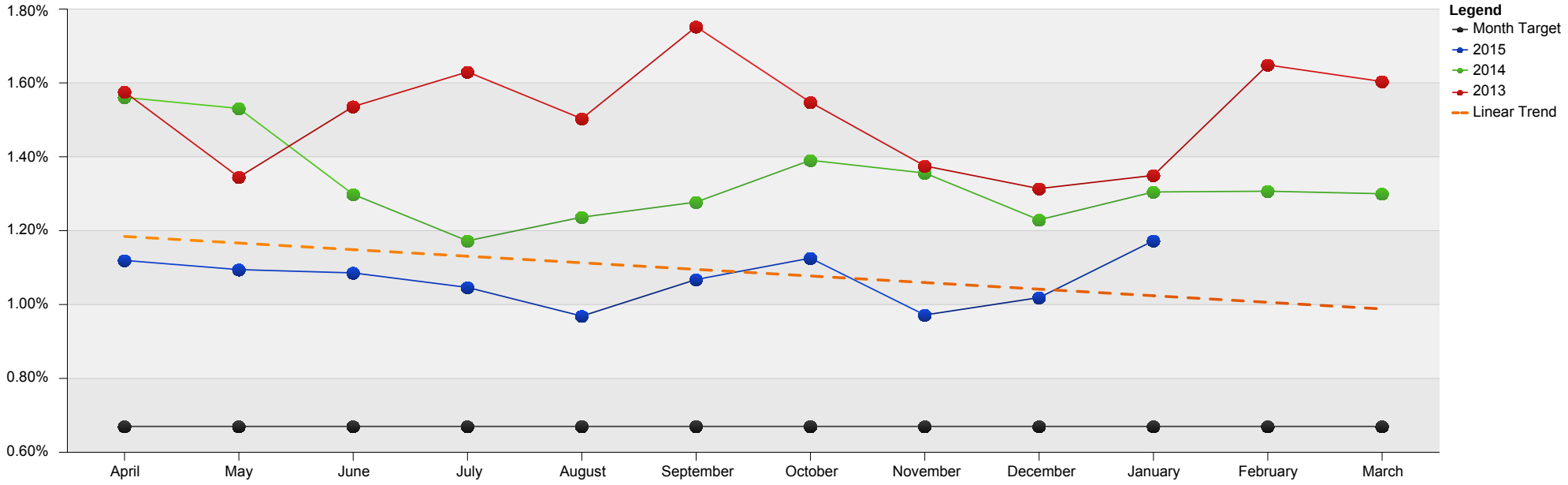


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	200.50	121.00	221.50	127.00	153.50	141.00	233.00	86.00	NA	NA		

Narrative
The Trust position for January 2016 is 200.50, which is 54.5 above the target of 146 but an improvement on December performance. The Trust position for the financial year to date is 121, which is 25 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



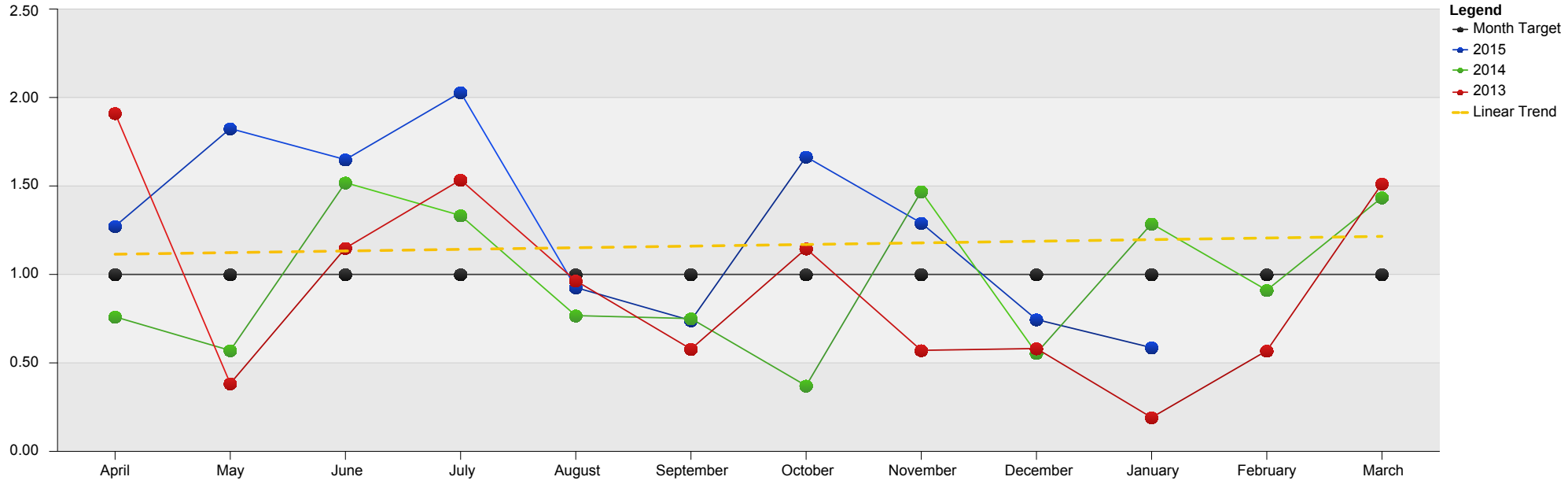
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of appointments cancelled by the Trust	1.17%	1.07%	1.28%	1.09%	0.97%	1.00%	1.49%	1.30%	0.22%	0.10%		

Narrative

The Trust position for January 2016 is 1.17%, which relates to 901 appointments out of 76840 that have been cancelled. This is 0.50% above the target of 0.67% and a deterioration compared to December performance. The Trust position for the financial year to date is 1.07%, which is 0.40% above target. Only Forensic services are achieving target.Work continues to implement the new outcome codes within the services. The Information Service Managers in all localities are continuing to address data quality issues within this area. 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



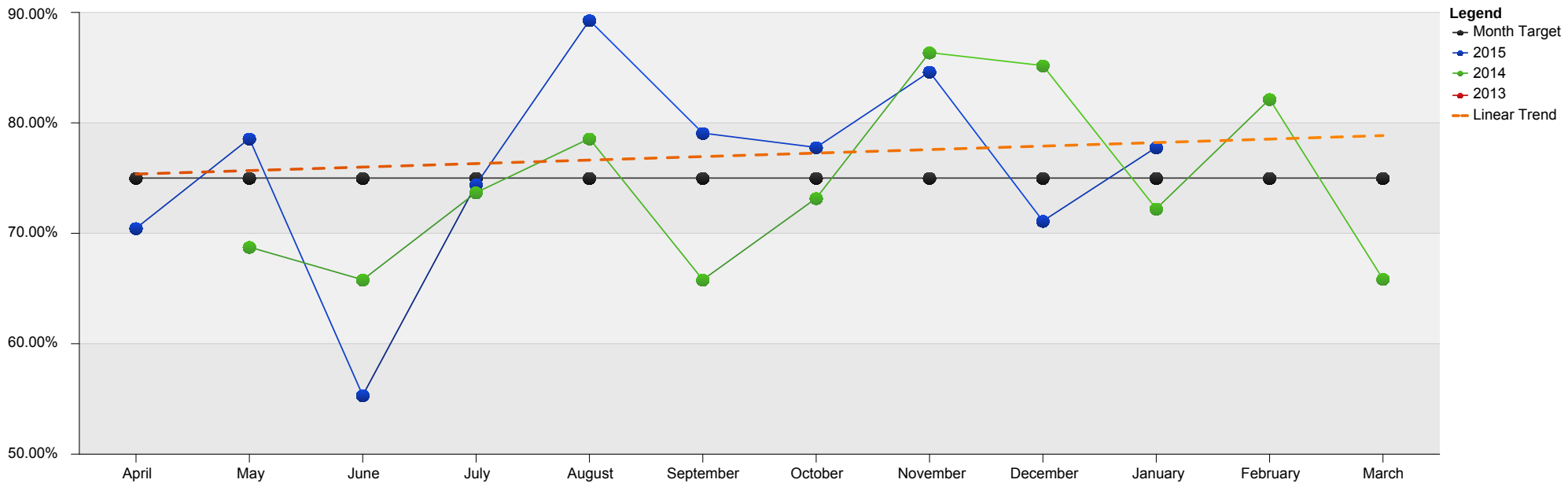
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.59	12.78	0.91	11.01	0.62	12.23	0.00	16.40	0.00	25.73		

Narrative

The Trust position for January 2016 is 0.59, which is 0.41 below the target of 1.00 and an improvement on December performance. This rate relates to 3 unexpected deaths, 1 in Teesside and 2 in Durham & Darlington Services. The Trust position for the financial year to date is 12.78, which is 2.78 above target.Performance has improved across the year; however the number of deaths classed as serious incidents has primarily been higher than the equivalent months in 2014/15 & 2013/14. Based on this it is likely that we will 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)

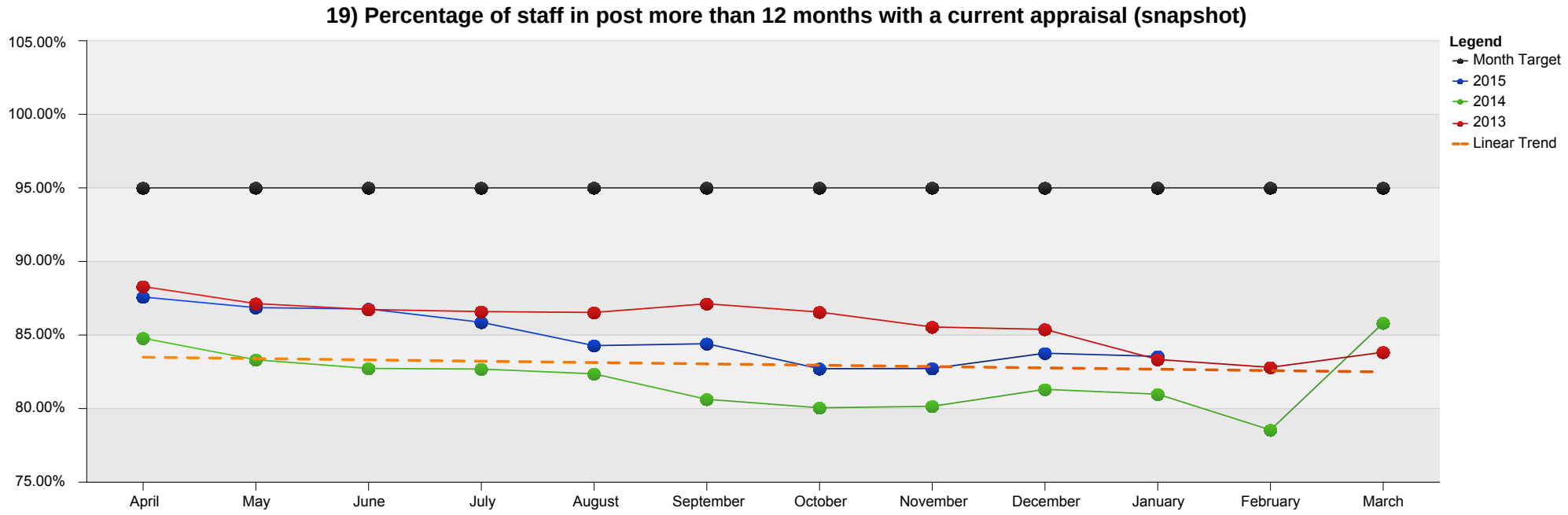


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	77.78%	74.47%	100.00%	88.29%	63.64%	85.00%	100.00%	71.43%	42.86%	41.46%		

Narrative

The Trust position reported in January relates to December performance. The Trust position for December 2015 is 71.78% with 8 wards out of 36 surveyed not scoring higher than 80%. This is 2.78% above the target of 75.00% and is an improvement on November's position. Durham & Darlington 100% and North Yorkshire 100% achieved target. Teesside are reporting 63.64% (4 wards) and Forensics are reporting 42.86% (4 wards).All teams are monitoring surveys and work closely with Patient Experience to investigate any trends. The Trust position for financial year to date is 74.47%, which is 0.53% below target. Performance at Trust level is reporting a slightly improving trend and 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

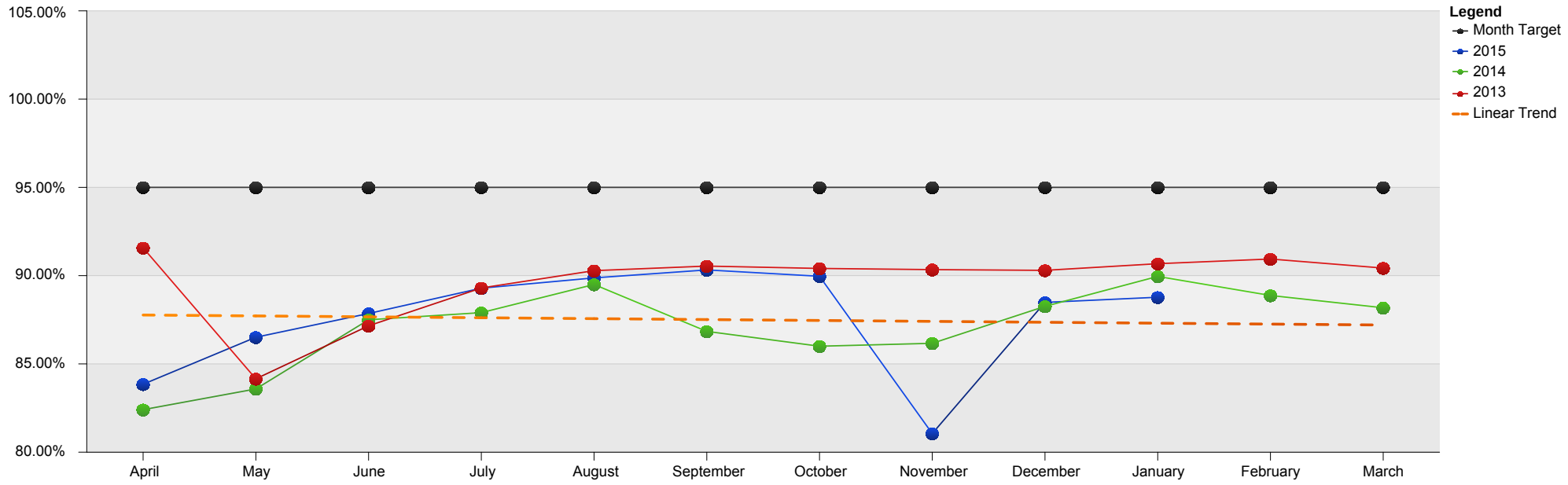


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	83.55%	83.55%	79.96%	79.96%	87.80%	87.80%	85.30%	85.30%	86.72%	86.72%	44.44%	44.44%

Narrative
The Trust position for January 2016 is 83.55% which relates to 852 members of staff out of 5179 that do not have a current appraisal. This is 11.45% below the target of 95%; which is comparable to the figure reported in December. The compliance figure is 83.62% when York and Selby figures are excludedManagers 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. 14 staff had their pay progression withheld at the end of January due to non-compliance of mandatory training and/or appraisal; 26 staff are due to have their increment withheld at the end of February. Despite performance consistently reporting higher than that during 2014/15, based on the deteriorating trend and January's performance there remains a significant risk that we will not achieve the annual target of 95%, unless further action is taken.The annual outturn for 2014/15 was 85.41%.

Trust Dashboard Graphs for TRUST

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

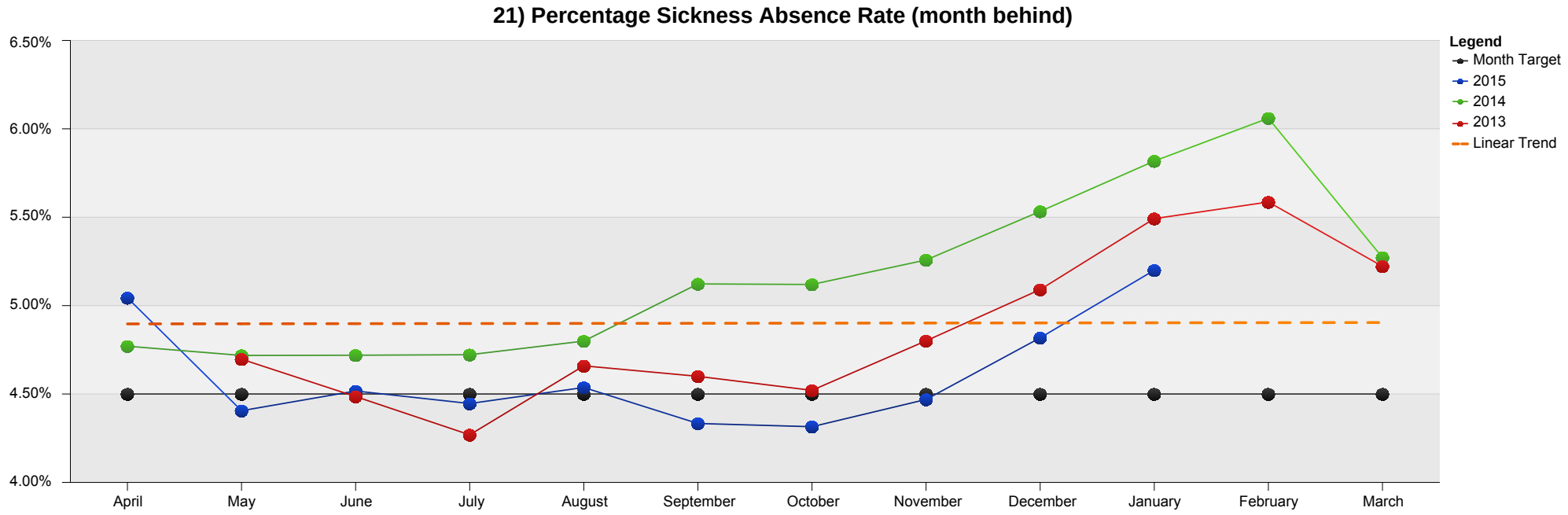


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Percentage compliance with mandatory and statutory training (snapshot)	88.78%	88.78%	89.35%	89.35%	91.83%	91.83%	87.82%	87.82%	92.03%	92.03%	67.39%	67.39%

Narrative

The position for January 2016 is 88.78%. This is 6.22% below the target of 95% but an improvement on December 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 91% when York and Selby figures are excluded. This is an improvement on the 82.43% achieved in November.Development work is underway to enhance the available HR related information available through IIC. It is envisaged that this will include more detailed information reports relating to appraisal and mandatory & statutory training that highlight competencies due to expire, in addition to those that have already expired. It is hoped this will support managers to proactively manage these key performance indicators.Based on past performance there remains a risk that we will not achieve the annual target of 95%, unless further action is taken.The annual outturn for 2014/15 was 82.29%.

Trust Dashboard Graphs for TRUST



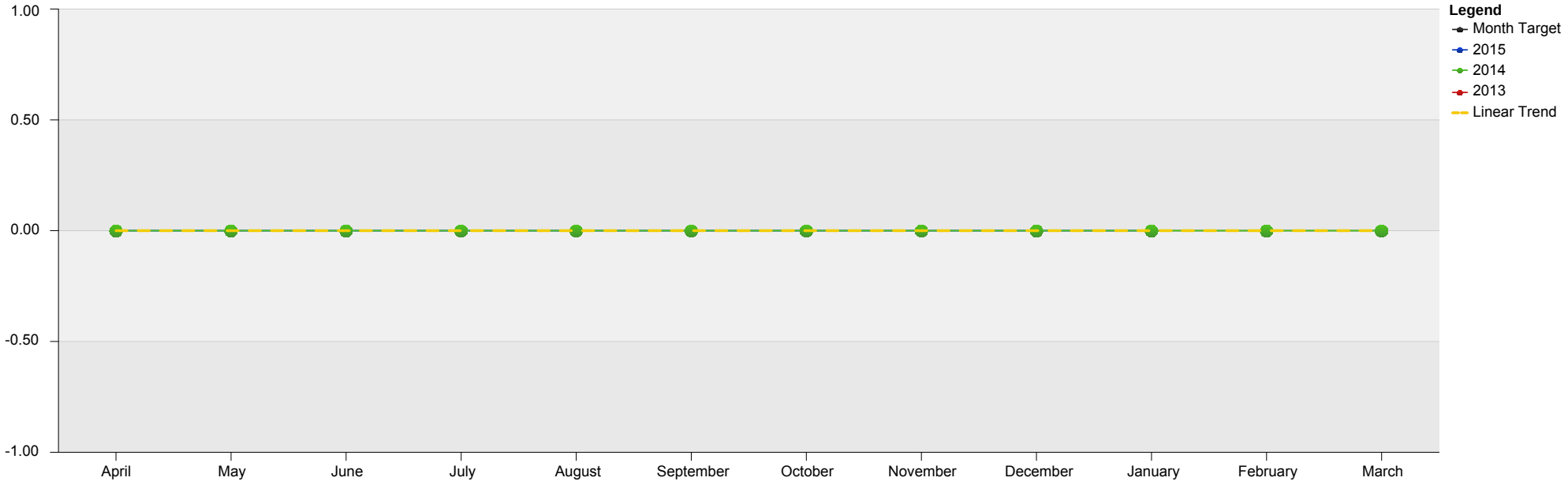
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Percentage Sickness Absence Rate (month behind)	5.20%	4.62%	5.52%	4.57%	5.92%	5.04%	5.58%	4.54%	5.73%	5.86%	6.11%	6.33%

Narrative

The Trust position reported in January relates to the December sickness level. The Trust position reported in January 2016 has risen to 5.20%, which is 0.7% above the Trust target of 4.50%. The Trust position for the financial year to date is 4.62%. The figure includes York and Selby sickness information. The figures reduce to 5.11% when York and Selby information is excluded. The figure reported is significantly below the sickness rate recorded for the same period last year which was 5.9%. Historically higher levels of sickness are reported between December and February. 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)

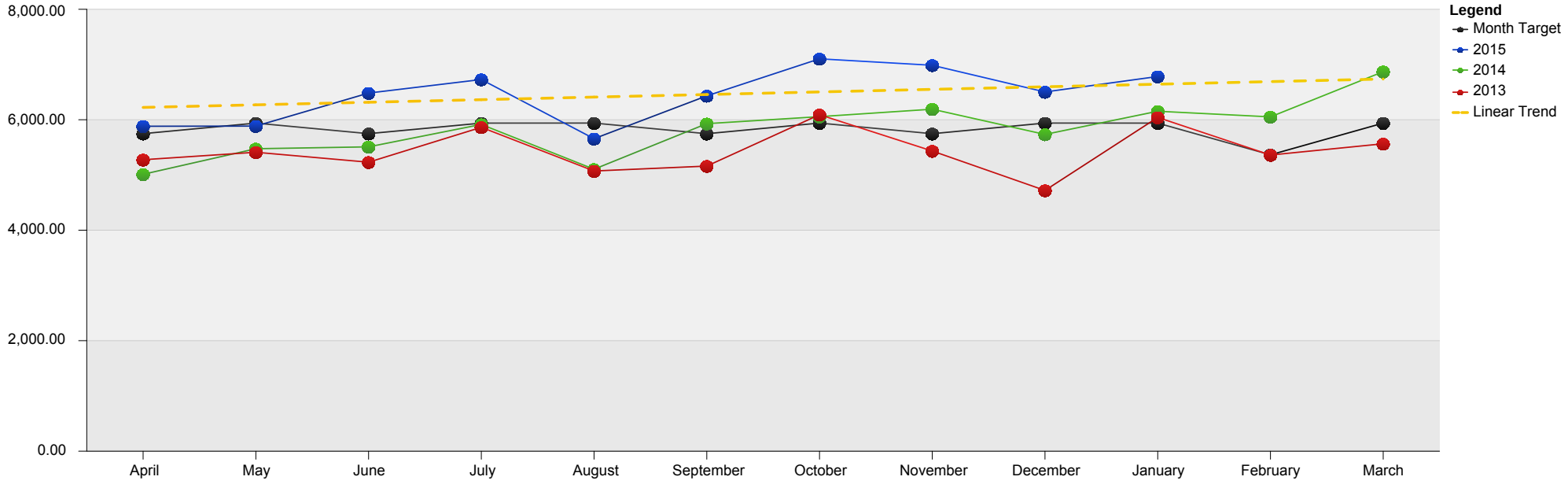


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00	0.00	0.00	0.00	0.00	0.00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

Narrative
The Trust position for January 2016 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

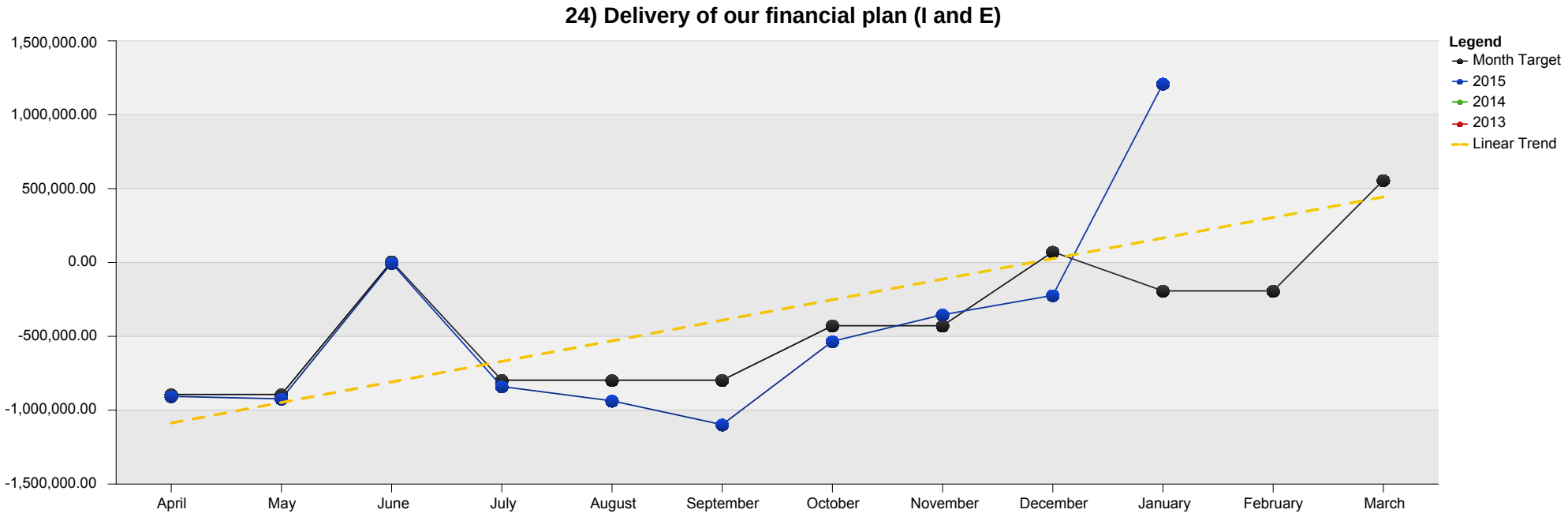
23) Total number of External Referrals into the Trust Services



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
23) Total number of External Referrals into the Trust Services	6,783.00	64,442.00	1,986.00	19,252.00	1,830.00	19,585.00	1,958.00	18,831.00	787.00	5,833.00	221.00	922.00

Narrative
The Trust position for January 2015 is 6,783 which is 844 above the Trust target of 5,939 and a slight increase on the number received in December. The Trust position for the financial year to date is 64,442 which is 5,815 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)	1,210,000.00	-4,610,000.00	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative

The Trust achieved a surplus of £4,610k for the financial year to date period ending 31 January 2016 which is equivalent to 1.8% of turnover and is £540k behind plan. This is largely due to a planned impairment of Trust property being £1,287k higher than anticipated. Excluding impairments the Trust is ahead of plan by £747k.The forecast outturn for the Trust is a deficit of £5,859k, however this includes £12,012k of additional impairments.Excluding impairments the forecast outturn for the Trust is a surplus of £6,153k which is £1,369k ahead of plan and due to non-recurrent surplus' in Corporate Services, higher than planned contract income and reduced PDC Dividend as a result of the asset revaluation.

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

	January 2016												April 2015 To January 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	98.00%	81.41%	98.00%	75.95%	98.00%	88.55%	98.00%	73.56%	98.00%	99.69%			98.00%	82.52%	98.00%	77.92%	98.00%	89.55%	98.00%	74.85%	98.00%	99.84%		
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	82.79%	98.00%	74.72%	98.00%	88.99%	98.00%	84.33%	98.00%	73.33%			98.00%	86.53%	98.00%	80.90%	98.00%	92.15%	98.00%	89.20%	98.00%	53.62%		
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%	64.58%	50.00%	63.64%	50.00%	69.57%	50.00%	33.33%	NA	NA			50.00%	71.87%	50.00%	62.23%	50.00%	80.47%	50.00%	71.43%	NA	NA		
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	87.72%	75.00%	97.88%	75.00%	42.31%	75.00%	89.74%	NA	NA			75.00%	83.85%	75.00%	98.43%	75.00%	55.59%	75.00%	75.06%	NA	NA		
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	97.09%	95.00%	100.00%	95.00%	90.00%	95.00%	95.19%	NA	NA			95.00%	94.53%	95.00%	99.82%	95.00%	80.68%	95.00%	93.21%	NA	NA		
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	15.00%	14.10%	15.00%	13.00%	NA	NA	15.00%	15.80%	NA	NA			15.00%	13.36%	15.00%	12.58%	NA	NA	15.00%	14.56%	NA	NA		
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	46.65%	50.00%	47.94%	50.00%	37.80%	50.00%	48.41%	NA	NA			50.00%	46.07%	50.00%	45.41%	50.00%	44.37%	50.00%	48.14%	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%	96.43%	95.00%	94.44%	95.00%	97.18%	95.00%	97.67%	NA	NA			95.00%	97.10%	95.00%	96.07%	95.00%	97.34%	95.00%	97.95%	NA	NA		
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.27%	95.00%	98.33%	95.00%	97.44%	95.00%	100.00%	NA	NA			95.00%	97.83%	95.00%	98.16%	95.00%	98.18%	95.00%	96.54%	NA	NA		
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.92%	98.00%	98.85%	98.00%	99.77%	98.00%	97.90%	98.00%	100.00%			98.00%	98.92%	98.00%	98.85%	98.00%	99.77%	98.00%	97.90%	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%	90.62%	85.00%	87.95%	85.00%	93.13%	85.00%	87.83%	85.00%	100.00%			85.00%	89.94%	85.00%	89.22%	85.00%	91.12%	85.00%	87.75%	85.00%	91.84%		

Trust Dashboard - Locality Breakdown for TRUST

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

	January 2016												April 2015 To January 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	15.93%	15.00%	19.35%	15.00%	13.33%	15.00%	19.67%	NA	NA		3.85%	15.00%	16.66%	15.00%	17.17%	15.00%	10.80%	15.00%	25.31%	NA	NA		6.59%
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	23.61%	15.00%	24.00%	15.00%	22.22%	15.00%	26.32%	NA	NA			15.00%	24.62%	15.00%	23.08%	15.00%	22.71%	15.00%	28.44%	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)	18.00	21.00	5.00	5.00	5.00	11.00	6.00	4.00	NA	NA			175.00	222.00	54.00	76.00	54.00	70.00	66.00	75.00	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	200.50	146.00	221.50	146.00	153.50	146.00	233.00	NA	NA			146.00	121.00	146.00	127.00	146.00	141.00	146.00	86.00	NA	NA		
16) Percentage of appointments cancelled by the Trust	0.67%	1.17%	0.67%	1.28%	0.67%	0.97%	0.67%	1.49%	0.67%	0.22%			0.67%	1.07%	0.67%	1.09%	0.67%	1.00%	0.67%	1.30%	0.67%	0.10%		
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.59	1.00	0.91	1.00	0.62	1.00	0.00	1.00	0.00			10.00	12.78	10.00	11.01	10.00	12.23	10.00	16.40	10.00	25.73		
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	77.78%	75.00%	100.00%	75.00%	63.64%	75.00%	100.00%	75.00%	42.86%			75.00%	74.47%	75.00%	88.29%	75.00%	85.00%	75.00%	71.43%	75.00%	41.46%		

Trust Dashboard - Locality Breakdown for TRUST

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

	January 2016												April 2015 To January 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	83.55%	95.00%	79.96%	95.00%	87.80%	95.00%	85.30%	95.00%	86.72%	95.00%	44.44%	95.00%	83.55%	95.00%	79.96%	95.00%	87.80%	95.00%	85.30%	95.00%	86.72%	95.00%	44.44%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.78%	95.00%	89.35%	95.00%	91.83%	95.00%	87.82%	95.00%	92.03%	95.00%	67.39%	95.00%	88.78%	95.00%	89.35%	95.00%	91.83%	95.00%	87.82%	95.00%	92.03%	95.00%	67.39%
21) Percentage Sickness Absence Rate (month behind)	4.50%	5.20%	4.50%	5.52%	4.50%	5.92%	4.50%	5.58%	4.50%	5.73%	4.50%	6.11%	4.50%	4.62%	4.50%	4.57%	4.50%	5.04%	4.50%	4.54%	4.50%	5.86%	4.50%	6.33%

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

	January 2016												April 2015 To January 2016											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
23) Total number of External Referrals into the Trust Services	5,939.00	6,783.00	1,939.00	1,986.00	1,985.00	1,830.00	1,826.00	1,958.00	189.00	787.00		221.00	58,627.00	64,442.00	19,141.00	19,252.00	19,595.00	19,585.00	18,024.00	18,831.00	1,867.00	5,833.00		922.00
24) Delivery of our financial plan (I and E)	-192,700.00	1,210,000.00	NA	NA	NA	NA	NA	NA	NA	NA			-5,149,700.00	-4,610,000.00	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

		Jan-16				October 2015 - January 2016			Annual
		Target	Month	Status	Change on previous month	Target	YTD	Status	Target
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral								
2	Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral								
3	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	50.00%	55.56%	●	↓	50.00%	56.41%	●	50.00%
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral *	75.00%	90.22%	●	↑	75.00%	86.28%	●	75.00%
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral*	95.00%	98.91%	●	↓	95.00%	99.12%	●	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%	9.65%	●	↑	15.00%	8.21%	●	15.00%
7	Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery*	50.00%	48.78%	●	↑	50.00%	41.16%	●	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%	84.62%	●	↑	95.00%	89.80%	●	95.00%
9	Percentage CPA 7 day follow up (AMH)*	95.00%	100.00%	●	–	95.00%	95.24%	●	95.00%
10	Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	96.04%	●	↓	98.00%	96.04%	●	98.00%
11	Percentage of community patients who state they have been involved in the development of their care plan (month behind)								

		Jan-16				April 2015 - January 2016			Annual
		Target	Month	Status	Change on previous month	Target	YTD	Status	Target
12	The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP)								
13	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)								
14	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)								
15	Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)								
16	Percentage of appointments cancelled by the Trust								
17	Number of unexpected deaths classed as a serious incident per 10,000 open cases								
18	Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)								
Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce									
19	Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	58.00%	●	↑	95.00%	58.00%	●	95.00%
20	Percentage compliance with mandatory and statutory training (snapshot)	95.00%	67.39%	●	↑	95.00%	67.39%	●	95.00%
21	Percentage Sickness Absence Rate (month behind)	4.50%	6.11%	●	↑	4.50%	6.39%	●	4.50%
Strategic Goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve									
22	Number of reds on CQC action plans (including MHA action plans)								
23	Total number of External Referrals into the Trust Services								
24	Delivery of our financial plan (I and E)								

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

Data Quality Assessment

Appendix C

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

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

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

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death	1																				**1**
Natural causes	1					1															**2**
Hanging	3	1	2								1						1		1		**9**
Suicides	6	3	6										1				1				**17**
Open	1		1																		**2**
Drug related death	1	2																			**3**
Drowning																					**0**
Misadventure	1		1																		**2**
Awaiting verdict	20	10	5	1		1		1			1	2	3			1	5		1		**51**
Total	**34**	**16**	**15**	**1**	**0**	**2**	**0**	**1**	**0**	**0**	**2**	**2**	**4**	**0**	**0**	**1**	**7**	**0**	**2**	**0**	**87**

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	3		

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

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
39	25	20	3	0

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

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

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

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

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

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd February 2016**
TITLE:	**Trust Dashboard 16/17 Proposed Targets**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communications**
REPORT FOR:	**Discussion and 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 purpose of this report is to present to the Board of Directors the proposed targets for the agreed Key Performance Indicators for the 16/17 Trust Dashboard for discussion and agreement

Recommendations:

- The Board of Directors are asked to discuss and agree the proposed targets/approaches in Appendix A
- The Board of Directors are also asked to support the proposals outlined in 3.3 and 3.4

MEETING OF:	**Board of Directors**
DATE:	**23rd February 2016**
TITLE:	**Trust Dashboard 16/17 Proposed Targets**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors the proposed targets for the agreed Key Performance Indicators for the 16/17 Trust Dashboard for discussion and agreement.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In October 2015, as part of the Board Business Planning Event, members of the Board, EMT and Senior Clinical Directors discussed the Trust Dashboard for 16/17 as part of the planning process.

2.2 In November 2015, the Board of Directors discussed and agreed the final set of Key Performance Indicators for inclusion in the 16/17 Trust Dashboard.

3. KEY ISSUES:

3.1 As part of the 16/17 development process, targets must be set for each of the indicators identified. A range of methodologies are used for target setting including compliance with National Monitor Targets and internal improvements. The target setting for 16/17 is slightly more complex than previous years with the inclusion of York & Selby Locality where baseline data isn't available for the majority of the indicators. Therefore we have suggested **targets** for some of the Key Performance Indicators and an **approach** for the remaining Key Performance Indicators where further information is needed.

3.2 Executive Management Team reviewed the proposals identified by the Corporate Performance Team on the 3rd February 2016 and discussed the targets/approaches for each of the Key Performance Indicators. The final recommended targets/approaches are detailed in Appendix A.

3.3 Given the complexities of target setting for 16/17 and in some cases a lack of baseline data for York & Selby Locality, it is proposed that we review the targets after 3 and 6 months to ensure they are still appropriate, and where necessary these will be revised.

3.4 In addition the Executive Management Team supported the following proposals suggested by the Corporate Performance Team:

- Removal of indicator **100% Compliance with Monitor Targets** as the data will always be a month behind given it's a composite indicator based on a number of sub indicators. Instead a monthly "Monitor Scorecard" will be monitored by the Corporate Performance Team and by **exception** reported to the Trust Board within the covering paper of the monthly Trust Dashboard.

- The introduction of “amber” traffic lights for the majority of indicators in order to be clearer about the level of risk (which will be evidenced by “red” traffic lights). Proposed thresholds for these ambers are contained within Appendix A for consideration.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** There are no CQC implications arising from this report.

4.2 **Financial/Value for Money:** Financial measures are included in the key performance indicators for 16/17.

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

4.4 **Equality and Diversity:** There are no direct equality and diversity implications arising from this report.

4.4 **Other implications:** There are no other implications arising from this report.

5. RISKS:

5.1 There are no direct risks associated with this report.

6. CONCLUSIONS:

6.1 The Corporate Performance Team in consultation with the Executive Management Team have proposed targets/approaches for each of the Key Performance Indicators in the 16/17 Trust Dashboard.

7. RECOMMENDATIONS:

7.1 The Board of Directors are asked to discuss and agree the proposed targets/approaches in Appendix A

7.2 The Board of Directors are also asked to support the proposals outlined in 3.3 and 3.4

Sarah Theobald
Head of Corporate Performance

Background Papers:

Trust Dashboard 16/17 Proposed Targets **Appendix A**

No.	Trust Dashboard KPI	Current 15/16 Target	Current Forecast for 15/16	Proposed Target	Proposed Approach	Thresholds	Comments
Activity							
1	Number of External Referrals into Trust Services	69,931	77,331	TBC	13% increase on the out-turn to reflect inclusion of York & Selby* **minus the number of referrals to Tees IAPT*	G) within 5% of target A) between 5 and 10% of target R) 10% below or above target	Previous target setting was to maintain out-turn and given pressures on the teams it is not thought appropriate to propose an increase; however given the expansion into York & Selby it is proposed that a **13% increase on the out-turn** is used (based on the weighted populations for AMH & MHSOP and the un-weighted population for CYP). *Data for Tees IAPT will be removed from the baseline given we will no longer provide this service from April 16.
2	Caseload turnover	N/A	N/A	TBC	% improvement	TBC	Target to reflect an improvement based on the %age improvement that could be achieved by all teams moving to average caseload turnover eg if all teams moving to average delivered a 20% improvement then we would look to set a target below 20% but at a level we think is achievable. Work is ongoing to identify the baseline
3	Number of patients with a length of stay over 90 days (AMH and MHSOP A&T Wards)	N/A	N/A	TBC	% reduction	G) on target or less A) up to 5% above target	To calculate baseline on out-turn and given the expansion into York & Selby would suggest increase by 13% (based on the weighted populations for AMH & MHSOP) then an **overall**

						R) 5% or more above target	**reduction** (based on general trend of discharged patients from the EMT OOL/OOA report)
No.	**Trust Dashboard KPI**	**Current 15/16 Target**	**Current Forecast for 15/16**	**Proposed Target**	**Proposed Approach**	**Thresholds**	**Comments**
4	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	N/A	N/A	85%	N/A	G) 85-87.5% A) 82.5-84.9% or 87.5-90.0% R) Less than 82.5% or more than 90%	This is the existing bed occupancy target within the Trust for Assessment & Treatment Wards as well as the national recommended occupancy rate.
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15%	24.62%	15%	N/A	G) 15% or less A) 15-20% R) More than 20%	Same as 15/16 target subject to current detailed analysis being undertaken.
6	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	209	267	237	N/A	G) 0-237 (on target or less) A) 237-249 (up to 5% above target) R) 250 or more (5% or more above target)	15/16 target increased by 13% (based on the weighted populations for AMH & MHSOP) subject to current detailed analysis being undertaken.
Quality							
7	Number of unexpected deaths classed as a serious incident per 10,000 open cases	12.00	12.78	12.00	N/A	G) 12.00 or less A) 12.01-13.20 (within 10% of target) R) 13.20 or more (10% or	Same as 15/16 target

						more above target)	
No.	**Trust Dashboard KPI**	**Current 15/16 Target**	**Current Forecast for 15/16**	**Proposed Target**	**Proposed Approach**	**Thresholds**	**Comments**
8	Percentage of patients seen within 4 weeks for a first appointment following an external referral	98%	82.52%	90%	N/A	G) 90% or more A) 85-89.9% R) Less than 85%	Reduction to accommodate expansion into York & Selby where overall performance not known and pressures within existing services.
9	Percentage of Out of Locality Admissions to assessment and treatment wards (AMH & MHSOP)	15%	16.66%	15%	N/A	G) 15% or less A) 15-20% R) More than 20%	Same as 15/16 target
10	Percentage of patients surveyed reporting their overall experience as excellent or good	N/A	N/A	TBC	Maintain out-turn	G) on target or less A) up to 5% below target R) 5% or more below target	Maintain the out-turn with the knowledge that the data will start to include York & Selby over the year
11	Percentage of appointments cancelled by the Trust	0.67%	1.07%	0.67%	N/A	G) 0.67% or less A) 0.67-0.70% (within 5% or target) R) More than 0.70% (more than 5% above target)	Same as 15/16 target
12-13	Outcome measure - to await for Monitor confirmation on payment mechanisms	N/A	N/A	TBC	TBC	TBC	Details still awaited - possible 2 outcome measures

	for Adult Mental Health and Mental health Services for Older people						
No.	**Trust Dashboard KPI**	**Current 15/16 Target**	**Current Forecast for 15/16**	**Proposed Target**	**Proposed Approach**	**Thresholds**	**Comments**
Workforce							
14	Percentage Sickness Absence	4.5%	4.62%*	4.5%	N/A	G) 4.5% or less A) 4.51-4.99% R) More than 4.99%	Same as 15/16 target *December data included for Y&S
15	Percentage of staff in post more than 12 months with a current appraisal	95%	83.55%*	95%	N/A	G) 95% or more A) 88.00% - 94.99% R) Less than 88%	Same as 15/16 target and current threshold *December data included for Y&S
16	Percentage compliance with mandatory and statutory training	95%	88.78%*	95%	N/A	G) 95% or more A) A) 88.00% - 94.99% R) Less than 88%	Same as 15/16 target and current threshold *December data included for Y&S
17	Actual number of workforce in month	N/A	N/A	90-95%	N/A	None – within target otherwise red	(Establishment 90%-95%)
18	Percentage of registered healthcare professional jobs that are advertised two or more times	N/A	N/A	5%	N/A	G) 5% or less A) 5-7.5% R) 7.5% or more	e.g. 5% which would equate to 1 in 20 jobs that are advertised two or more times
Money							
19	Are we delivering our financial plan (Income and Expenditure)	£4,784,000	FYTD Actual £4,610,000	Achievement of Plan	N/A	None – within target otherwise red	To be set once Financial Plan approved

			Target £5,149,700				
20	Delivery of CRES against plans	N/A	N/A	Achievement of Plan	N/A	None – within target otherwise red	To be set once Financial Plan approved
21	Cash against plan	N/A	N/A	Achievement of Plan	N/A	None – within target otherwise red	To be set once Financial Plan approved

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 14

FOR GENERAL RELEASE

Board of Directors

DATE:	**23rd February 2016**
TITLE:	**Strategic Direction Performance Report – Quarter 3 2015-16**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 3 (31st December) 2015/16.

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

The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics; however the overall position remains positive in line with quarter 2. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

Recommendations:

The Board of Directors are asked to receive this report and provide comment/ feedback as appropriate.

MEETING OF:	**Board of Directors**
DATE:	**23rd February 2016**
TITLE:	**Strategic Direction Performance Report – Quarter 3 2015-16**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 3 (31st December) 2015/16.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

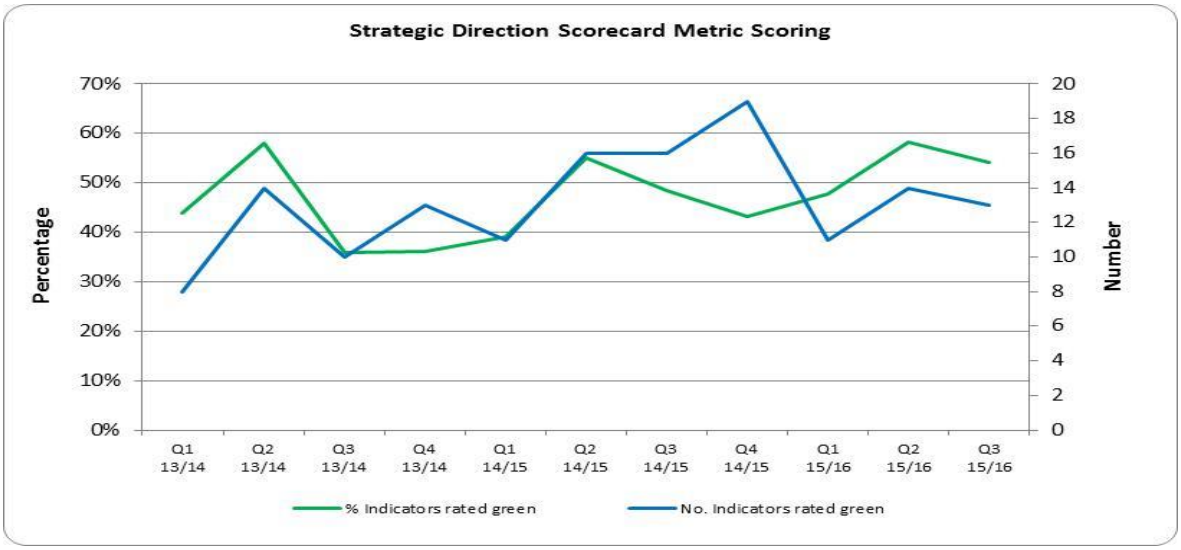
3.1 Trust Strategic Direction Scorecard

The Strategic Direction Scorecard is shown under each strategic goal.

The following table and graph provide a summary of the RAG ratings at quarter 3 compared to the position in the previous quarter (Q2) and the previous financial years 2014/15 and 2013/14:

	2013/14 Actual		2014/15 Actual		Q1 2015/16		Q2 2015/16		Q3 2015/16		2015/16 Actual YTD	
	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	11	31%	18	42%	11	48%	14	58%	13	54%	14	54%
Indicators rated red	25	69%	25	58%	12	52%	11	46%	11	46%	12	46%
Indicators with no target	5		2		1		1		1		1	
Indicators currently under development/being finaliased	1		1		2		2		2		2	
Indicators where data is not yet available/not applicable in qtr	5		0		12		10		11		9	

The percentage is based on the number of indicators that can be RAG rated (24 for quarter 3). The NHS Employers Assessment of Wellbeing (KPI 20) is now being reported with data included for quarter 2, therefore the number of indicators rated green has been increased and the number of indicators with data not available has decreased by 1.



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

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of 7 as at quarter 3, with 1 indicator showing an improvement on the quarter 2 position.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16										
	Indicator	Q3 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)										
1	Percentage of patients surveyed reporting their overall experience as excellent or good	>90.14%	89.96%	92.32%	91.81%	↓	>90.14%	91.44%	>14/15 out-turn	>18/19 out-turn
2	Percentage of patients who have not waited longer than 4 weeks from "referral " to "assessment" for external and internal referrals	98.00%	83.94%	83.67%	85.32%	↑	98.00%	84.30%	98.00%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	78.05%	80.34%	80.16%	↓	85.00%	79.49%	85.00%	tbc
4	Number of community teams who have implemented the model line way of working	2	2	3	2	↔ *	7	7	11	tbc
5	The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)	Surveys: Top 20% of MH Trusts	Results due in Q3	Results due in Q3	YES	↔	Surveys: Top 20% of MH Trusts	YES	Surveys: Top 20% of MH Trusts	Surveys: Top 20% of MH Trusts
6	The Trust ranks in the top 10th percentile of all mental health Trusts for the NHS Staff Survey (annual)	n/a	Results due in Q4	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	Surveys: Top 10% of MH Trusts	Surveys: Top 10% of MH Trusts
7	Percentage of service users with a recovery focussed action plan (Adult Mental Health)	95.00%	94.29%	93.46%	93.18%	↓	95.00%	93.18%	95.00%	95.00%

*KPI 4 (Model lines) arrow shows as “no change” on the previous quarter as there is no improvement or deterioration but achieved the planned target for this quarter.

Indicators of concern are:

- **KPI 2 - Percentage of patients who have not waited longer than 4 weeks from "referral" to "assessment" for external and internal referrals** – the Trust position for quarter 3 is 85.32% against a target of 98% which is a small reduction on the quarter 2 position.

  All localities are reporting below target with Durham and Darlington the lowest at 78.95% and North Yorkshire slightly above at 80.69% although both areas are showing an improvement on the quarter 2 position.

  Within Durham and Darlington locality, the main areas of underperformance are in relation to Adult Mental Health services (AMH) and Children and Young People's Services (CYP). Within the AMH Access teams recruitment is being progressed and all vacancies have been filled except for one. CYP resources are being aligned to assist teams to achieve target but the service is experiencing significant number of vacancies in addition to long term sickness absences.

  Within North Yorkshire locality all services are under performing, reporting issues relating to the levels of sickness, vacancies and maternity leave within the teams. Recruitment is ongoing although some staff are yet to commence employment. The MHSOP Memory Service action plan was delayed due to sickness; however staff have since returned to work and the action plan is back on track. The position has shown an improvement as at the end of January 2016. CYP have also been impacted by a rise in demand and sickness but new staff have commenced their post so improvements are expected in the forthcoming months.

- **KPI 3 – Percentage of patients reporting "yes always" to the question "did you feel safe on the ward"** – the Trust position for quarter 3 is 80.16% against a target of 85% and reflects a small reduction on the quarter 2 position.

  Only Teesside is achieving target. Of those reporting under performance, Durham and Darlington report the highest performance at 83.62% and Forensic Services the lowest at 60.14%. All localities are reporting some areas of concern as detailed below:

  Durham and Darlington – **Willow ward** reports 42.86% of patients completing the survey felt safe (3 out of 7). In an effort to combat some bullying behaviour demonstrated by a minority of patients the level of staffing was increased pending a patient relocation. An anti-bullying campaign was completed for patients and staff together with some additional "Raising Awareness" training for staff. **Tunstall ward** reports 70.59% of patients completing the survey felt safe (24 out of 34). The ward had a cluster of patients that were very distressed or agitated that had an impact on the other patients' mental health wellbeing. The ward ensured that all patients were

spoken to and supported. Weekly patient meetings are held to enable patients to express concerns regarding the care they receive and staff can signpost patients to other support services when necessary and appropriate.

Teesside – **Overdale ward** reports 78.72% (37 out of 47) of patients completing the survey felt safe. The ward holds regular meetings with patients to understand why the survey results are low for this indicator. Feedback from patients has confirmed that they do not feel safe as a direct result of their own mental illness. Patients have identified a need to increase activities so the ward has begun the process of recruiting volunteers to support this, using Occupational Therapy out of hours and increasing ward based activities. The wards have also added the "feel safe" question to their weekly patient meeting to obtain real time feedback and facilitate the ward responding immediately to any issues raised.

North Yorkshire – Cedar Ward (Harrogate) reports 55.56% of patients completing the survey felt safe (15 out of 27). The ward is actively working to improve this by putting patient safety on the weekly patient meeting agenda so that any areas of concern in relation to patient safety are discussed and addressed immediately and the Trust wide "Safe Wards" project has been implemented.

Forensic Services – Hawthorn and Runswick wards reports 0% of patients felt safe on the wards out of 6 patients. During the reporting period both wards had difficult situations to manage that impacted on both patients and staff. **Kestrel and Kite wards** reports 0% of patients completing the survey felt safe out of 5. Both wards experienced safeguarding issues during quarter 3. During the reporting period both wards had difficult situations to manage that impacted on both patients and staff. The ward increased enhanced observations and increased staffing levels when it was necessary. **Linnett ward** reports 33.33% of patients felt safe on the ward (4 out of 12). The ward has some unwell and unsettled patients whom the team are currently managing but the ward continues to implement ways to improve in this area. This includes "feeling safe" discussions in community meetings, staff meetings and in supervision sessions; provision of one to one discussions with patients on request; collaborative completion of "My Shared Pathway" intervention plans; the continuation of resource programmes and psychology sessions for patients. **Kirkdale ward** reports 40% of patients felt safe on the ward (10 out of 25). However investigations confirm this is a data quality issue.

- **KPI 7 - Percentage of service users with a recovery focussed action plan (Adult Mental Health)** – the Trust position for quarter 3 is 93.18% against a target of 95% which is a small reduction on the quarter 2 position.

  All localities are under reporting with Teesside reporting the highest performance at 93.63% and Durham and Darlington the lowest at 92.68%. There are two concerns to note in relation to the achievement of this indicator:
  - All services have access to IIC to monitor the Recovery Star tool for patients on the assertive outreach and psychosis team's caseloads. Both

Tees and Durham and Darlington Assertive Outreach teams are achieving the target of 95% and North Yorkshire Assertive Outreach teams are showing an improvement. However for the Durham and Darlington and Tees Psychosis teams caseloads it is not clinically appropriate to complete a Recovery Star tool immediately after referral; discussions about recovery usually take place with the patient after 12 weeks, dependent on the individual circumstances of the patient.

- An additional impact on the achievement of this indicator relates to significant staffing issues experienced in some teams within Durham and Darlington locality which are being addressed and are expected to improve in the forthcoming months.

Additional information to note:

- **KPI 4 – Number of community teams who have implemented the model line way of working** – the Trust position for quarter 3 is 2, which is achieving the target of 2. However it should be noted that the annual target of 11 will not be achieved. The suggested target of 11 originally set for the Business Development scorecard was incorrect. The original plans for 2015/16 were to have 7 teams implement the "model line way of working" which has now been achieved and there are no further teams planned to implement model lines under the current project structure. The model lines project will cease in March 2016 and this work will be incorporated into the new Community Productivity project. **Therefore the Board of Directors are asked to approve the annual target of 11 be reduced to 7.**

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 3 were rated green (95.1%) which was an improvement on Q2 (85.3%). Whilst 9.0% of the priorities / service developments in the Business Plan are at high risk of failure to deliver on-time or within budget, this is an improvement on the Q2 position (11.6%).

The 9.0% represents 14 priorities / service developments. Of these:

- 7 are recommended for removal from the Plan for which Board approval is needed
- 1 requires a change in completion date to 16/17 for which Board approval is needed but this does not significantly impact on overall achievement of this Strategic Goal
- 4 require "in-year" timescale changes which have been agreed by EMT
- 2 require changes to project plans and revised PM2a forms are to be developed

There is also 1 action which is grey as this cannot now be delivered due to reasons external to the Trust and the Board is required to approve its removal. There are a further 2 'grey' actions relating to changes in completion date to 16/17 for which Board approval is also needed.

Where a Board decision is required to change or remove an action, this is contained in Appendix 1 for approval.

3.2.3 Other Qualitative Intelligence

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

- **Positive Practice Mental Health Awards –** the Trust was announced as the winner for two categories of the Positive Practice Mental Health Awards on 14th October 2015:
    - The CAMHS Crisis and Liaison team in Durham and Darlington has been announced the winner of the category "Innovation in Child, Adolescent and Young People's Mental Health".
    - Talking Changes in Durham and Darlington was announced the winner for the category "Partnership Working".

- **Royal College of Psychiatrists** – Ward 15, The Friarage, Northallerton was announced as the winner for the Team of the Year award on 10th November 2015.

- **Nursing Times Awards 2015** – the Nursing Times Awards for 2015 took place on 12th November and the Trust had two finalists in the category of "Child and Adolescent Services":
    - The CAMHS Crisis and Liaison team in Durham and Darlington who were announced as the winners of the category.
    - Person Centred Care Planning for Young People with Emerging Personality Disorders.

- **Ministry of Justice - Grant Award** – The Ministry of Justice has awarded TEWV a grant of £83,702 to pilot develop and assess the proof of concept of schemes / initiatives which may reduce the risk of self-harm or self-inflicted death in prison to your organisation.

- **Assurance Visit by Commissioner to Kirkdale Ward** – the Trust received a positive Assurance Visit by NHS England (North) Commissioners to Kirkdale Ward, Roseberry Park on the 28th September 2015. Recommendations have been developed into an action plan to address these but overall the visit was positive.

- **Quality Visit by Commissioner to Harrier and Hawk Ward** - the Trust received a positive Quality Visit to Harrier / Hawk ward on 22nd December 2015 by NHS England (North) Commissioners. Some issues were suggested for consideration to improve patient and staff experience, which are being addressed by the service but overall the visit was positive.

- **Care Quality Commission (CQC) Community Mental Health Survey 2015 –** the survey was carried out on behalf of the Trust by Quality Health and analysed by the CQC and benchmarked against 55 other NHS Mental Health Trusts. The report was published on the CQC website on 21st October 2015. A total of 238 people took part in the survey giving a response rate of 29%. The survey is divided into 10 sections and the Trust scored highly overall in all areas. There are four areas where the Trust has scored significantly above what would be expected when compared with most other trusts within the survey. These are:
    - Organising Care (9/10)
    - Planning Care (7.6/10)
    - Reviewing Care (8/10)
    - Crisis Care (7.2/10)

  There were no areas where the Trust scored significantly below other Trusts. There is no statistically significant change in any of the scores when comparing the 2015 report to the Trust's 2014 report.

3.2.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs, Business Plan and qualitative intelligence, the overall position is positive and is improving with the exception of waiting times and there has been a declining trend in the percentage of service users with a recovery focused outcome plan from quarter 1 to quarter 3. The Trust Board received a detailed report in November 2015 on progress made towards the delivery of the waiting times standards. Further work was agreed and is currently being implemented.

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

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated red out of 8 as at quarter 3, and 1 indicator is rated green for the first time.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16										
	Indicator	Q3 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 2 (To continuously improve the quality and value of what we do)										
8	Number of outstanding action points for **more than 31 days** for Level 5 SUIs and action points for safeguarding serious case reviews and domestic homicide reviews	0	4	7	0	↑	0	0	0	0
9	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	8	1	11	↓	0	11	0	0
10	Friends & Family Test - **Patient** Survey Question: "How likely are you to recommend our ward/services to friends and family if they needed similar care or treatment?"	>89.75%	86.55%	88.07%	84.54%	↓	>89.75%	86.31%	>89.75%	> previous year out-turn
11	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	22.22%	75.00%	75.00%	↔	50.00%	56.00%	50.00%	>=75%
12	Percentage of staff reporting that they can 'contribute towards improvements at work'*	n/a	Results due in Q4	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	> 2014/15 and in top 20%ile for MH/LD Trusts	> 2018/19 and in top 20%ile for MH/LD Trusts
13	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"	n/a	82.87%	82.47%	n/a	n/a	n/a	82.69%	>77.85%	> previous year out-turn
14	For Trust hospital sites with over 10 beds, the trust score for each category (Cleanliness, Food, Privacy & Dignity, Condition, Appearance & Maintenance, Dementia Friendly) > national average PLACE (new PEAT) assessments.	80%	Assessment due in Q2	80.00%	80.00%	↔	80%	80.00%	80%	80%
15	Hospitality Assured Accreditation score*	n/a	Assessment due in Q4	Assessment due in Q4	Assessment due in Q4	n/a	n/a	Assessment due in Q4	82.00%	86.00%

Indicators of concern are:

- **KPI 9 - Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days** – the Trust position for quarter 3 is 11 against a target of zero and all relate to Clinical Audit.

  The 11 outstanding action points more than 31 days at the end of quarter 3 are from 9 audits. There are varied reasons for the delays. The longest time an action was outstanding was 122 days past the target date, 4 actions were outstanding for 92 days and 6 actions were outstanding 61 days.

  All of the 11 actions were completed as at 27th January 2016.

3.3.2 Trust Business Plan

The majority of the business plan actions are rated green (90.5%) as a quarter 3 which is a deterioration on quarter 2 (100.0%). There are 2 priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget. Both of these required "in-year" timescale changes which have been approved by EMT.

3.3.3 Other Qualitative Intelligence

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

- **Accreditation for Inpatient Mental Health Services (AIMS)** - accreditation was achieved for Rowan Lea in Scarborough within North Yorkshire MHSOP services. This is the first MHSOP ward to achieve this standard with the Trust.

- **Home Treatment Accreditation Scheme (HTAS) standard -** The crisis team in Scarborough achieved external recognition, having achieved the home treatment accreditation scheme (HTAS) standard. This is the first team to achieve this standard with the Trust

3.3.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs, the Business Plan and qualitative intelligence, the overall position remains positive. However further work is needed in terms of ensuring the completion of action points for Clinical Audit in a timely manner.

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

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 4 indicators rated red out of 12 as at quarter 3, although 1 of these is showing an improvement on the quarter 2 position. A further indicator has improved on the quarter 2 position and one on the quarter 1 position, although not rated.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16										
	Indicator	Q3 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 3 (To recruit, develop and retain a skillled, compassionate and motivated workforce)										
16	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"	n/a	71.04%	70.46%	n/a	n/a	>66.57%	70.77%	>66.57%	> previous year out-turn
17	Percentage of medical students and junior doctors reporting satisfaction with their placement	87.00%	91.03%	90.44%	87.46%	↓	87.00%	87.46%	87.00%	90.00%
18	Percentage of positive nursing placement evaluations received	95.00%	96.86%	91.50%	94.41%	↑	95.00%	95.42%	95.00%	95.00%
19	Excess cost of employing medical agency versus substantive	£100k	£251.9K	£240.2K	£374.5k	↓	£300k	£866.6k	£400k	zero
20	NHS Employers Assessment of Wellbeing	100%	due in Q2	100.00%	90.00%	↓	100%	92.31%	100%	100%
21	Percentage of Culture Metrics showing improvement at year end*	n/a	due in Q4	due in Q4	due in Q4	n/a	n/a	due in Q4	100%	100%
22	Percentage of positive staff responses for training/development evaluations received	n/a	72.04%	no data for Q2	91.52%	↑	n/a	75.30%	Collect Baseline	tbc
23	Percentage of staff reporting that they have had a 'well-structured appraisal in last 12 months'*	n/a	Results due in Q4	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	>= 2014/15 & in top 20%	>= 2018/19 & in top 20%
24	Percentage of medical staff successfully revalidated	100%	100.00%	90.91%	100.00%	↑	100%	97.78%	100%	100%
25	The variation in percentage responses to the questions in NHS Staff Survey of those who identified themselves as disabled compared to those who did not identified themselves as disabled*	n/a	Results due in Q4	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	70% points or less	50% points or less
26	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	40%	21.74%	50.00%	31.82%	↓	40.00%	36.71%	40.00%	80.00%
27	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	n/a	Results due in Q4	Results due in Q4	Results due in Q4	n/a	n/a	Results due in Q4	< previous year out-turn: <38%	< previous year out-turn

Indicators of concern are:

- **KPI 19 – Excess cost of employing medical agency versus substantive** – the Trust position for quarter 3 is £374.5k against a target of £100k which is a deterioration on the quarter 2 position. The incurred costs are a result of covering sickness leave and vacancies whilst recruitment is ongoing. As at the end of quarter 3, there were 19 vacancies across the Trust which are detailed below:
  - Durham – 1 (Adults)
  - Teesside - 2 (1 for AMH and 1 for MHSOP);
  - North Yorkshire - 4 (2 for AMH and 2 for MHSOP);
  - Forensic Services – 1 (FMH)
  - York & Selby – 11 (1 for AMH, 6 for MHSOP, 1 for CAMHS, and 3 junior doctors).

- **KPI 20 – NHS Employers Assessment of Wellbeing** – the Trust position for quarter 3 is 90% against a target of 100%. This is a result of 1 action out of 10 within the Health and Wellbeing action plan not being completed by the end of quarter 3. The delay for the action "Complete an initial review of the Employee Psychology service pilot for EMT" was incurred to allow time for the service to collate all the financial information that was required for the report. The timescale was revised to quarter 4 by EMT on 20th January 2016 and the full review report was provided to EMT on 27th January. Therefore this action is now complete.

- **KPI 26 - Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above** – the Trust position for quarter 3 is 31.82% against a target of 40% which is a deterioration on the quarter 2 position. This relates to 7 advertised posts with at least 2 internal candidates out of 22 advertised posts. The implementation of Talent Management within the Trust will support the delivery of this indicator. The importance of embedding this has been recognised in the Business Plan for 2016/17 to 2018/19.

3.4.2 Trust Business Plan

The majority of business plan actions are rated green (90.0%) as at quarter 3 which is an improvement on quarter 2 (85.7%). There is 1 priority / service development in the Business Plan at high risk of failure to deliver on time or within budget. This requires an "in-year" timescale change which has been agreed by EMT.

3.4.3 Other Qualitative Intelligence

- **NHS North East Leadership Academy** - 2015 awards and conference took place on 23rd November. There were 9 award categories and the Trust had finalists in 2 categories:
  - NHS Development Champion of the Year – Sarah Dexter-Smith and Jennifer Oddy
  - NHS Inspirational Leader of the Year – Amy Colling who was announced the winner of the category. Amy will also go forward to the national awards which will be held in March 2016 in London.

- **Mindfulness – an example of good practice -** a report from the Mindfulness All Party Parliamentary Group (APPG) published in October 2015 identifies the Trust's staff mindfulness project and clinical mindfulness team as examples of good practice**.**

3.4.4 In conclusion it can be seen for this strategic goal that taking into account progress against the quantitative KPIs, the Business Plan and qualitative intelligence, the overall position is positive; however the excess costs of employing medical agency remains a challenge.

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

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing no indicators rated red out of 5 as at quarter 3 and the overall change is positive, with 2 indicators showing an improvement on the quarter 2 position.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16										
	Indicator	Q3 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 4 (To have effective partnerships with local, national and international organisations for the benefit of the communities we serve)										
28	Attendance rate at H&WB Boards	90%	83.33%	57.14%	100.00%	↑	90%	82.61%	90%	90%
29	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	100.00%	100.00%	↔	98%	100.00%	98%	98%
30	Proportion of student nursing placements provided as a % of placements requested	90%	100.00%	99.48%	100.00%	↑	90.00%	99.80%	90.00%	90.00%
31	Research and Development Outcomes (to be developed)	tbc	KPI under development	KPI under development	KPI under development	n/a	tbc	KPI under development	tbc	tbc
32	Corporate Governance Statement signed off annually by Board with no conditions* and Monitor Governance Risk Rating maintained at 'GREEN' each quarter	Signed & Green	Signed and Green	Signed and Green	Signed and Green	↔	Signed & Green	Signed and Green	Signed & Green	Signed & Green

There are no areas of concern however it should be noted that the Research and Development (R&D) team have suggested the following measures for this report in relation to R&D Outcomes:

- Annual number of recruits to National Institute of Health Research studies supported by TEWV R&D staff (10% year on year increase from year 1 2015/16 baseline)
- Annual external R&D income (including external grants and commercial income) (10% year on year increase after year 1 2015/16 baseline)

The Board is requested to review and approve which of these metrics should be included in the Strategic Direction Scorecard for the 5 year strategy for the period covering 2015/16 to 2019/20.

3.5.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 3 were rated green (100.0%) which is an improvement on quarter 2 (87.5%). There are no priorities / service developments in the Business Plan at high risk of not being delivered.

3.5.3 Other Qualitative Intelligence

- **Local Government Association (LGA) review -** positive feedback was received from the LGA review across Teesside that looked at early help for children. The review highlighted the changes that partner agencies had all described in CYPs services and the shift in relationships and support went beyond the investment alone. They also highlighted the Crisis and Liaison service impact.

- **CQC and Ofsted inspections** in Hartlepool and Middlesbrough also presented CYP and AMH services in a very positive light due to efforts of staff to engage with partner agengies.

- **Integrated Care for Older People (ICOP) –** The Care Quality Commission provided an initial feedback session for the ICOP thematic review that took place within Stockton during November 2015. The review was to explore "*How does the integration of care affect older people's experience" with a particular focus on care following fractured neck of femur and care following a stroke*". This was a national thematic review involving 10 localities across the country. A final report is expected in May 2016 but feedback given in November was very positive for all providers within Stockton and a final comment from the CQC assessor reflected they did not expect to see the level of integration and good communication witnessed. Some positive comments particularly relating to TEWV services are detailed below:
    - Excellent feedback regarding the living well dementia hub which was supported by patient / service user feedback
    - Excellent links between services
    - Liaison service is an excellent example of working together to improve patient experience
    - Assessor spoke positively regarding CMHT and Westerdale North and South.
    - Impressed by the joined up care for people with dementia however this is not fully replicated across other client groups (i.e. long term physical health conditions)
    - Assessors complemented the Intensive Community Liaison Service who they said had received positive feedback from a number people in relation to their responsiveness and integrated care planning approach

There were also five areas for improvement identified, three of which relate to "system issues".

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

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

3.6.1 Trust Strategic Direction Scorecard

This strategic goal is showing 2 indicators rated red out of 6 as at quarter 3, which is a deterioration on the quarter 2 position, although one of these indicators is showing an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2015/16										
	Indicator	Q3 Target 2015/16	Quarter 1 Actual 2015/16	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter/year	YTD Target 2015/16	FYTD 15/16 Actual	Annual Target 2015/16	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 5 (To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve)										
33	Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)	56.25%	81.25%	75.00%	68.75%	↑	56.25%	68.75%	<=56.25%	<=6.25%
34	Percentage of Information Strategy outcomes achieved that are reported on Information Strategy Metrics Scorecard	n/a	due in Q3	due in Q3	establishing baseline data	n/a	n/a	establishing baseline data	Collect Baseline	tbc
35	Percentage change in income for Trust contracted services compared to previous year	-1.30%	-0.01%	-0.25%	7.07%	↑	-1.30%	6.82%	-1.30%	Better than deflator
36	Productivity Metric (to be developed)	tbc	KPI under development	KPI under development	KPI under development	n/a	tbc	KPI under development	tbc	tbc
37	EBITDA **	6.35%	8.41%	8.18%	6.12%	↓	7.55%	7.52%	7.01%	8.00%
38	Good Corporate Citizenship audit scores*	n/a	due in Q4	due in Q4	due in Q4	n/a	n/a	due in Q4	60.00%	75.00%

Indicators of concern are:

- **KPI 33 - Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)** – the Trust position for quarter 3 is 68.75% which is 12.5% above the target of 56.25%.

  The Data Quality Scorecard is monitored by the Data Quality Group and actions are derived from the discussions at this meeting. This includes focussed work to

be completed by the Information Service Managers (ISM) directly with services and by ISMs highlighting issues at Performance Improvement Group. The improving position reflects this focused work.

- **KPI 37 – EBITDA** – the Trust position for quarter 3 is 6.12% which is 0.23% below the quarter 3 target of 6.35%. Although the quarter 3 and financial year to date is below target for the first time this year is felt to be very marginal and Trust performance is in line with Trust plans.

Additional information to note:

- **KPI 34 - Percentage of Information Strategy outcomes achieved that are reported on Information Strategy Metrics Scorecard** – the Information Strategy Metrics Scorecard is being finalised for final approval. During 2015/16 the baseline data will be collated for 9 of the 15 metrics and will be reportable from April 2016. The other 6 metrics will be included once the information projects are completed and new capabilities, for example the Knowledge Management System comes on stream.

- **KPI 36 – Productivity Metric (to be developed)** – Finance have suggested the following metrics be used as a measure of productivity within this report:
  - Reference cost index score for in-scope PbR services
  - Reference cost index score for out-of-scope PbR services

The Board is requested to review and agree these metrics so they can be included in the Strategic Direction Scorecard for the 5 year strategy for the period covering 2015/16 to 2019/20.

3.6.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 3 were rated green (100.0%) which is an improvement on quarter 2 (63.6%). There are no priorities / service developments in the Business Plan at high risk of not being delivered.

3.6.3 Other Qualitative Intelligence

- **Reference Cost Index** - the Department of Health has published the Reference Cost Index (RCI) for 2015 that covered the period April 2014 to March 2015 for all mental health services for clustered and non-clustered services (Learning Disability services are excluded). The Trust's published RCI figures for 2014/15 remains below 100 at an index of 93 (after Market Forces Factor). This index of 93 compares favourably to our neighbours Northumberland, Tyne & Wear NHS foundation Trust at **130;** Leeds and York Partnership NHS Foundation Trust at **112**; Rotherham, Doncaster and South Humber at **107;** South West Yorkshire Partnership NHS Foundation Trust at **97** and Humber NHS Foundation Trust at **103**.

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

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:**
The report highlights that one of the Sustainability metrics is below target. Although this is slightly below target the Trust performance is in line with Trust plans and therefore not a significant risk.

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

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

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

5. RISKS:

There are no identified risks associated with this paper.

6. CONCLUSIONS:

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

The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics; however the overall position remains positive in line with quarter 2. In addition there are some business plan actions that need to be re-profiled in the light of changing circumstances.

7. RECOMMENDATIONS:

The Board is asked to:

- Note the changes to the Trust Business Plan that requires Board approval in Appendix 1.
- Note the suggested measures for 2 key performance indicators under development referenced in section 3.5.1 and 3.6.1.

Sharon Pickering
Director of Planning Performance and Communications

Background Papers:

Appendix 1

Board requests for changes:

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Q3 Due Status	Future Risk Status	Comment and requests for decisions
1.5.011	Develop and implement plans to deliver significant service changes/developments required for each service - **Redevelopment of Ramsey ward**	Durham and Darlington	ALD	Development of inpatient provision in response to Winterbourne – redevelopment of Ramsey	Outline Business Case approved	15/16 Q1	John Savage			The project was closed in December as work has been overtaken by the Trust wide Transforming Care project. **Req: removal.**
1.5.011	Develop and implement plans to deliver significant service changes/developments required for each service - **Redevelopment of Ramsey ward**	Durham and Darlington	ALD		Full Business Case approved	15/16 Q2				
1.5.011	Develop and implement plans to deliver significant service changes/developments required for each service - **Redevelopment of Ramsey ward**	Durham and Darlington	ALD		Project completed	16/17 Q2		**N/A**		
1.5.048	Develop and implement plans to deliver significant service changes/developments required for each service - **Single Service Rosta (AMH)**	Durham and Darlington	AMH	Implementation of single rosta as agreed by locality (subject to positive outcome of pilot and agreement of D&D approach)	Implementation in line with project plan	15/16 Q3	Mark College			Within the Rehab & Recovery Service the movement of staffing is to cover immediate short term requirements and is facilitated by the Unit Managers. However in light of the changes to unit and bed numbers for complex rehab a piece of work will be completed to confirm the staffing

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Q3 Due Status	Future Risk Status	Comment and requests for decisions
										requirements and how these will be managed flexibly across the service. This has been identified within the 16/17 business plan. **Req: removal.**
1.5.125	Develop and implement plans to deliver significant service changes/developments required for each service - **Development of a model for Early Intervention for children**	Tees	CYP Tier 2 and 3	Develop a model for Early Intervention	Business case and implementation plan approved by appropriate governance body	~~15/16 Q3~~ 15/16 Q4	Chris Davis	**N/A**		Although this action is not due until Q4, following on from the above it is already clear that a further 3 months will be needed for completion, **r** **Req: Q1 16/17**.
1.5.135	Develop and implement plans to deliver significant service changes/developments required for each service - **Assess the impact of technology on admin**	Tees	MHSOP	Following rollout of Big Hand, review the impact on admin (including Psychology) to ensure it supports the outcomes of the MHSOP Community Review	Review carried out	15/16 Q3	Shaun Mayo			Trust evaluation carried out and considered by EMT which reflects the views of the service. It is therefore now believed a separate review would be unnecessary. **Req: removal.**
					Action plan developed (if required following outcome of review)	15/16 Q4	Shaun Mayo	**N/A**		In line with the above comment, **Req: removal.**

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Q3 Due Status	Future Risk Status	Comment and requests for decisions
1.5.137	Develop and implement plans to deliver significant service changes/developments required for each service - **Development of Mental health Liaison - Chronic Fatigue Syndrome/ME**	Tees	CYP Tier 2 and 3	Consider development of Mental health Liaison - Chronic Fatigue Syndrome/ME	Potential demand for mental health liaison identified	15/16 Q4	Chris Davis	**N/A**		Reviewed and agreed that this is no longer a priority area. (This was something we wanted to progress with the acute trust but given issues of capacity and waiting times there isn't time to formally review – also now apparent it isn't the issue previously thought) **Req: removal.**
				Consider development of Mental health Liaison - Chronic Fatigue Syndrome/ME	Should need be identified, submission of bid to commissioners	16/17 Q1	Chris Davis	**N/A**		In line with the above comment, **req: removal.**
1.5.154	Develop and implement plans to deliver significant service changes/developments required for each service - **Maximising the role of support workers**	Tees	MHSOP	Develop an option appraisal for sustaining memory services, exploring the potential benefits of each option. Consider requirement for improvement event once appraisal completed	Option appraisal complete within timescales	~~15/16 Q4~~ 15/16 Q3	Shaun Mayo			Due to other priorities within the service, it has been agreed that this review be carried out next year and as such this forms part of the Tees Older Persons Business Plan for 2016/17. **Req: removal to include within Tees 2016/17 local plan.**
1.5.108	Develop and implement plans to deliver significant service changes/developments required for each service - **Develop proposals for a MUPS service that could operate within GP practices and reduce pressure on GP workloads**	North Yorkshire	All	Engage local GP leads in discussions with view to producing Business Case for each CCG area	Business Case(s) produced for EMT	16/17 Q1	Adele Coulthard	**N/A**		North Yorkshire LMGB, as part of its 2016/17 Business Planning process agreed that the locality was not in a position to progress this due to competing priorities. **Req: removal.**

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Q3 Due Status	Future Risk Status	Comment and requests for decisions
1.5.111	Develop and implement plans to deliver significant service changes/developments required for each service - **Identify whether there is sufficient demand and clinical case to develop a Child LD Assessment and Treatment Inpatient Unit and a Behavioural Secure Unit (Strategic Plan Objective)**	North Yorkshire	CYP Tier 4	In conjunction with NHS England, undertake a review of demand and consider options to develop a Trustwide Secure Behavioural Unit	Market assessment and business model scoring completed	16/17 Q4	Adele Coulthard / Bridget Lentell / Jackie Ennis	**N/A**		North Yorkshire LMGB, as part of its business planning process agreed that this action/metric would not be progressed due to existing financial climate. **Req: removal.**
1.5.113	Develop and implement plans to deliver significant service changes/developments required for each service - **Make the case for further NY T3 and / or Child LD provision over the next 2-3 years (Strategic Plan Objective)**	North Yorkshire	CYP Tier 2 and 3	Submit NY Tier 3 business proposal within CCG commissioning intention cycle linked to review of NY T3 Model of care	Business proposal submitted to NY CCGs	~~15/16 Q1~~ 15/16 Q4	Liz Herring	**N/A**		North Yorkshire CCGs have had Transformation Plans Approved. CYP element of this priority has been completed. North Yorkshire LMGB, as part of its business planning process agreed that the LD action/metric would not be progressed due to existing financial climate. **Req: removal.**

Business Plan Ref	Priority Title	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Timescale	Service Lead	Q3 Due Status	Future Risk Status	Comment and requests for decisions
				Submit NY Child LD business proposal within CCG commissioning intention cycle	Business proposal submitted to NY CCGs	16/17 Q2	Liz Herring / Bridget Lentell	**N/A**		North Yorkshire LMGB, as part of its business planning process agreed that this action/metric would not be progressed due to existing financial climate. **Req: removal.**
1.5.116	Develop and implement plans to deliver significant service changes/developments required for each service - **Respond to NHS England CYP Tier 4 Procurement**	North Yorkshire	CYP Tier 4	Respond to T4 Procurement opportunity when published (including CYP Eating Disorders)	PQQ/ITT submitted within timescales as set out	15/16 Q4	Jackie Ennis	**N/A**		This priority is dependent on NHS England timescales. Latest information is that the tender will be released approximately May 2016. This priority/action has been included in draft proposals for the 2016/19 Business Plan which will be discussed by EMT and Board in early 2016. At this stage it is proposed to amend timescales to Q2 2016/17. **Req: Q2 16/17.**
1.5.079	Develop and implement plans to deliver significant service changes/developments required for each service - **Disability Access Audit Project**	Human Resources	NA	Review year one of the process	Review and recommendations presented to EMT	15/16 Q4	Sarah Jay	**N/A**		EMT has agreed a new process and this is being implemented therefore this action requires changes to timescale. **Req: Q4 16/17.**

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**23rd February 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:	**23rd February 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:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
257	21/1/16	Contract documents relating to Parkside, Middlesbrough.	Mr. B. Kilmurray, Chief Operating Officer, Mr. C. Martin, Director of Finance
258	29/1/16	Lease for Peppermill Court, York.	Mr. B. Kilmurray, Chief Operating Officer, Mr. D. Levy, Director of HR & Organisational Development
259	29/1/16	Licence to alter Peppermill Court, York.	Mr. B. Kilmurray, Chief Operating Officer, Mr. D. Levy, Director of HR & Organisational Development
260	4/2/16	Lease relating to part of Jennyfield, Grantley Drive, Harrogate.	Mr. C. Martin, Director of Finance, Mr. P. Bellas, Trust Secretary

261	4/2/16	Licence for alterations to Jennyfield, Grantley Drive, Harrogate.	Mr. C. Martin, Director of Finance, Mr. P. Bellas, Trust Secretary

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

4.2 **Financial/Value for Money:** None identified.

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

4.4 **Equality and Diversity:** None identified.

4.4 **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)