AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 31ST JANUARY 2017 VENUE: THE DURHAM CENTRE, BELMONT INDUSTRIAL ESTATE, DURHAM, DH1 1TN AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meetings of the Board of Directors held on **29th November** and **20th December 2016**.		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To receive a briefing on key issues in the County Durham and Darlington Locality.	**Patrick Scott to attend**	**Presentation**
Item 7	To consider the six monthly "Hard Truths" Nurse Staffing Report.	**EM**	**Attached**
Item 8	To approve the Recovery and Wellbeing Strategy 2017-2020.	**BK**	**Attached**
Item 9	To consider a report on waiting times in Child and Adolescent Mental Health Services.	**BK**	**Attached**

Performance (11.00 am)

Item 10	To consider the summary Finance Report as at 31st December 2016.	**DK**	**Attached**
Item 11	To consider the Trust Performance Dashboard as at 31st December 2016.	**SP**	**Attached**
Item 12	To approve the targets for the 2017/18 Performance Dashboard.	**SP**	**Attached**

Item 13	To consider the Trust Workforce Report as at 31st December 2016.	**DL**	**Attached**

Governance (11.30 am)

Item 14	To consider a report on the Single Oversight Framework.	**PB**	**Attached**

Items for Information (11.35 am)

Item 15	To receive and note a report on the use of the Trust's seal.	**CM**	**Attached**
Item 16	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 17 To note that the next meeting of the Board of Directors will be held on Tuesday **28th February 2017** in the Board Room, West Park Hospital Darlington at 9.30 am.

Confidential Motion (11.40 am)

Item 18 **The Chairman to move:**

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

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

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

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

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

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
25th January 2017

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 29TH NOVEMBER 2016 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. J. Tucker, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Dr. H. Griffiths, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. B. Kilmurray, Chief Operating Officer and Deputy Chief Executive
Mr. D. Kendall, Interim Director of Finance and Information
Dr. N. Land, Medical Director
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:
Ms. H. Griffiths, Public Governor for Harrogate and Wetherby
Mr. S. Hughes, Staff Governor for Teesside
Mr. N. Ayre, York Healthwatch
Dr. M. Kwentoh, Consultant Psychiatrist
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Dr. E. Herring, Acting Director of Operations for North Yorkshire (minute 16/282 refers)
Dr. N. Mayfield, Deputy Medical Director for North Yorkshire (minute 16/282 refers)
Prof. J. Reilly, Clinical Director for Research and Development (minute 16/283 refers)
Mrs. K. Ord, Deputy Trust Secretary

Ms. T. Guy, Ms. A. Hutchinson, Ms. N Hughes and Mr. J. McGlone, Student Nurses

16/277 MINUTES

Agreed *– that the public minutes of the special meeting held on 6th October 2016 and the last ordinary meeting held on 25th October 2016 be approved as correct records and signed by the Chairman.*

16/278 PUBLIC BOARD ACTION LOG

The Board noted that there were no outstanding matters in the Board Action Log.

16/279 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/280 CHAIRMAN'S REPORT

The Chairman:

(1) Drew attention to her report which had been presented to the meeting of the Council of Governors held on 17th November 2016.

(2) Advised that her planned visit to services in Scarborough had had to be postponed due to travelling conditions.

(3) Reported that, over the next few weeks, her activities included a rescheduled visit to Scarborough; the presentation of a "Living the Values Award" to a member of staff at Peppermill Court in York; and a meeting with Cllr Runciman, the Executive Member for Adult Social Care and Health at the City of York Council.

16/281 GOVERNOR ISSUES

No issues were raised.

16/282 LOCALITY BRIEFING – NORTH YORKSHIRE

Dr. Herring (Acting Director of Operations) and Dr. Mayfield (Deputy Medical Director) gave a presentation on the key issues facing the North Yorkshire Locality.

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

The Chairman asked Dr. Herring and Dr. Mayfield to ensure that staff were aware that the Board understood the challenges they were facing.

Board Members raised the following issues:

(1) The development of the CAMHS single point of access.

It was noted that:

(a) The single point of access had been embedded into daily practice.

(b) Difficulties had been experienced in arranging interventions, due to the staffing situation in CAMHS, but this had been resolved as the service was now fully staffed.

(c) Going forward it was intended to capture all activity to support understanding of the single point of access and to ensure that its benefits in providing advice and guidance to patients and their carers, in addition to responding to referrals, were recognised.

(2) The position on inpatient admissions.

Dr. Herring advised that, at one point, bed occupancy had reached 120% and during October 2016 there had been 17 out of locality admissions; however, some of these were to PICUs or in response to patient need e.g. single sex requirements.

It was noted that, although the level of admissions in the Locality was comparatively high, this situation had been exacerbated by the lack of inpatient services in York prior to the opening of Peppermill Court.

Dr. Herring assured the Board that the situation was being monitored and work was being undertaken to understand the normal patient flow and the contribution the intensive home treatment teams could make to reducing inpatient admissions.

(3) The progress being made on the Harrogate Vanguard.

The Board noted that the Harrogate Vanguard was viewed positively in the Locality and consideration was being given to how the Trust could proactively respond to its development and make best use of its potential benefits.

(4) The pressures being experienced in the Locality in recent months.

The Board noted that the Locality had been subject to significant challenges in recent months as a result of staffing pressures; changes in leadership; and the demand on services.

Mr. Kilmurray advised that the staff had responded impressively to the challenges they had faced and there had not been an increase in serious incidents or complaints during the period.

At the conclusion of the discussions the Chairman thanked Dr. Herring and Dr. Mayfield for their excellent presentation and asked them to pass on the Board's appreciation to the staff in the Locality.

16/283 ANNUAL REPORT ON RESEARCH AND DEVELOPMENT

The Board received and noted the Annual Report on Research and Development which:
(1) Provided an overview of research activity for the period April 2015 to March 2016.
(2) Described key areas of progress, to date, for 2016/17.

Prof. Reilly drew attention to the following matters contained in the report:
(1) The work being undertaken to disseminate the results of two substantial multicentre studies in which the Trust was a site: the PEPS study of psychoeducation and problem solving in personality disorder; and the COBRA study of behavioural activation compared with cognitive behavioural therapy in primary care.

(2) The focus on achieving externally funded research grants with academic partners which had led to the award of the first substantial research grant where the Trust was the lead hosting organisation (the CHEMIST Study).

The Board noted that it was hoped that the results of this research would be of global importance.

(3) The development of further collaboration with the University of York in response to the risks to the Trust's capacity to generate and sustain large research programmes arising from Durham University's decision to move its School for Medicine, Pharmacy and Health to the University of Newcastle.

Dr. Land highlighted:

(1) The Trust's performance, on the time taken from receipt of a valid application to study approval, of 8 days in 2015/16 against the national target of 30 days.
(2) That there had been a significant increase in the number of people recruited to participate in research during the first six months of 2016/17 (615) compared to the whole of the previous year (404).
(3) That the changes made in response to loss of income had also made the department more effective.
(4) The increase in the range of studies being undertaken which now included biological and pharmaceutical studies.

Arising from the report Board Members raised the following issues:

(1) How the results from the COBRA study had been disseminated both internally and externally and the practical changes arising from them.

Prof. Reilly advised that:

(a) The results of the study had been reflected in NICE guidance. This had been aided by the Trust's Principal Investigator, Dr. David Ekers, being a member of NICE's committee on depression in adults.
(b) A paper on the study had been published in "The Lancet".
(c) It was recognised that staff needed to be trained to deliver simple interventions in accordance with the findings of the study and this had been supported through Dr. Ekers' work with the Trust's MHSOP specialty.

(2) Whether communications between the research and development team and clinical teams had improved following the death of a participant in the LABILE trial of lamotrigine versus placebo in borderline personality disorder in 2015.

The Board noted that the serious incident (SI) report had found the death was not directly preventable but that there had been some role confusion between the clinical team and the research and development team.

Prof. Reilly assured the Board that the actions arising from the SI investigation for the research and development team, which related to ensuring clarity of roles, had been completed by the end of June 2016.

(3) Whether the costs to the Trust in excess of those met from research grants were monitored.

Prof. Reilly responded that excess costs, (e.g. the costs of interventions during clinical trials above those funded by the CCGs) were not routinely captured but it might be worthwhile to do so in the future.

Dr. Land emphasised that the excess costs needed to be balanced with the additional benefits which flowed from the Trust's involvement in research and development including improved GP satisfaction and its support for the recruitment and retention of medical staff. He also observed that a significant proportion of research and development activity was undertaken by medical staff in their own time.

Mr. Martin advised that discussions had been held within the Trust about the excess costs and it would be appropriate to raise this issue with the CCGs.

The Board congratulated Prof. Reilly and the staff in the Research and Development Department for their achievements.

16/284 QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of its meeting held on 6th October 2016 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 3rd November 2016.

Mrs. Moody provided clarity that:

(a) The issue of patient falls on Westerdale South (referenced in the Tees LMGB report) was associated with the environment on the ward not easily facilitating the observation of patients.

(b) The points raised under section 4.3 of the report ("Patient Safety Group and Patient Experience Group") were related to the Patient Safety Group only.

The Board's discussions focussed on concerns about bed pressures in the Trust which the Committee had escalated to the Board.

Dr. Griffiths, the Chairman of the Committee, reported that:

(1) Bed pressures in adult mental health and MHSOP inpatient services, arising from high levels of admissions, greater acuity of patients, increasing complexity of patients and, for MHSOP services, the reduction in the availability of nursing home placements, appeared to be becoming more persistent.

(2) The associated risks relating to high bed occupancy (e.g. the impact on quality and increased pressure on staff) were considered to be increasing.

(3) The number of out of locality admissions being experienced in the Tees Locality suggested that bed pressures had not been mitigated by the opening of Peppermill Court in York.

The Chairman highlighted that, from discussions during a recent Directors' visit to Roseberry Park, it had been evident that there was a need to improve communications between inpatient and community services for out of locality admissions.

In response the Board noted that:

(1) The position on bed pressures was complex.

(2) Whilst the opening of Peppermill Court had been a welcome addition to bed capacity, the development had always been planned as an interim solution and out of locality admissions had been expected to continue albeit at a reduced level.
(3) Bed occupancy had improved since the opening of Peppermill Court but the number of admissions and the increasing difficulty in arranging discharges due to a lack of placements for patients from MHSOP (e.g. there were now no nursing homes in Hartlepool) was increasing.
(4) Work was being undertaken to seek to mitigate the bed pressures including:
    (a) The Positive and Proactive Community Services Programme.
    (b) The review of rehabilitation services.
    (c) The refresh of the PIPA approach to rebase standard work and reduce lengths of stay in inpatient services.
    (d) A review of the reasons for the spike in admissions to AMH inpatient services during the summer of 2016.
    (e) A review of community services in the York and Selby Locality including whether the enhanced arrangements put in place prior to the opening of Peppermill Court should be reinstated.
(5) Whilst admission rates to AMH services tended to be volatile, there had been no out of Trust admissions to assessment and treatment beds.

Mrs. Moody advised that a rounded view of the impact of bed pressures was required including in relation to:
(1) Safe staffing levels and the impact on activities in inpatient units, an issue mentioned by the CQC in informal feedback following the inspection in November 2016.
(2) The impact on the ability of services to release staff to undertake mandatory training.

The Chairman asked for a report to be presented to the Board, as soon as practicable, to provide assurance on future bed capacity taking into account the inpatient developments planned for York and Selby and Harrogate and the impact of work being undertaken to reduce bed pressures.

Action: Mr. Kilmurray

In addition the Board discussed the actions being taken to address cultural risks on night shifts in view of the issues highlighted in the Tees LMGB report to the Committee in relation to Westerdale South.

Mrs. Moody provided an overview of the concerns which had been raised about a range of activities which had taken place on the ward during night shifts and provided assurance that they had been addressed.

In response to questions the Board noted the controls in place, and planned, to mitigate cultural risks and provide proper oversight of inpatient services at night including:
(a) Ad hoc reviews of CCTV footage.
(b) Actions to increase the visibility of senior staff at night including GEMBA visits being undertaken by the Heads of Nursing; band 7 staff being rostered onto night shifts; and the work on the establishment of “night co-ordinator” posts.
(c) Changes to rosters to ensure the rotation of staff.

It was also noted that, based on the reporting of concerns by staff, there was some assurance that the Trust's escalation processes were working effectively.

16/285 NURSE STAFFING REPORT

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

Mrs. Moody advised that the accuracy of the following matters included in the report would be checked:

(1) The low fill rates for Minster and Danby Wards.

The Board noted that the figures included in the report might not reflect agency usage on the wards which had to be added manually.

(2) The reduction in the number of missed breaks by 399 compared to September 2016 as this was not considered to be correct.

Action: Mrs. Moody

The report also provided an update, in accordance with minute 16/94 (26/4/16), on the work streams of the safer staffing project.

In relation to this matter:

(1) Mrs. Moody provided details of the work being undertaken to improve rostering efficiency.

(2) Dr. Land highlighted the contribution made by effective rostering to the efficient use of resources e.g. the reduction in the requirement for bank shifts as a result of work undertaken in forensic services.

(3) The Board noted that, in view of safe staffing being identified as a Business Plan priority (minute 16/C/270 - 25/10/16 refers), the project would now be paused to enable standards and metrics to be reviewed.

Board Members raised the following matters:

(1) Whether the quality metrics, against which the staffing data was triangulated, included staffing indicators e.g. disciplinary cases.

Mrs. Moody:

(a) Advised that the quality metrics included serious incidents (at levels 3, self-harm, and 4), PALS issues, complaints and use of restraint, with other quality issues being highlighted in the narrative of the report.

(b) Considered that the use of HR metrics to support triangulation might be beneficial.

(2) Whether there was a direct relationship between staffing levels and quality as the report stated that there were "No direct risks or implications to patient safety from the staffing data" but the quality data triangulation and the information provided on serious incidents citing staffing levels might be taken to suggest otherwise.

Mrs. Moody:

(a) Advised that the report now included information on investigations where issues relating to staffing levels had been found; however, work would be undertaken, under the safe staffing project, to further develop and refine the metrics at ward level as current national measures were broad and it was difficult to evidence 'direct risks or implications' from the data.

(b) Undertook to explore this matter further in the next six monthly nurse staffing report.

Action: Mrs. Moody

Mr. Martin considered that there would be benefits, in terms of visibility, from reporting the information on wards provided in Appendix 2 to the report ("Scored Fill Rate compared to Quality Indicators") based on the quality indicators rather than, at present, alphabetically.

Mrs. Moody agreed to do this in future reports.

Action: Mrs. Moody

16/286 NURSE RECRUITMENT AND RETENTION

Further to minute 16/160 (21/6/16) the Board received and noted an update report on nurse recruitment and retention including the Recruitment and Retention Action Plan (Appendix A to the covering report) that had been recently agreed by the Executive Management Team.

The Board discussed arrangements for future nurse training in the context of ensuring a sustainable flow.

In relation to this matter Board Members raised the following issues.

(1) The impact of Health Education England (HEE) ceasing to commission student nurse places and this function being transferred to providers.

Mr. Levy advised that:

(a) The change provided the Trust with greater freedom and flexibility and supported the proposed development activities to "grow our own workforce" to complement other training schemes.

(b) HEE had previously expressed the view that Trusts in the region might have underestimated the number of new nurses that they required and he considered that, if this continued, there might be risks to future supply.

(2) The risks arising from the arrangements introduced by a neighbouring Trust which enabled a nurse to complete their training in 18 months, rather than the usual three years.

The Board noted that:

(a) The 18 months' timescale took into account accredited prior learning.

(b) The Trust had a number of staff who held a foundation degree in health and social care and enabling them to become qualified in a shortened period might support nurse recruitment in the medium term.

(3) Whether there would be benefits of seeking greater take up of the Open University route to qualification whereby an employee could remain in employment and undertake a pre-registration nursing course at the same time.

Although it was recognised that the Open University course was lengthy it was considered expanding participation would be relatively straight-forward to implement; support the Trust meet its requirements; and benefit employees in relation to their work/life balance.

It was noted that backfilling funding for students on this course had previously been an issue.

Mrs. Moody advised that there was a significant challenge in providing sufficient placements for student nurses, particularly in learning disability services as a result of the Transforming Care agenda, and, in view of this, the Trust was scoping other models of mentorship and considering the extent these were transferrable to mental health.

It was also noted that there were significant variations between services in placement activities and this issue would be looked into.

Action: Mrs. Moody and Mr. Levy

Board Members also:

(1) Questioned the assumption in section 3.5.3 of the report that the Trust's demand for nurses would remain at approximately at its current level over the next five years.

Mr. Levy responded that:

(1) Forecasting the number of nurses required in the future was difficult due to the number of unknown variables e.g. safe staffing requirements, the impact of the PPCS programme, the levels of retirement and return, etc.
(2) The assumed demand for nursing staff was based on feedback received from services; however, it was recognised that the position might change and should be kept under review.
(3) There might be greater clarity on future demand by the time the Board was recommended to review progress against the Recruitment and Retention Plan in May 2017.

(2) Highlighted their concerns about the balance between experienced nurses and those in preceptorship in Trust services.

It was noted that the majority of nurses offered places at the Trust at recent recruitment events had recently completed their training.

Mr. Levy agreed that, probably, there had been too much emphasis to date on recruiting numbers of nurses and that he would look into developing a more refined approach.

Action: Mr. Levy

(3) Sought clarity on whether the data on nurse recruitment in 2015/16 (section 3.3.1 of the report) and the forecast number of posts to be recruited to over the next

five years (section 3.5.3 of the report) suggested that recruitment activity at the present level would be sufficient to meet the Trust's requirements.

In response the Board noted that this was not the case as the data provided in section 3.3.1 was for all recruitment including internal movements.

(4) Sought assurance on whether there had been improvements to the processes to support "retire and return" in view of the concerns raised under minute 160 (21/6/16).

Mr. Levy advised that:

(a) All registered nurses had been emailed and asked whether they would wish to meet with their respective Head of Nursing to discuss a range of workforce supply issues.
(b) To date, 465 nurses had responded and this suggested that there was the potential to increase the number of nursing hours available from within the existing workforce.
(c) It was expected that the outcomes of these conversations would be known and communicated by March 2017.

***Agreed** – that a progress report on the implementation of the Recruitment and Retention Action Plan be provided to the Board meeting to be held on 23rd May 2017.*

Action: Mr. Levy

16/287 MENTAL HEALTH LEGISLATION COMMITTEE

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

(1) The confirmed minutes of its meeting held on 25th July 2016 (Appendix 1 to the report).
(2) The key issues discussed by the Committee at its meeting held on 24th October 2016.

In response to a question, the Board noted that, although the percentage of people discharged from the Crisis Assessment Suite at Roseberry Park without mental health follow up or sign-posting to other services appeared high (16% of all assessments undertaken during Quarter 2, 2016/17) this was not considered to be unusual in the context of the tendency of the police to bring people to the service where they had concerns about their behaviour (which was often as a result of intoxication).

16/288 COMPOSITE STAFF ACTION PLAN

Further to minute 16/127 (24/5/16), the Board received and noted a progress report on the implementation of the Composite Staff Action Plan and locality/corporate directorate action plans as at the end of Quarter 2 2016/17.

The Board noted that, although some actions were outstanding, progress on the delivery of the staff action plan was more advanced at this stage than in previous years.

Arising from the discussion Mr. Levy advised that it usually took approximately two years before the impact of actions was reflected in the staff survey results.

16/289 EMBEDDING THE TRUST'S VALUES

Further to minute 16/187 (21/7/16) consideration was given to proposals to further embed the Trust's values and behaviours statement.

Mr. Levy drew attention to the proposals to undertake a values consultation exercise, to be completed by July 2017, which would provide an opportunity for TEWV-wide engagement and for a fresh perspective to be obtained on this matter.

The discussions focussed on the scope and approach of the proposed work to embed the Trust's values including:

(1) Whether it should be taken forward as a standalone piece of work or as part of the Business Plan Priority "Refreshing the TEWV way".
(2) Whether the work would be focussed on refreshing the values rather than only on how they were embedded in the Trust.

The Chairman:

(1) Advised that the values of organisations were relatively consistent and should not be subject to continual change.
(2) Considered that the key issue was how the values were understood and lived by staff on a day to day basis.
(3) Supported the proposed consultation exercise but considered that it should be undertaken as part of the Business Plan priority.
(4) Considered that the approach should be further discussed during the early summer of 2017 prior to the launch of the consultation exercise.

The Board also discussed the proposal to produce team based culture metrics reports, including themed qualitative information, by the autumn of 2017 and to cease present reporting arrangements until that time.

In relation to this matter Board Members considered the benefits of:

(1) Including safer staffing data as part of the statistical information to be provided in the culture metrics reports.
(2) Aligning the reporting on the culture metrics with the work being undertaken on meeting the information needs of team managers as part of the PPCS programme.

Agreed -

(1) that the proposed values consultation exercise be supported but that a further report be provided to the Board in the early summer of 2017 prior to its launch;
(2) that a report on the findings of the values consultation exercise be provided to the meeting of the Board of Directors to be held on 26th September 2017;
(3) that the proposal to introduce team based culture metrics reports, to include themed qualitative information, by the autumn of 2017, be supported; and

(4) that further culture metrics reporting be deferred until the autumn of 2017.

Action: Mr. Levy

16/290 INVESTORS IN PEOPLE SCHEME

Consideration was given to a report which sought the Board's views on whether or not the Trust ought to seek re-accreditation under the Investors in People (IiP) scheme in 2017.

In response to questions it was noted that:

(1) The Workforce Development Group had recommended to the Board that the Trust should seek re-accreditation.

(2) Only 2% of organisations were awarded the gold or, recently introduced, platinum standards, a reduction from the 5% of organisations achieving the gold standard when the Trust was awarded that accreditation in 2014.

Board Members recognised the importance of the external assurances which would be provided by the re-accreditation and therefore:

***Agreed** – that, subject to the Executive Management Team being assured that sufficient resources are available to support the process, the Trust seek re-accreditation under the Investors in People scheme in November 2017.*

Action: Mr. Levy

16/291 FINANCE REPORT AS AT 31st OCTOBER 2016

The Board:

(1) Received and noted the Summary Finance Report as at 31st October 2016.

(2) Considered the draft agency self-certification checklist (as set out in Appendix 1 to the report) which was required to be submitted to NHS Improvement.

Arising from the report:

(1) In response to a question Mr. Kendall advised that the graphs on CRES in section 3.2 of the report showed the actual cash released by identified schemes.

It was noted that budgets were adjusted at the beginning of the year to reflect identified CRES schemes and failure to deliver them was treated as an overspend.

(2) The Non-Executive Directors sought clarity on the statement in the report that the level of receivables was "not a cause for concern" even though, at 8.2%, it was above the 5% finance risk tolerance.

Mr. Kendall responded that there were no concerns as the debts were kept under constant review and there was assurance that they would be paid. He undertook to review the commentary provided on this matter in future reports.

Action: Mr. Kendall

16/292 PERFORMANCE DASHBOARD AS AT 31st OCTOBER 2016

The Board:

(1) Received and noted the Performance Dashboard Report as at 31st October 2016.

The Board congratulated the Executive Management Team and staff on achieving the highest level of performance on external waiting times (KPI 7) in the past three years.

(2) Considered a recommendation from the Executive Management Team, following a further review in accordance with minute 16/222 (27/9/16), that the target for KPI 1 ("Total number of External Referrals into Trust Services") should be increased from 86,407 to 91,759.

Mrs. Pickering advised that, in the absence of historical data for York and Selby, the original target had been based on the estimated number of external referrals for the Locality's population (which equated to approximately 13% of all referrals). However, the proposed target reflected the actual levels of referrals received for the first six months of the year where the proportion that related to the Vale of York CCG was approximately 21% of all referrals.

The Non-Executive Directors questioned the reasons for setting a target and assigning RAG ratings for external referrals.

Mrs. Pickering explained that the indicator enabled the Board to consider the impact of external referrals on capacity and the target and RAG ratings provided confidence levels and acted as a catalyst for further attention.

Agreed *– that the target for KPI 1 ("Total number of External Referrals into Trust Services") be increased to 91,759.*

Action: Mrs. Pickering

16/293 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report for Quarter 2, 2016/17 including proposed changes to:

(1) The Trust Business Plan (as set out in Appendix 1 to the report).
(2) The targets for key performance indicators.

Mrs. Pickering provided clarity that the only change proposed was to set the target for KPI 3 (Percentage of patients reporting 'yes always' to the question, 'did you feel safe on the ward?') for 2017/18, 2018/19 and 2019/20 at 85%, the same as for 2016/17.

Board Members raised the following matters:

(1) Performance on KPI 8 (Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days) where the Trust's position at Quarter 2 was 15 against a target of zero and a deterioration on the Quarter 1 position.

The Non-Executive Directors highlighted that this issue had been previously escalated to the Board by the Audit Committee and emphasised the importance of maintaining focus in this area.

Mr. Martin responded that he would be looking into this matter and would take a view on whether, taking into account the priority of the actions, there was a need to provide further assurance.

Action: Mr. Martin

(2) The reason why the target for KPI 6 (Percentage of service users with a recovery focussed action plan - Adult Mental Health) was set at 95% rather than 100%

Mrs. Pickering advised that:

(a) The indicator related to the "recovery star" which took time to complete.

(b) In view of the explanation for breaches received from the Tees Locality (that as recovery stars were completed at an appropriate point in the model line process, but within 12 weeks of the patient first being seen, patients could appear as 'breaches' for some time) the performance team had been asked to look into the construction of the indicator to ensure it was aligned to the model of care.

(c) If required proposals to change the indicator in the light of this work would be presented to the Board in due course.

The Chairman:

(1) Highlighted the importance of the qualitative intelligence provided in the report.

(2) Noted that the Trust had been the first in the UK to adopt Teepa Snow's "Positive Approach™ to Care for people living with Dementia" and considered that it would be beneficial to receive a briefing on this at a Board Seminar.

Action: Mr. Martin

Agreed -

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

(2) that the target for KPI 3 be set at 85% for 2017/18, 2018/19 and 2019/20.

Action: Mrs. Pickering

16/294 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.

16/295 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting was due to be held, in conjunction with a seminar, at 9.30 am on Tuesday, 20th December 2016 in the Board Room, West Park Hospital, Darlington.

16/296 CONFIDENTIAL MOTION

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

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 1.25 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

North Yorkshire Locality Board Presentation 29 November 2016

Dr Liz Herring

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

- Proud
  - CQC Feedback
  - Awards
  - Service developments
    - T3 CAMHS eating disorders
    - Single Point of Access in CAMHS
  - IAPT performance improvement
  - Staff resilience
  - Clinical & service Leadership
- Progressing
  - All age crisis triage & response
  - Memory service model
  - Clinical Leadership
  - Capital development decisions
  - HR CCG – transforming mental health

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work.

- QIS
  - PPCS
  - PIPA reboot within our inpatients
  - LD Transformation
- Participation in research growing across AMH & MHSOP
- Productivity
  - Clearer line of sight on our team efficiency
  - Information is shaping our decision-making on service delivery

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Recruitment Issues
  - Qualified nursing staff
  - Medical staff in certain geographic areas
  - Bespoke nursing bank for the localities
- Retention Issues
  - Retirements
  - Career progressions
- Skill, compassion and motivation issues
  - Compassion in practice
  - Nurse development programme
  - Inpatient development days

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
  - Harrogate Vanguard
  - MHCCC
  - 'Transforming care'
- National
  - IAPT
- International
  - No formal links internationally

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

- Performance
  - CAMHS waiting times
  - Access performance
  - Financial balance – locum and agency costs
  - Access to nursing homes provision - DTOC
  - Out of Area admissions reducing
  - Geographical challenges linked to workforce
- LMGB
  - Structured oversight & quality assurance
  - QAGs – managing a broad range of issues
  - Good sense of team

making a difference together

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 20TH DECEMBER 2016 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 9.30 AM

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

In Attendance:
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Dr. C. Lanigan, Head of Planning and Business Development (representing Mrs. Pickering)
Mr. N. Moan, Advanced Clinical Practitioner (shadowing Mrs. Moody)
Ms. R. Tattersall, Clinical Psychologist
Mr. T. Laverick, Trainee Psychologist

16/307 APOLOGIES

Apologies for absence were received from Mr. M. Hawthorn, Senior Independent Director and Mrs. S. Pickering, Director of Planning, Performance and Communications.

16/308 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/309 CHAIRMAN'S REPORT

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

(1) Visited the children and young people's services in Scarborough and presented "Living the Values" awards to three members of staff.

The Board noted that the visit had been very interesting and, through conversations with team members, it was apparent that the service was recovering and making progress following some challenging times.

(2) Attended a meeting of Trust Chairmen for the North East region on 8th December 2016.

Mrs. Bessant advised that the discussions had highlighted on-going concerns about staffing, the financial positions of acute providers and STPs.

16/310 GOVERNOR ISSUES

No issues were raised.

16/311 QUALITY ASSURANCE COMMITTEE

Consideration was given to the report of the Quality Assurance Committee (QuAC) including:

(1) The confirmed minutes of its meeting held on 3rd November 2016 (appended to the report).

(2) The key issues discussed by the Committee at its meeting held on 1st December 2016.

The discussions focussed on the revised Quality Strategy (appended to the report) which the Committee had recommended to the Board for approval at its meeting held on 1st December 2016.

In relation to this matter:

(1) Mrs. Moody highlighted that the draft Operational Plan 2017/18 (minute 16/C/320 refers) included reference to the Quality Strategy being refreshed by April 2017 and questioned whether the relevant paragraph of that document should be reworded to reflect the present position.

It was agreed that the draft Operational Plan should be updated prior to submission to NHS Improvement.

(2) It was suggested that the date for the Trust to achieve its ambition of providing single en-suite rooms for assessment and treatment beds under Goal 2 should be amended from 2017/18 to 2018/19 to be aligned with the Trust's capital plans.

This was taken on board.

(3) The Board noted the discussions at the meeting of the Quality Assurance Committee on target setting.

(4) Mrs. Moody undertook to review the page numbering of the document.

(5) The Non-Executive Directors:

(a) Welcomed the identification of assurances to support the delivery of the objectives of the Quality Strategy but asked that consideration should be given to how they could be pulled together to provide an overall picture of quality.

(b) Suggested that the implementation plans being developed to deliver the Quality Strategy should:

- Set milestones for the achievement of the objectives by 2020.
- Group the actions by their specific objectives.

Mrs. Moody advised that further work was being undertaken on the reporting and presentation of the assurances included in the Quality Strategy.

Action: Mrs. Moody

In addition the Board:

(1) Recognised that the decision to bring forward the closure of Worsley Court was based on a number of existing genuine concerns about the operation of the unit (e.g. staffing levels) and was not as a direct result of the feedback received from the Care Quality Commission (CQC) following its unannounced inspection in November 2016.

(2) Sought clarity on the 145 deaths for the period 1st October to 15th November 2016 reported through the Datix system.

The Board noted that:

(a) There had been significant national concerns about the way in which NHS providers investigated and learnt from the deaths of people in their care following the failings identified at Southern Health NHS Foundation Trust (SHFT) in 2015.

(b) Whilst unexpected deaths were reported on the STEIS system, expected deaths were not reported through this system but recorded on the PARIS system.

(c) In view of the national concerns, the Trust had sought to better understand the deaths of all people who had been in its care and services had been asked to report these through the DATIX system. This exercise had resulted in the reporting of the 145 deaths mentioned in the report.

(d) An exercise had also been undertaken to review the deaths of people on the CPA, in view of their significant involvement with the Trust, during the reporting period using the categories developed by Mazars LLP in its investigation of SHFT. From this work it had been recognised that there was a cohort of middle aged service users who had died from physical health causes.

(e) It was now planned to develop a process to establish when a mortality review would be warranted, to test the review tools and to consider how information on the deaths should be gathered. This would support learning on how the Trust could make improvements for people in the identified cohort.

(f) On 13th December 2016 the CQC had published a report "A review of the way NHS trusts review and investigate the deaths of patients in England". The Secretary of State had accepted the recommendations of the report including the development of national guidance on mortality reviews. It was considered that the work being undertaken by the Trust would be an important contribution to this initiative.

Agreed –

(1) that the revised Quality Strategy (appended to the above report), as amended, be approved;

Action: Mrs. Moody

(2) that the Operational Plan 2017/18 be amended to reflect the above decision.

Action: Mrs. Pickering

16/312 ACTIONS TO MITIGATE STAFFING RISKS IN FORENSIC SERVICES

Further to minute 16/217 (27/9/16) the Board received and noted a report which detailed the nature and degree of staffing pressures within the forensic inpatient wards and sought to provide assurance on both the mitigations in place to manage them and the steps being undertaken to reduce their long-term impact (as set out in Appendix 1 to the report).

The Non-Executive Directors sought clarity on the following matters:

(1) The destinations of band 5 staff leaving forensic services.

The Board noted that:

(a) The main destinations for staff leaving the service were community services, liaison services, CAMHS and, uniquely, to undertake disability assessments for Atos Healthcare.

(b) The main reasons for staff wishing to leave forensic services were related to similar posts in community services being at a higher band (band 6); to work in a less pressured environment; and for more favourable shift patterns.

In response to a question it was noted that it was not practicable for staff to rotate between inpatient and community services.

(2) The extent that NHS England was aware that uncertainties arising from the Transforming Care agenda were contributing to staffing pressures in learning disability services.

Mr. Martin advised that he had raised this matter during telephone conversations with Dr David Hambleton, Senior Responsible Officer for the Transformation Programme, and Mr. Tim Rideout, Director of Commissioning Operations (Cumbria and the North East) at NHS England. He added that Mr. Buckley (Director of Operations for Forensic Services) had also highlighted the issue at regional meetings on the Transforming Care agenda.

He considered that changes were required to the national narrative on the Transforming Care agenda to recognise the continuing importance of learning disability inpatient services.

Mrs. Moody highlighted that the impact of the uncertainty on the future provision of learning disability inpatient services was being seen in the reduction in interest in pre-registration courses for the speciality; the high rate of attrition of students on those courses; and the withdrawal of courses by universities.

The Board noted that, in the medium term, there was an opportunity to develop RMNs to take responsibility in a learning disability setting, to mitigate the lack of specialist nurses for this speciality, and this would be looked into.

Action: Mrs. Moody

(3) Whether, in view of the impact on staff retention in forensic services, the differential banding between band 5/band 6 staff in inpatient and community services, respectively, was correct.

Mr. Levy advised that:

(a) The banding of inpatient and community roles had been tested through job evaluation processes and was considered to be correct.

(b) The difference in the banding arose from staff in community services having greater responsibility as a result of them being on their own during visits.

In relation to this matter the Board discussed potential options to address the financial incentives for staff to transfer from inpatient to community services. These included the use of recruitment and retention premia and opportunities to use resources arising from vacancies to change the skill mix and provide greater opportunities for promotion (an approach taken by the Head of Nursing which had led to the provision of three additional Band 6 posts in forensic mental health services).

Mr. Levy cautioned that, in making any changes, the Trust needed to be seen to be equitable and consistent and he assured the Board that his Directorate was working with forensic services to seek to address the Locality's concerns.

Mr. Levy also informed the Board that the staff bank had undertaken a pilot scheme to address pressures arising from staff being absent from work at short notice due to sickness. This had been successful with all requests received for short notice cover during November 2016 being met.

The Chairman also highlighted the importance of maintaining staffing levels to facilitate activities and leave, both of which were essential to recovery.

Mr. Kilmurray responded that:

(1) Significant work had been undertaken to match capacity to facilitate leave with demand.

(2) Only 2.1% of the 51K leaves planned during 2016 had had to be cancelled.

(3) Other activities, particularly the focus on physical health, placed pressure on the capacity of the service to provide leave.

(4) The model wards programme supported the provision of additional purposeful activities on wards.

At the conclusion of the debate the Chairman:

(1) Thanked Mr. Kilmurray for the report.

(2) Considered that it would be beneficial for the Quality Assurance Committee to receive a report detailing the proportion of experienced nursing staff versus those on preceptorship on each ward in forensic services.

Mrs. Moody agreed to take this forward.

Action: Mrs. Moody

16/313 INTEGRATED GOVERNANCE FRAMEWORK

Consideration was given to proposed revisions to the Integrated Governance Framework (as set out in Appendix 1 to the covering report) which had been recommended to the Board for approval by the Audit Committee subject to discussions on the rationale for the replacement of the Investment Committee with the proposed Resources Committee.

The Board noted that that the establishment of a Resources Committee had arisen from a number of discussions and reflected changes to the environment in which the Trust was operating. The proposal was considered to provide a number of benefits including enabling:

(1) A more balanced view of the total resources available to the Trust.
(2) More focussed consideration of the key financial strategies of the Trust prior to presentation to the Board.
(3) Greater attention to workforce matters in recognition that staff were one to the Trust's major resources.

In general, Board Members supported the establishment of the proposed Resources Committee; however, some concerns were raised about whether it would duplicate the role of the Board and whether the proposed membership of the Committee was appropriate as workforce responsibilities spanned a number of the Trust's directorates.

The Chairman responded that:

(1) The proposed Resources Committee should not detract from the role of the Board but would provide additional capacity enabling more in-depth discussions on important issues facing the Trust.

It was also noted that the work of the Committee would support the Board undertake its role more effectively through its focus on the provision of assurance on the sufficiency and appropriateness of resource availability and in relation to the alignment and delivery of key strategies and plans.

(2) The proposed terms of reference of the Committee sought to achieve a balance between making best use of Directors' time whilst ensuring their participation in the consideration of matters within their portfolios.

Mr. Bellas undertook to review the terms of reference to ensure that this matter was explicit.

Action: Mr. Bellas

The Chairman advised that, in view of the concerns being raised, it would be appropriate for the operation of the Committee to be reviewed after 12 months or earlier if issues arose.

Agreed -

(1) that the proposed amendments to the Integrated Governance Framework (set out in Annex 1 to the covering report) be approved;
(2) that a Resources Committee be established in place of the Investment Committee;

(3) *that the establishment of the Resources Committee be reviewed after 12 months or earlier if issues arise;*

(4) *that the Chairman and Non-Executive Directors of the Resources Committee be as follows:*

(a) *Chairman – Jim Tucker*

(b) *Non-Executive Members – Marcus Hawthorn, David Jennings and Paul Murphy; and*

(5) *that the focussed work being undertaken to strengthen assurance and risk management processes, following the Board Seminar held on 8th November 2016, and the need for the outcome of this initiative to be reflected in the next iteration of the Integrated Governance Framework, be noted.*

Action: Mr. Bellas

16/314 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting of the Board of Directors was due to be held, in public, at 9.30 am, on Tuesday 31st January 2017 in The Durham Centre, Belmont Industrial Estate, Durham, DH1 1TN.

16/315 CONFIDENTIAL MOTION

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

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

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

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

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 11.15 am.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31st January 2017**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

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

Date	Minute No.	Action	Owner(s)	Timescale	Status
24/05/2016	16/121	Dr. Alison Brabban to be invited to provide a briefing on the Recovery Programme when the business case for its next phase of development is due to be considered by the Board	BK	~~Dec-16~~	The Recovery and Wellbeing Strategy 2017 - 2020 is due for approval under agenda item 8 to enable its implementation to commence. Due to changes to the Board Seminar Programme in response to the CQC "well-led" review, it is planned to invite the Non-Executive Directors to a separate briefing on the Recovery Programme. Notification of this event will be provided in due course.
24/05/2016	16/121	The Experts by Experience to be invited to attend Board Seminars to provide their stories	BK	~~Dec-16~~	
24/05/2016	16/123	A briefing on human rights to be provided to a future Board Seminar	DL/PB	Mar-17	

Date	Minute No.	Action	Owner(s)	Timescale	Status
21/07/2016	16/176	A briefing on pathways to be provided to a Board Seminar	BK/PB	Apr-17	
21/07/2016	16/183	The approach taken by East London NHS Foundation Trust to Directors' visits to be revisited to seek further learning	CM	Dec-16	Completed
27/09/2016	16/218	Automatic reporting of seclusion from the PARIS system to be urgently addressed	DK	~~01/12/2016~~ June-17	Proposed change to timescale to reflect ongoing negotiations with suppliers. Manual process in place through the MHL team to provide assurance on the accurate recording and reporting of episodes of seclusion.
27/09/2016	16/219	Future reports on waiting times in CAMHS to include information on the funding of the services in each Locality	BK	Jan-17	See agenda item 9
27/09/2016	16/219	A further report on waiting times in CAMHS to be presented to the Board	BK	Jan-17	See agenda item 9
27/09/2016	16/223	Work to be undertaken to seek further understanding of why some staff are taking positions at lower grades	DL	Jan-17	See agenda item 13
25/10/2016	16/258	The existing international links of local universities to support overseas medical recruitment to be explored	NL	Feb-17	
29/11/2016	16/284	Report to be provided to assure the Board on future bed capacity taking into account the developments planned in Harrogate and York and the impact of work to reduce bed pressures	BK	Mar-17	
29/11/2016	16/285	The low fill rates for Minster and Danby Wards in October and the reduction in missed breaks compared to September 2016 to be checked	EM	Jan-17	Completed

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/11/2016	16/285	The relationship between staffing levels and quality data triangulation and information on serious incidents to be further explored in the next six monthly nurse staffing report	EM	Jan-17	See agenda item 7
29/11/2016	16/285	The information provided in Appendix 2 to the Nurse Staffing Reports (Scored Fill Rate compared to Quality Indicators) to be listed based on the quality indicators rather than alphabetically	EM	Feb-17	
29/11/2016	16/286	The significant variation between services in relation to nurse placement activities to be looked into	EM/DL	Mar-17	
29/11/2016	16/286	A more refined approach to nurse recruitment focussed on experience as well as numbers to be looked into	DL	May-17	
29/11/2016	16/286	A progress report to be provided to the Board on the Recruitment and Retention Action Plan	DL	May-17	
29/11/2016	16/289	A report to be provided to the Board on the proposed values consultation in early summer 2017 prior to its launch	DL	Jun-17	
29/11/2016	16/289	A report on the findings of the values consultation exercise to be provided to the Board	DL	~~Sept-17~~ Mar-18	Timescale to reflect Operational Plan
29/11/2016	16/289	Team based culture metrics reports to be introduced	DL	Nov-17	
29/11/2016	16/289	Approval to defer reporting on the culture metrics until the autumn of 2017	DL	-	Approved
29/11/2016	16/290	Subject to the EMT being assured that sufficient resources are available to support the process, the Trust seek re-accreditation under the Investors in People scheme	DL	Nov-17	
29/11/2016	16/291	The narrative in finance reports on receivables to be reviewed	DK	Jan-17	See agenda item 10
29/11/2016	16/292	Approval to increase the target for KPI 1 in the Performance Dashboard (External Referrals) to 91,759	SP	-	Approved
29/11/2016	16/293	Consideration to be given on whether further assurance is required on the completion of complaints and clinical audit action plans	CM	-	Completed

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/11/2016	16/293	A briefing to be provided to a Board Seminar on Teepa Snow's "Positive Approach to Care for people living with Dementia"	CM	Mar-17	
29/11/2016	16/293	Approval of changes to the Business Plan	SP	-	Approved
29/11/2016	16/293	The target for KPI 3 in the Strategic Direction Performance Report to be set at 85% for 2017/18 - 2019/20	SP	-	Approved
20/12/2016	16/311	Further work to be undertaken on the reporting and presentation of assurances in relation to the Quality Strategy	EM	Mar-17	
20/12/2016	16/311	Approval of the revised Quality Strategy	EM	-	Approved
20/12/2016	16/311	The Operational Plan to be amended to reflect the approval of the Quality Strategy	SP	Dec-16	Completed
20/12/2016	16/312	Opportunities to develop RMNs to take responsibility in a learning disability setting to mitigate the lack of specialist nurses for this speciality to be looked into	EM	Apr-17	
20/12/2016	16/312	A report to be provided to the QuAC detailing the proportion of experienced nursing staff versus those on preceptorship on each ward in forensic services.	EM	Mar-17	
20/12/2016	16/313	Approval of the revised Integrated Governance Framework	PB	-	Approved
20/12/2016	16/313	Approval of the establishment and membership of the Resources Committee	PB	-	Approved
20/12/2016	16/313	The operation of the Resources Committee to be reviewed in 12 months or sooner if issues arise	PB	Dec-17	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Durham and Darlington Locality
An Interesting Year

Patrick Scott

Director of Operations

making a difference together

Key Themes

" Sort performance and Create an identity"

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

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

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

To continuously improve the quality and value of our work

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

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

- Locality Head of Nursing leading workforce plan; Recruit, Retain, Develop and Engage

- Challenges and opportunities
  - Medical staffing
  - Safer staffing - broadest sense
  - Talent management - embedding within locality

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

- Local
  - Urgent Care Vanguard / Crisis Care Concordat
  - Local Authorities
  - System leadership - Clinical, Operational and strategic
- National
  - Input into NICE Guidelines and other national work, e.g. IAPT Trailblazer pilot
  - Member of National Collaborative for Positive Practice in Mental Health
  - Parent rep's C&YPS presented to House of Lords on impact of self harm and experiences with CAMHS
  - National conferences
- International
  - Virginia mason

To be recognised as an excellent and well governed Foundation Trust that makes best use of it's resources for the benefit of our communities

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

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31st January 2017**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

The purpose of the report is to advise the Board of a 6 monthly review (1st June 2016 to 30th November 2016) of in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) and in line with the NQB Guidance.

A safer staffing steering group has been established to oversee a work plan to ensure the Trust has robust systems and processes in place to assure them that there is sufficient capacity and capability to provide high quality care to patients. In addition work is being undertaken utilising a work stream approach which is reporting to OMT. It has also been agreed that Safe Staffing will be one of the annual plan priorities for the trust board and a safe staffing programme has nows
been approved by EMT.

In conclusion, the following is of relevance:

- Work is underway to review the current staffing establishments within inpatient areas – this will conclude by the end of March 2017.
- Roster reviews are underway and an interim report has been submitted to OMT.

- Changes to numbers of staff in post can be overserved as follows:
  - A reduction in staffing within Durham and Darlington following the closure of Picktree and reduction of beds within Bek, Talbot and Ramsey.
  - Forensic services an increase in both registered and un-registered staff can be observed across a number of wards.
  - North Yorkshire a reduction of registered nurses is observed and relates to Danby Ward and Cedar (NY).
  - Within Teesside an increase of registered nurses is observed and relates to the Evergreen Centre, Westerdale South and Westwood Centre. A reduction in un-registered nurses is also highlighted and relates to Stockdale Ward, Bankfields Court and Wingfield.

  - An increase of both staff groups can be observed within York and Selby and relates to Ebor and Minster, Cherry Tree House and Meadowfields.
  - These changes were part of the transforming care agenda and agreed 2016/17 CRES plans.
- In line with 'NQB guidance for Right Skills', the paper sets out a number of development programmes in place to enhance the skills of our workforce.

- Regarding staffing activity, the 6 month average shows:
  - The actual hours worked exceeding the planned hours across all months. All metrics are reporting above the 89.9% tolerance.
  - Primrose Lodge as having the lowest fill rate for registered nurses on days and relates to sickness and vacancies. The use of HCA's to backfill some of the registered nurses is evident.
  - Danby Ward as having the second lowest fill rate for registered nurses on days and relates to sickness, vacancies and preceptees who were unable to take charge. Inaccuracies within the roster were identified and changes to the roster made.
  - Sickness as the biggest factor impacting on staffing with 48 wards. Maternity Leave (19 wards) and vacancies (16 wards) were cited as the second and third highest.
  - An increase in the amount of additional duties created with a reason of 'enhanced observations' when compared to the previous 6 month report (8,721 shifts this reporting period compared to 6,612).
  - Westerdale South as the highest users of additional duties. This was in relation to an agreed budget uplift which had not been committed to the HealthRoster system (this change has now been made and will reflect positively in the figures from January 2017).
  - Bank usage greater than 25% equateing to 5 wards in 3 separate localities.
  - Agency usage relating to 17 wards but predominantly used within York and Selby and North Yorkshire.
  - All wards are using overtime to fill shifts however, those in excess of 4% equates to 31 wards. Teesside are using the most overtime whilst York and Selby are using the least.

- Ttriangulation of quality data over the 6 month average:
  - Shows an increase in the number of incidents being raised via Datix citing staffing issues (121 incidents raised) with an increase of 55 incidents when compared to the previous 6 month report. This could be attributable following the implementation of an escalation process.
  - Triangulation of SIs, level 4 incidents, level 3 self-harm, complaints and incidents control and restraint with bank usage and the fill rates did not highlight any correlations between these strands of data.
  - Triangulation of falls that have resulted in significant harm, pressure ulcers, medication errors, breaks not taken, with that of bank usage and the fill rate indicators. From this it is not possible to draw any meaningful conclusions from this data for the period of this report.
  - In terms of patient, staff and carer feedback an analysis of the data from complaints, friends and family test and compliments has been undertaken but there were no specific issues raised with regards to staffing levels.

- The safe staffing programme will develop a ward dashboard of safe nursing indicators. An interim approach being utilised within the trust is the use of the 9 safe nursing indicators.
- Care hours per patient day has been produced in a shadow format further work is required to analyse this data further and understand what this means to TEWV.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**31st January 2017**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of a 6 monthly review (1st June 2016 to 30th November 2016) in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) following the format of the new NQB 2016 Guidance.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (http://www.tewv.nhs.uk/site/about/how-well-are-we-doing/nurse-staffing). The full monthly data set of day by day staffing for each of the 69 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

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

2.4 In addition work is being undertaken Trust wide via a work stream approach reporting to OMT and include:

- Rostering Efficiencies
- Future Reporting
- Flexibilities of Staff Deployment
- Escalation
- Evidence Based Planning

2.5 The format of this report follows the NQB Guidance published in July 2016 and will be developed further once the safe staffing programme is established.

2.6 There is a national work stream looking at service specific guidance, recently this has included the draft publication of Learning Disability guidance, which is currently out for consultation. It is expected that Mental Health service guidance will follow shortly. The guidance will be considered within the trust safe staffing work stream as it emerges.

2.7 It has been agreed that Safe Staffing will be one of the annual plan priorities for the trust Board, accordingly the Executive Management Team have approved a Safe Staffing Programme that will manage the implementation of the NQB guidance.

3.0 TRIANGULATED APPROACH TO STAFFING DECISIONS:

3.1 Right Staff

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

3.1.2 The Trust is progressing with the implementation of the Hurst Tool and the mental health multiplier in order to review the current staffing establishments within inpatient areas (excluding Learning Disabilities – awaiting final guidance). The work stream have developed a standard process (please refer to appendix 1) and implementation is underway with an anticipated completion timescale of the end of March 2017. This will include a triangulated approach including professional judgement and evidence based tools. This piece of work is integral to not only ensure compliance with the national requirements but will ensure that the staffing establishments and skill mix in place are appropriate based on the acuity of our patients as well as enhancing the quality of care by ensuring that our resources are deployed effectively and efficiently across the inpatient areas. A report of the establishment review findings will be presented for discussion and agreement to board once this process has concluded.

3.1.3 As an interim approach the budgeted staffing establishments as at 1st June 2016 and the 30th November 2016 have been obtained from HealthRoster and have been used to compare the actual establishments in post. Attached at appendix 2 of this report is the full breakdown by ward and locality. The key points are as follows:

- Durham & Darlington - Registered nurses in post has decreased by 9 WTE and a reduction of 3.20 WTE unregistered nurses can also be observed across the locality. The closure of Picktree ward accounts for 5.40 WTE of the registered nurse reduction with the remainder being spread across multiple wards. In terms of the unregistered staffing reduction the largest relates to Bek, Talbot and Ramsey following the reduction of beds as part of the transforming care agenda. In addition the closure of Picktree is relevant in terms of the reduction of unregistered nurses in post. Additional budget has been added to Ceddesfeld ward resulting in an increase of 7.8 WTE unregistered nurses.
- Forensics – Registered nurses in post has increased by 7 WTE and an increase can also be observed with regards to unregistered nurses (16.4 WTE). The closure of Heron and Robin accounts for a reduction of 6 WTE registered nurses whilst additional registered nurses in post can be observed with regards to Northdale Centre (3WTE), Eagle and Osprey (3WTE) and Kestrel / Kite (4WTE). In terms of unregistered nurses a

reduction of 8.6WTE can be observed following the closure of Heron and Robin whilst additional unregistered nurses in post can be observed with regards to Kestrel / Kite (8.20 WTE), Lark (3 WTE), Brambling (3 WTE) and Swift (2.6 WTE).

- North Yorkshire – Registered nurses in post has decreased by 6.9 WTE and an increase can be observed with regards to unregistered nurses (3.7WTE). The reduction of registered nurses relates to Danby Ward (a reduction of 3 WTE) and Cedar NY with a reduction of 2.7 WTE. In terms of unregistered nurses in post, Danby have an additional 2WTE and Rowan Ward with 1.7 WTE.
- Teesside – Registered nurses in post has increased by 6.5 WTE and a reduction can be observed with regards to unregistered nurses (10.3 WTE). The increase can be observed with regards to The Evergreen Centre with an increase of 3 WTE registered nurses in post. Also, Westerdale South (1.9 WTE) and Westwood Centre (1.6 WTE) have also increased their registered nurses in post. The reduction in unregistered nurses largely equates to 4 wards (Stockdale Ward with 2.9 WTE less in post, 2.70 WTE less in Lustrum Vale, 2.2 WTE less at Bankfields Court and 1.7 less at Wingfield).
- York and Selby – An increase can be observed with regards to both registered (16.9 WTE) and unregistered nurses (5.7 WTE) in post across the locality. The additional registered nurse staffing in post is attributable to the new wards Ebor and Minster. In addition Cherry Tree House has additional 5.8 WTE registered nurses in post. In terms of unregistered nurses in post the increase is wholly attributable to Ebor and Minster. A reduction of registered (3.6 WTE) and unregistered nurses (6.7 WTE) can also be observed with regards to Meadowfields.

3.2 Right Skills

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

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

3.2.3 Consideration is being given as to incorporation of triangulation with mandatory training in future reports highlighting those that are reporting less than 75% compliance.

3.2.4 The trust does operate a number of development programmes to enhance the skills of our workforce, these are summarised below:

- ***Framework for inpatient HealthCare Assistants*** – all new starters from April 2012 have been recruited utilising the HCA Framework and options were presented to existing staff. A database of all Trainee HCA's and the existing HCA workforce is held by the Workforce Department and collates all of the training activity.

- ***Developing new roles for non*-registered staff** – this work includes health care assistants (band 2), health care support workers (band 3) and introduces associate nurse practitioner (band 4) roles, ensuring an appropriate skill mix to meet complex patient needs whilst freeing up registered practitioners to deliver more specific nursing and leadership roles. We have agreed an initial cohort of ten associate practitioners from our existing HCA staff group.
- ***Band 2 to 4 development plan*** – this is currently being developed for those bands and will support team managers in areas of skill shortages or where there are recruitment difficulties and provide a career pathway for more junior members of staff or as a route to registered professional roles
- ***Clinical staff development* –** there are a number of developments currently ongoing within the trust that include a band 5 development programme and a professional development programme. Having consistency of nursing staff can on occasion be more important than the numbers of staff or registration. Over the last 6 months wards have flexed their staffing resources when clinically appropriate to do so, using an unregistered staff who know the ward and the patients as opposed to using an agency/bank registered nurse.
- ***Preceptorship* -** preceptor preparation workshops are delivered across the Trust to support preceptors in this role. Each preceptee has a specific work based developmental programme that follows a continuum of the four key task areas from the pre-registration programme.
- ***Band 7/Ward Manager development days*** – bi-monthly development days have been established to ensure that the Ward Managers are receiving appropriate development and information sharing from the Board and other external guidance. These meetings are led by the Director of Nursing and Governance and provide peer support and reflective practice space for learning from each other's incidents and good practice.

- ***Nursing Conference* –** on the 16th September 2016 over 300 nurses from across the Trust attended a nursing conference. The conference focussed on the added value which nurses bring and the new national nursing strategy. The feedback and evaluation was extremely positive.

3.2.5 To date to safe staffing has focussed more on inpatient nursing staff numbers, but within the proposed safe staffing programme we have identified the need to extend into community and multi-disciplinary working. It is expected that the LD and MH service specific guidance will include more detail on requirements of this approach which we will take into account.

3.2.6 The Trust is also taking a more strategic approach to the development and recruitment of the Registered Nurse workforce recognising there are predicted future pressures with this group of staff. This includes evaluating the range of options for shortening nurse training whilst maintaining NMC compliance, and different ways of funding nurse training to make it attractive to potential candidates following the proposed removal of the existing training bursary scheme. In line with this the Trust has recently funded six further candidates to join the Open University part-time training scheme towards registration.

3.2.7 Work is underway jointly with the HR, and Nursing and Governance Directorates to develop a strategic approach to nurse recruitment and development. This will involve initiatives to retain staff such as the approach to retire and return options and other employer flexibilities. In addition conversations are being offered to existing qualified nurses to gather the views

about current and future nurse workforce supply issues with the intention of increasing available nursing hours across TEWV.

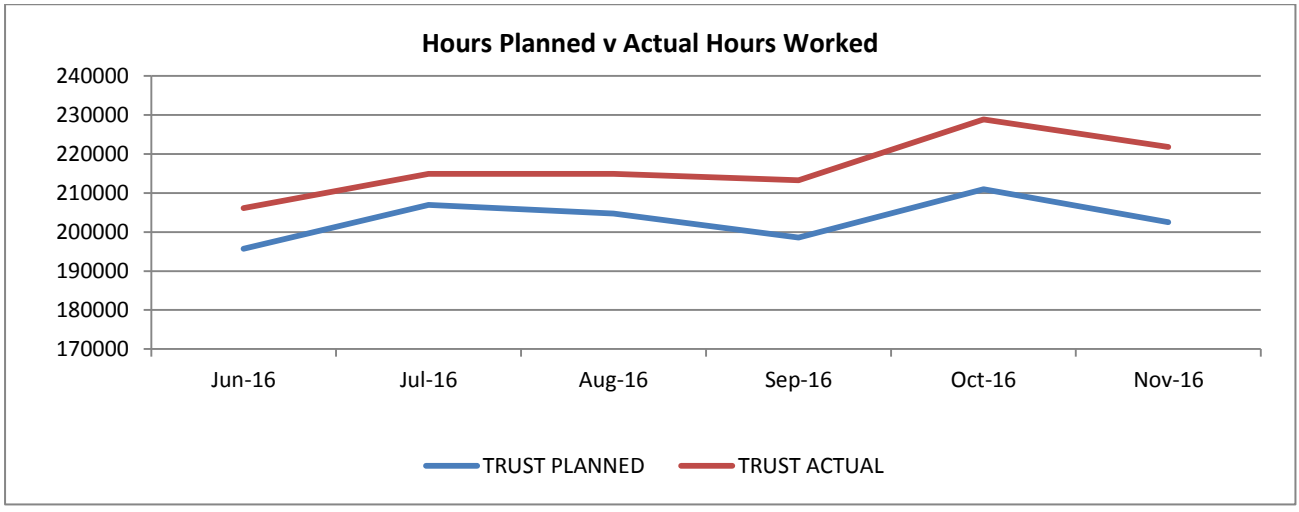
3.2.8 The Apprenticeship Levy comes into effect on the 6 April 2017. The levy will be paid by all employers with a pay bill of over £3 million each year the levy payment will be 0.5% of the Trust's pay bill minus an allowance of £15,000 which equates to £1.4 million. The Apprenticeship Levy will only apply to programmes that meet the requirements set out in the apprenticeship framework/standards. Work has already begun to align current programmes so that we can access the apprenticeship levy. The national approach to Registered Nursing Apprenticeships has just been announced and further work will take place jointly between HR and Nursing Directorate teams to clarify the way forward on this.

3.2.9 The trust has a long established approach to continuous improvement and there are key associations with programmes such as the Purposeful Productive Community Service (PPCS). A key component for the proposed safe staffing programme will be to ensure synergies with these existing programmes, so that they can feed into an overarching safe staffing approach. Update and progress against the pathway and workforce work stream within PPCS is being considered through EMT. Pathways are well underway and future reports will describe this work in more detail.

3.3 Right place and right time

3.3.1 The NQB guidance states that Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

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



3.3.3 It is important to highlight that at no point during the 6 month review did the actual hours meet the planned. Further work is to be undertaken to look at the planned versus actual hours worked over a protracted period of time, this will identify any trends or themes emerging from the data. This will be presented in future reports.

3.3.4 Appendix 3 of the report shows the average fill rate (1st June 2016 to 30th November 2016) for both days and nights for both registered and non-registered staff. The 6 monthly position shows that there were 35 wards who had fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts. Health care assistants on daytime shifts there was only 4 wards who had a fill rate below 89.9%.

3.3.5 In terms of the night time shifts the 6 monthly position shows that there were 7 wards who had fill rates of less than 89.9% (shown as red) for registered nurses and health care assistants there were 0 wards who had a fill rate below 89.9%.

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

Month	Final 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
Jun-16	91.10	↓	114.10	↑	96.40	↓	114.20	↑
Jul-16	87.40	↓	113.60	↓	97.90	↑	112.60	↓
Aug-16	86.90	↓	115.60	↑	97.30	↓	115.20	↑
Sep-16	89.60	↑	116.80	↑	99.70	↑	119.50	↑
Oct-16	89.90	↑	118.70	↑	99.80	↑	120.70	↑
Nov-16	92.90	↑	119.40	↑	100.20	↑	120.50	↓

From the table it is important to highlight the following:

- The average fill rate for registered nurses on day shifts has improved from 91.20% in June 2016 when compared to 92.90% in November 2016 (1.8% increase).
- The average fill rate for health care assistants on day shifts has increased from 114.10% in June 2016 to 119.40% in November 2016 (5.3% increase).
- The average fill rate for registered nurses on night shifts has increased from 96.40% in June 2016 when compared to 100.20% in November 2016 (3.8% increase).
- The average fill rate for health care assistants on night shifts has improved from 114.20% in June 2016 when compared to 120.50 in November 2016 (6.3% increase).
- All fill rate indicators are within the 89.9% tolerance.

3.3.7 The overall total red rated occurrences utilising the average fill rate (i.e. less than 89.9%) was 46 occurrences. The table below shows the breakdown by locality:

Locality	Total Number of Red Occurrences	Trend on previous 6 months
Durham & Darlington	5	↓ (6)
Teesside	4	↓ (6)
North Yorkshire	7	↑ (5)
Forensic Services	22	↑ (21)
York and Selby	7	↓ (10)

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

3.3.8 The 6 month average highlights Primrose Lodge as having the lowest fill rate of 58.0% for registered nurses on days. The low fill rate is as a result of sickness and vacancies. The ward do flex the use of HCA to fill some of the vacant duties, this is evident by the HCA on days fill rate reporting at 137.8% over the 6 month period.

3.3.9 The second lowest fill rate utilising the 6 month average highlights Danby Ward with a fill rate of 63.2% for registered nurses on days. Some of the shortfall is in relation to sickness, vacancies and preceptees who were unable to take charge. In addition inaccuracies in the roster were also identified which will affect the fill rate for registered nurses actually used. Work has taken place to correct the roster and this will be evident in January 2017.

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

- 19 wards who had maternity absence greater than 5% loss of the actual hours
- 48 wards who had sickness absence rates greater than 5% loss of actual hours
- 16 wards who had vacancies greater than 10% loss of actual hours
- 5 wards who had bank usage greater than 25% of actual hours worked
- 7 wards who had agency usage greater than 4% of actual hours worked

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

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

Month	Number of duties	Number of Hours
June	997	10,030
July	1,144	11,668
August	1,266	13,074
September	1,612	16,265
October	1,798	18,182
November	1,904	19,531
TOTAL	**8,721**	**88,750**

- This table highlights a month on month increase in the number of additional duties being created within the trust.

- 8,721 additional duties were created within the reporting period this is an increase of 2,109 duties when compared to the previous 6 month period.

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

Ward / Team	Number of Duties	Number or Hours
Westerdale South	1471	13072.08
Westwood Centre	819	8654.48
Merlin Ward	490	5464.25
Kestrel/Kite.	425	4032.83
Bedale Ward	402	4608.75
Cedar Ward	368	4365.57
Swift	358	3916.00
Clover/Ivy	350	3486.80
The Evergreen Centre	298	3332.25
Bankfields Court	284	3285.08
	5,265	**54,218.10**

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

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

Locality	Ward	Bank Usage %
Teesside	Westerdale South	**45.0%**
Durham & Darlington	Cedar	**36.8%**
Forensics	Merlin	**31.2%**
Forensics	Robin	**27.6%**
Teesside	Stockdale	**25.7%**

- This equates to 5 wards in 3 separate localities.

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

3.3.17 In terms of Agency usage within the reporting period, this is outlined in full below:

Locality	Ward	Total Hours	Agency Usage %
York and Selby	Worsley Court	5,829.00	27.3%
York and Selby	Ebor Ward	459.50	9.6%
North Yorkshire	Springwood	1,816.00	9.5%
North Yorkshire	Rowan Ward	1,279.00	7.4%
York and Selby	Meadowfields	1,068.50	5.6%
York and Selby	Minster Ward	287.50	5.5%
North Yorkshire	Cedar (NY)	974.70	4.6%
Forensics	Harrier / Hawk	810.00	3.5%
York and Selby	Cherry Tree House	668.00	3.2%
Forensics	Oakwood	372.45	3.1%
Forensics	Northdale Centre	618.75	2.2%
North Yorkshire	Ward 14	80.50	0.5%
Forensics	Kestrel / Kite.	135.00	0.5%
Forensics	Robin	67.50	0.5%
Teesside	Westerdale South	34.50	0.1%
Forensics	Thistle	11.15	0.1%
York and Selby	Oak Rise	11.00	0.0%

- This equates to 17 wards, the majority of which are from within the York and Selby and North Yorkshire localities.

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

Locality	Ward	Total Hours	Overtime Usage %
North Yorkshire	The Orchards (NY)	1,615.00	12.5%
Durham & Darlington	Holly	1,036.33	10.9%
Teesside	Baysdale	1,705.73	10.8%
North Yorkshire	Rowan Lea	2,162.21	9.4%
Teesside	Westwood Centre	3,175.94	9.3%
North Yorkshire	Springwood	1,618.90	8.5%
Durham & Darlington	Bek-Ramsey Wards	2,081.98	8.2%
North Yorkshire	Cedar (NY)	1,591.32	7.5%
Forensics	Clover / Ivy	1,705.51	7.3%
Forensics	Thistle	1,278.09	7.1%
Teesside	Stockdale	1,107.74	6.6%
Teesside	Bankfields Court Unit 2	904.85	6.5%
Durham & Darlington	Tunstall Ward	1,089.80	6.4%
North Yorkshire	Rowan Ward	1,108.60	6.4%
Durham & Darlington	Elm Ward	999.69	5.9%
Durham & Darlington	Birch Ward	1,086.07	5.7%
North Yorkshire	Ward 14	875.81	5.7%
York & Selby	Minster Ward	283.50	5.5%
York & Selby	Cherry Tree House	1,135.50	5.4%
Teesside	Bedale Ward	1,183.73	5.2%
Forensics	Northdale Centre	1,471.42	5.2%
Teesside	Aysgarth	696.53	5.0%
Forensics	Harrier / Hawk	1,152.12	4.9%

Forensics	Eagle / Osprey	915.36	4.9%
Durham & Darlington	Maple	772.37	4.8%
Teesside	Bilsdale	693.25	4.4%
Teesside	Westerdale North	677.75	4.2%
North Yorkshire	Ayckbourn Esk Ward	616.75	4.1%
Forensics	Langley	685.75	4.1%
Teesside	Newberry Centre	860.87	4.0%
Durham & Darlington	Farnham Ward	671.25	4.0%

- All wards across the trust are using overtime.
- Teesside are using the most overtime (15,342.61) whilst York & Selby are using the least (2,240.71).

3.3.19 The Corporate Products Team is currently working through a programme of reviews with regards to the electronic rostering solution for all inpatient areas. The reviews are to ensure maximum efficiency is created from the rostering solution and also addressing any system or training issues that may exist. An interim report has been submitted to OMT and it is anticipated that this work will be complete by end March 2017. The findings highlighted within the interim report include but not limited to:

- Auto rostering and the amount of manual adjustments as a result of redundant rules, incorrect shift patterns, outdated contractual information and employee requests.
- Annual leave distribution
- Unused hours

3.4 Patient outcomes, people productivity and financial sustainability

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

3.4.2 In turning to the triangulation of staffing data with other safety indicators. Appendix 5 provides an overview of all quality indicators for all inpatient wards. Firstly there were 12 SUI's that occurred in in-patient areas within the 6 month period. These are summarised below utilising the bank fill rate and staffing fill rates as comparative data:

No. of SUI's	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
2	Elm Ward	**12.6%**	**105.4%**	**104.4%**	**106.1%**	**111.9%**
1	Farnham Ward	**9.2%**	**121.9%**	**101.1%**	**100.4%**	**105.0%**
1	Ceddesfeld	**6.3%**	**89.3%**	**100.4%**	**132.4%**	**100.8%**
1	Hamsterley	**14.6%**	**85.1%**	**102.1%**	**155.8%**	**123.9%**
1	Roseberry Wards	**13.4%**	**90.2%**	**100.0%**	**96.0%**	**100.7%**
1	Ayckbourn Danby Ward	**12.4%**	**63.2%**	**96.4%**	**114.7%**	**94.3%**
1	Rowan Ward	**12.1%**	**90.6%**	**102.8%**	**131.0%**	**105.6%**

1	Westerdale North	5.3%	96.2%	101.2%	128.9%	103.3%
1	Westerdale South	45.0%	114.4%	99.3%	277.8%	227.3%
1	Worsley Court	2.5%	82.0%	109.7%	109.7%	169.1%
1	Cherry Tree House	8.3%	94.0%	95.8%	99.7%	160.4%

- From those wards that did have an SUI within the reporting period all had a 'green' for their bank usage with the exception of Westerdale South who reported as 'red'.
- There were only 4 fill rate indicators that were reported as 'red'; all of which related to registered nurses on days.
- All other fill rate indicators are reporting as either 'green' or 'blue'.

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

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

No. L4 Incidents	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Cedar	36.8%	105.7%	101.8%	166.5%	149.7%
1	Elm Ward	12.6%	105.4%	104.4%	106.1%	111.9%
1	Ceddesfeld	6.3%	89.3%	100.4%	132.4%	100.8%
1	Hamsterley	14.6%	85.1%	102.1%	155.8%	123.9%
2	Roseberry Wards	13.4%	90.2%	100.0%	96.0%	100.7%
1	Langley	18.7%	84.9%	102.3%	137.3%	202.4%
1	Ayckbourn Danby Ward	12.4%	63.2%	96.4%	114.7%	94.3%
1	Rowan Ward	12.1%	90.6%	102.8%	131.0%	105.6%
1	Westerdale North	5.3%	96.2%	101.2%	128.9%	103.3%
1	Westerdale South	45.0%	114.4%	99.3%	277.8%	227.3%
2	Worsley Court	2.5%	82.0%	109.7%	109.7%	169.1%
1	Cherry Tree House	8.3%	94.0%	95.8%	99.7%	160.4%

- From those wards that did have a L4 incident within the reporting period all had a 'green' for their bank usage with the exception of Cedar who reported as 'amber' and Westerdale South as 'red'.
- There were only 5 fill rate indicators that were reported as 'red'; all of which related to registered nurses on days.
- All other fill rate indicators are reporting as either 'green' or 'blue'.

3.4.4 There were 67 level 3 self-harm incidents occurred within the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No. L3 (self-harm) Incidents	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
3	Cedar	36.8%	105.7%	101.8%	166.5%	149.7%
3	Elm Ward	12.6%	105.4%	104.4%	106.1%	111.9%
3	Maple	15.2%	99.1%	100.0%	98.7%	100.8%
2	Tunstall Ward	3.6%	106.2%	104.4%	106.8%	104.2%
1	Clover / Ivy	22.9%	94.2%	100.0%	115.7%	150.5%
1	Northdale Centre	17.0%	71.3%	96.7%	110.9%	108.9%
3	Brambling	14.4%	79.5%	97.5%	111.1%	98.1%
2	Sandpiper Ward	18.8%	90.8%	77.0%	107.7%	134.2%
1	Fulmar Ward	13.9%	75.1%	101.3%	101.5%	104.5%
3	Ayckbourn Esk Ward	9.5%	68.6%	99.6%	111.8%	92.7%
12	Cedar (NY)	8.7%	99.0%	103.7%	99.1%	121.3%
1	Rowan Lea	4.7%	91.5%	114.4%	113.6%	109.8%
1	Bedale Ward	23.8%	90.7%	115.0%	173.9%	131.1%
1	Bilsdale	9.7%	92.4%	100.8%	116.5%	101.5%
6	Bransdale	20.3%	77.5%	94.4%	125.9%	101.2%
1	Lincoln Ward	8.6%	106.0%	94.7%	98.0%	110.1%
2	Overdale	8.4%	92.1%	106.0%	105.4%	98.2%
12	Newberry Centre	7.9%	81.2%	108.7%	115.8%	109.9%
2	The Evergreen Centre	11.4%	94.7%	106.7%	133.4%	127.2%
7	Westwood Centre	24.3%	100.0%	98.8%	164.3%	203.3%

- From the 67 level 3 self-harm incidents this equated to 20 wards across 4 localities.
- Teesside had the highest number of level 3 incidents in the reporting period with 32 incidents in total.
- Cedar (NY) and the Newberry Centre had the highest number of level 3 incidents across the reporting period with 12 incidents each.
- 5 out of 20 wards reported as ‘amber’ for their bank usage whilst all the others reported as ‘red’.
- There were 7 fill rate indicators that reported as ‘red’ whilst the others all reported as either ‘green’ or ‘blue’.

3.4.5 There were 32 complaints raised during the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No. of Complaints	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Cedar	36.8%	105.7%	101.8%	166.5%	149.7%
1	Elm Ward	12.6%	105.4%	104.4%	106.1%	111.9%
1	Farnham Ward	9.2%	121.9%	101.1%	100.4%	105.0%
2	Tunstall Ward	3.6%	106.2%	104.4%	106.8%	104.2%
1	Birch Ward	21.9%	85.4%	100.7%	107.8%	131.8%
1	Ceddesfeld	6.3%	89.3%	100.4%	132.4%	100.8%
2	Roseberry Wards	13.4%	90.2%	100.0%	96.0%	100.7%
1	Eagle / Osprey	11.2%	88.0%	100.0%	94.5%	102.4%

1	Kestrel / Kite.	24.8%	85.0%	87.4%	121.5%	134.2%
1	Langley	18.7%	84.9%	102.3%	137.3%	202.4%
1	Thistle	8.6%	78.3%	97.8%	114.0%	103.0%
1	Mallard	17.8%	87.5%	101.2%	111.0%	143.5%
1	Sandpiper Ward	18.8%	90.8%	77.0%	107.7%	134.2%
2	Ayckbourn Danby Ward	12.4%	63.2%	96.4%	114.7%	94.3%
1	Ayckbourn Esk Ward	9.5%	68.6%	99.6%	111.8%	92.7%
2	Ward 15	14.6%	81.2%	98.1%	128.3%	101.2%
1	Rowan Ward	12.1%	90.6%	102.8%	131.0%	105.6%
2	Bransdale	20.3%	77.5%	94.4%	125.9%	101.2%
1	Stockdale	25.7%	98.9%	102.8%	107.8%	96.7%
2	Newberry Centre	7.9%	81.2%	108.7%	115.8%	109.9%
1	The Evergreen Centre	11.4%	94.7%	106.7%	133.4%	127.2%
1	Westwood Centre	24.3%	100.0%	98.8%	164.3%	203.3%
2	Lustrum Vale	9.7%	97.3%	102.4%	103.4%	103.5%
2	Cherry Tree House	8.3%	94.0%	95.8%	99.7%	160.4%

- From the 32 complaints this equated to 22 wards across all localities.
- Durham & Darlington and Teesside localities had the highest number of complaints in the reporting period with 9 incidents occurring within each locality.
- All wards with the exception of 6 wards (Cedar, Birch and Kestrel/Kite, Bransdale, Stockdale and Westwood Centre) all reported as 'green' for bank usage whilst the 6 wards reported as 'amber'.
- 15 fill rate indicators were reporting as 'red' with 13 of these relating to registered nurses on days. All other metrics are reporting as either 'green' or 'blue'.

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

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

Ward	Locality	Incidents of Restraint				Bank Usage
		Incidents	PRO used	Other	Restraint Total	
The Evergreen Centre	Teesside	439	0	722	722	11.4%
Westwood Centre	Teesside	390	9	694	703	24.3%
Sandpiper	Forensic Services	323	33	870	903	18.8%
Springwood	North Yorkshire	209	0	236	236	5.5%
Newberry Centre	Teesside	196	2	314	316	7.9%
Bankfields Court	Teesside	155	0	242	242	5.1%
Bedale Ward	Teesside	130	6	208	214	23.8%
Kestrel / Kite	Forensic Services	110	1	217	218	24.8%
Cedar	Durham & Darlington	101	12	178	190	36.8%
Rowan Lea	North Yorkshire	88	0	147	147	4.7%

- The Evergreen Centre had 439 incidents requiring the use of restraint during the reporting period. 722 restraints in total as a result of the 439 incidents that occurred.

- 4 of the wards identified within the top 10 had an 'amber' rating for their bank usage whilst the others reported as 'green'.

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

Ward Name	Registered Average %		Unregistered Average %	
	Day	Night	Day	Night
The Evergreen Centre	**94.7%**	**106.7%**	**133.4%**	**127.2%**
Westwood Centre	**100.0%**	**98.8%**	**164.3%**	**203.3%**
Sandpiper	**90.8%**	**77.0%**	**107.7%**	**134.2%**
Springwood	**76.1%**	**107.3%**	**130.1%**	**137.1%**
Newberry Centre	**81.2%**	**108.7%**	**115.8%**	**109.9%**
Bankfields Court	**81.4%**	**95.0%**	**100.9%**	**98.7%**
Bedale Ward	**90.7%**	**115.0%**	**173.9%**	**131.1%**
Kestrel / Kite	**85.0%**	**87.4%**	**121.5%**	**134.2%**
Cedar	**105.7%**	**101.8%**	**166.5%**	**149.7%**
Rowan Lea	**91.5%**	**114.4%**	**113.6%**	**109.8%**

3.4.9 With regards to the use of Prone restraint this will continue to be monitored within the Force reduction project and monthly within the Safe Staffing reports, however, it is worth highlighting that during the reporting period there were 90 episodes of Prone used. This is an increase of 15 incidents when compared to the previous 6 month report.

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

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

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

3.4.12 Falls that have resulted in significant harm for all inpatient services have been examined. Within the reporting period there have been a total of 6 incidents across 6 wards. The ward and teams that these each relate to are as follows:

Speciality	Ward / Team	Number of incidents
MHSOP	Ceddesfeld	1
MHSOP	Roseberry Wards	1
MHSOP	Rowan Ward	1
MHSOP	Westerdale North	1
MHSOP	Westerdale South	1
MHSOP	Cherry Tree House	1

- All of the falls incidents have occurred within the older people's service due to other health problems that they may encounter such as reduced vision, mobility and balance problems.
- In turning to the triangulation of data with the safe nursing indicators the following is of relevance:
  - The only ward to have a 'red' rated fill rate was in relation to Ceddesfeld and was in relation to registered nurses on days. All other fill rates are reporting as either 'green' or 'blue'.
  - Roseberry Ward, Rowan Ward and Westerdale South all had an 'amber' rated bank usage. All other bank usage rates are reporting as 'green'.
  - Agency and overtime are reporting as 'green' for all 6 wards

3.4.13 Data in relation to pressure ulcers was obtained covering the reporting period. There were 11 incidents reported across 6 wards as follows:

Speciality	Ward / Team	Number of incidents
MHSOP	Hamsterley	4
MHSOP	Rowan Lea	2
MHSOP	Ward 14	2
AMH	Bransdale	1
CYPS	The Evergreen	1
MHSOP	Westerdale South	1

- As expected, the majority of the incidents of 'pressure ulcers' occurred within the older people's service.
- In turning to the triangulation of staffing data:
  - Hamsterley, Ward 14 and Bransdale all had one metric within the staffing fill rate that was classified as 'red'. All other fill rate indicators are reporting as either 'green' or 'blue'
  - Rowan Lea and Ward 14 are all reporting as 'green' for bank usage. All other wards are reporting as 'amber' for bank usage.
  - Agency workers were utilised within Ward 14 and Westerdale South
  - Overtime was worked across all of the wards listed.

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

3.4.15 There were 448 incidents of medication errors reported within the reporting period across 64 wards. The top 6 wards are shown as follows:

Ward / Team	Number of incidents
Linnet	33
Lustrum Vale	22
Swift	20
Cherry Tree House	19
Elm	16
Westerdale North	15
Merlin	15

- Linnet, Merlin and Swift all have 1 fill rate reporting as 'red'. All other fill rate indicators are reporting as either 'green' or 'blue'.
- Lustrum Vale, Westerdale North and Cherry Tree House are reporting as 'green' for their bank usage. All other wards are reporting as 'amber'.
- From the wards listed agency working was only undertaken within Cherry Tree House
- Overtime working occurred within all of the wards listed.

3.4.16 In terms of shifts worked without a break there were 3902 shifts worked within the reporting period where breaks were not given. The top 5 wards were as follows:

WARD	No of eligible shifts	No. of eligible shifts without breaks 1st Jun 16 – 30th Nov 16	% of shifts without break	Days without breaks	Nights without break
Newberry Centre	2796	400	14.31	262	138
Baysdale	1291	264	20.45	264	0
The Evergreen Centre	3496	209	5.98	100	109
Westwood Centre	3517	177	5.03	92	85
Rowan Lea	2307	145	6.29	65	80

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

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

Ward Name	Registered Average %		Unregistered Average %	
	Day	Night	Day	Night
Newberry Centre	**81.2%**	**108.7%**	**115.8%**	**109.9%**
Baysdale	**118.8%**	**103.5%**	**105.4%**	**101.4%**
The Evergreen Centre	**94.7%**	**106.7%**	**133.4%**	**127.2%**
Westwood Centre	**100.0%**	**98.8%**	**164.3%**	**203.3%**
Rowan Lea	**91.5%**	**114.4%**	**113.6%**	**109.8%**

- There is only 1 fill rate indicator that is reporting as 'red' and that relates to the Newberry Centre for registered nurses on days.
- All other indicators are reporting as either 'green' or 'blue'.

3.4.17 Breaks not taken due to clinical need is being monitored on a monthly basis through the locality performance improvement groups.

3.5 Reporting, investigating and acting on incidents

3.5.1 The NQB guidance advises NHS providers to follow best practice guidance in the investigation of all patient safety incidents, including root cause analysis for serious incidents. As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified. In addition NHS providers should consider reports of the 'red flag' issues suggested in the NICE guidance, and any other incident where a patient was or could have been harmed, as part of the risk management of patient safety incidents. Incidents must be reviewed alongside other data sources, including local quality improvement data (e.g. for omitted medication) clinical audits or locally agreed monitoring information, such as delays or omissions of planned care. Furthermore, NHS providers should actively encourage all staff to report any occasion where a less than optimal level of suitably trained or experienced staff harmed or seems likely to harm a patient. These locally reported incidents should be considered patient safety incidents rather than solely staff safety incidents, and they should be routinely uploaded to the National Reporting and Learning System.

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

3.5.3 It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. Within the reporting period there were 121 incidents raised citing issues with staffing. This is an increase of 55 when compared to the previous 6 month report and could be attributable to the escalation policy following its introduction. The incidents citing staffing problems were from the following localities:

Locality	Number of incidents raised	Trend on previous 6 month
North Yorkshire	39	↑ (14)
Durham & Darlington	19	↑ (13)
Teesside	21	↑ (10)
Forensics	20	↑ (19)
York and Selby	22	↑ (10)

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
- Due to staffing, wards would be unable to provide a response should this be required during the course of the shift.

- Occasions whereby there would be insufficient staffing to undertake physical restraint should this be required during the course of the shift.
- Other reasons were highlighted and include:
  - Staff not being able to take breaks
  - Staff asleep whilst on duty
  - Unable to carry out regular reviews for those patients on seclusion, supervise patients or carry out escorts.
  - Unable to carry out correct level of observations
  - Issues with medication, obtaining a doctor and prescribing

Monthly monitoring of this occurs within the monthly safe staffing reports. The trust adopted an escalation process to ensure a standard approach was adopted across the Trust and a timely response to ensure patient safety is not compromised. The escalation process will be reviewed in January 2017 to ensure that it is delivering what it was intended to do however it is encouraging that increased reporting is evident since this was introduced.

3.6 Patient, staff and carer feedback

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

3.6.2 A further analysis of the 32 complaints has been undertaken to identify whether there were any specific issues rose citing staffing levels. The review concluded that there were no specific concerns raised in this regard.

3.6.3 In addition analysis has been undertaken with regards to patient and carer feedback that has been submitted in relation to the friends and family test. The analysis did not highlight any specific concerns with regards to staffing levels.

3.6.4 The trust receives compliments and these are captured and published via the weekly e-Bulletin. A total of 245 compliments were received during the reporting period covering all localities. A further review has been undertaken and these highlight a number of individuals and commends the work they have undertaken but nothing specific in relation to actual staffing levels.

3.6.5 Future development of this particular aspect will be undertaken as part of the safe staffing programme that will seek to triangulate specific comments against a range of safe staffing metrics ensuring that this is accessible in a single dashboard.

3.7 Care hours per patient day (CHPPD)

3.7.1 Although there is no requirement for TEWV to report nationally the care hours per patient day, a metric which emerged from the Lord Carter review programme, this is currently being developed in shadow format. A dedicated piece of work will be undertaken as part of the safe staffing programme that will undertake further analysis of this data to better understand what this means for TEWV and what 'good' may look like for the trust. The operational management team will also need to be involved in this key development.

3.8 Draft LD Staffing Guidance "An improvement resource for learning disability services (2016) NQB

3.8.1 Draft guidance has been published with regards to learning disability services. The guidance captures all aspects of the NQB staffing guidance with specific emphasis to LD services. This guidance focuses on a 5 year forward view in particular the transforming care agenda and the shift to community based services. The guidance is currently out for consultation. The Deputy Director of Nursing is coordinating the trusts response to the consultation and highlights are detailed below for the Boards consideration:

- The report sets ot an approach to staffing reviews and the use of decision making tools, with reference to an Appendix 3 setting out the methods, and link to CHPPD as a metric which we are collating in shadow form across the trust at moment.

- A key statement relates to the need for flexible contingency planning to ensure a flexible, moveable, multi-skilled and adaptable workforce from across the organisation that can be mobilised quickly in order to respond to people's often rapidly changing needs (this is in line with the Trusts current approach being piloted in Forensicservices and at West Park hospital)

- It suggests trend data are captured from recent episodes to give a guide to planning, then specifically recommends;

    - *providers ensure a skilled temporary workforce is available through a 'staffing bank' or other flexible working arrangements, that can respond 24 hours a day, seven days a week and adapt to specialing needs and unplanned variation in acuity and dependency levels (*This is in line with some of the creative responses the organisation has developed to complex individuals in recent years, not just in LD services, but seeks to put it on a more formal footing and with a clear commissioning route)

- There is an emphasis on minimising usage of agency staff in line with other NHS guidance; this is not particularly a feature locally within TEWV.

- Individuals making unplanned staffing decisions based on professional judgement should be backed up and guided by senior staff in the management team (This is normally a feature of our way of working, as evidenced by flexibility in fill-rates to meet temporary demand)

- The report also highlights the need for clear protocols etc. where there is multi-agency working and to ensure clarity with regards to roles within teams.

- A safe staffing dashboard is referred to within the document. This will be considered further as part of the safe staffing programme and will look to utilise the integrated information centre. Suggested metrics include sickness, supervisions, rates of restraint, length of stay, FFT, repeat admissions, reporting of incidents and lessons learned process etc.

- Given that NHS trusts provide a range of services and are configured in different ways, it is recommended that a framework approach is utilised to monitor safe staffing levels rather than a prescriptive or standardised model.

- 11 recommendations have been cited within the document and conclude with the need for further robust research on staffing in LD.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

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

This work is being progressed within the safe staffing work stream to build on the existing safe staffing approach and help prepare for the likely requirements of the new guidance. This work stream is managed within the OMT forum as outlined in section 3.2.3 of this report.

4.3 Legal and Constitutional (including the NHS Constitution):

The Care Quality Commission and NHS England have set regulatory and contractual requirements that the Trust ensures adequate and appropriate staffing levels and skill mix to deliver safe and effective care. Inadequate staffing can result in non-compliance action and contractual breach. The March 2013 NHS England and CQC directives set out specific requirements that will be checked through inspection and contractual monitoring as they are also included in standard commissioning contracts.

The Trust has complied with these directives to date.

4.4 Equality and Diversity:

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

4.5 Other implications:

There are no other implications identified

5.0 RISKS:

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

6.0 CONCLUSIONS:

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

6.2 The safe staffing work stream will continue to review existing processes and prepare for the new requirements and any guidance during the financial year 2016/17. Data collection and analysis will be further developed and reported on going forward.

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

7.0 RECOMMENDATIONS:

- That the Board of Directors notes the outputs of the reports including the LD consultation and raise any issues for further investigation and development.

Emma Haimes, Head of Quality Data
Stephen Scorer, Associate Director of Nursing
Elizabeth Moody, Director of Nursing and Governance

January 2017

APPENDIX 1

Standard Process Description – Establishment Reviews

Standard Process Description Establishn

Budgeted and Actual Staffing Establishments in WTE

Appendix 2

Locality	WARD	Speciality	Establishment at 1/6/16				Establishment at 30/11/16				Comparison 1/06/16 to 30/11/16 Budget v actual WTE hours			
			Registered Staff		Unregistered Staff		Registered staff		Unregistered staff		Registered Staff		Unregistered Staff	
			Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
Durham & Darlington	Cedar Ward	Adults	8.50	11.30	14.30	13.20	9.50	9.80	14.30	15.20	1.00	-1.50	0.00	2.00
	Birch Ward	Adults	8.60	7.30	15.90	14.30	8.60	5.60	15.90	10.70	0.00	-1.70	0.00	-3.60
	Primrose Lodge	Adults	8.60	9.80	11.40	13.00	8.60	8.00	11.40	13.00	0.00	-1.80	0.00	0.00
	Willow Ward	Adults	8.60	8.70	12.40	14.90	8.60	9.30	12.40	13.90	0.00	0.60	0.00	-1.00
	Maple Ward	Adults	8.60	10.40	11.40	10.60	8.60	9.40	11.40	10.60	0.00	-1.00	0.00	0.00
	Elm Ward	Adults	8.60	9.50	11.40	10.30	8.60	8.50	11.40	11.00	0.00	-1.00	0.00	0.70
	Farnham Ward	Adults	8.60	9.60	11.40	10.50	8.60	10.60	11.40	10.60	0.00	1.00	0.00	0.10
	Tunstall Ward	Adults	8.60	8.00	11.40	11.60	8.60	9.00	11.40	11.60	0.00	1.00	0.00	0.00
	Holly Unit	CYPS	4.80	4.60	5.20	5.60	4.60	4.60	5.60	5.60	-0.20	0.00	0.40	0.00
	Bek, Talbot Wards	LD	11.20	8.40	44.10	23.80	9.60	7.40	25.70	25.00	-1.60	-1.00	-18.40	1.20
	Ceddesfeld Ward	MHSOP	8.60	8.40	5.40	11.70	8.60	9.40	13.20	15.30	0.00	1.00	7.80	3.60
	Hamsterley Ward	MHSOP	8.60	8.00	7.00	9.70	8.60	9.40	13.20	13.00	0.00	1.40	6.20	3.30
	Picktree Ward.	MHSOP	8.60	5.40	8.30	9.10	0.00	0.00	0.00	0.00	-8.60	-5.40	-8.30	-9.10
	Oak Ward	MHSOP	8.60	9.40	11.40	11.20	8.60	8.80	11.40	11.20	0.00	-0.60	0.00	0.00
	Roseberry Wards	MHSOP	8.60	8.30	12.40	12.40	8.60	8.30	12.40	12.00	0.00	0.00	0.00	-0.40
Forensics	Clover/Ivy	Forensics LD	8.10	9.00	20.20	18.60	8.10	8.00	20.20	20.10	0.00	-1.00	0.00	1.50
	Thistle Ward	Forensics LD	10.70	6.00	14.80	12.50	10.70	6.00	148.00	13.90	0.00	0.00	133.20	1.40
	Northdale Centre	Forensics LD	8.10	5.00	27.80	24.90	8.10	8.00	27.80	23.90	0.00	3.00	0.00	-1.00
	Oakwood	Forensics LD	8.10	7.70	6.60	8.00	8.10	8.70	6.60	8.00	0.00	1.00	0.00	0.00
	Eagle/Osprey	Forensics LD	8.10	9.70	17.50	19.30	8.10	12.70	17.50	18.80	0.00	3.00	0.00	-0.50
	Harrier/Hawk	Forensics LD	8.10	7.90	20.20	16.00	8.10	8.90	20.20	17.80	0.00	1.00	0.00	1.80
	Langley Ward	Forensics LD	8.10	7.70	9.30	9.00	8.10	6.00	9.30	10.00	0.00	-1.70	0.00	1.00

	Robin (formally K,H & Robin)	Forensics LD	5.40	6.00	9.50	9.60	0.00	0.00	0.00	0.00	-5.40	-6.00	-9.50	-9.60
	Kestrel/Kite	Forensics LD	8.10	5.80	22.00	18.40	8.10	9.80	22.00	26.60	0.00	4.00	0.00	8.20
	Brambling Ward	Forensics MH	8.10	8.00	13.20	12.20	8.10	8.00	13.20	15.20	0.00	0.00	0.00	3.00
	Jay Ward	Forensics MH	8.10	6.40	13.40	13.00	8.10	7.30	13.40	13.00	0.00	0.90	0.00	0.00
	Sandpiper Ward	Forensics MH	10.70	9.00	17.10	16.50	10.70	10.00	17.10	17.50	0.00	1.00	0.00	1.00
	Merlin	Forensics MH	10.70	8.50	15.30	14.60	10.70	9.50	15.30	14.20	0.00	1.00	0.00	-0.40
	Swift Ward	Forensics MH	8.10	8.00	15.30	14.10	8.10	8.90	15.30	16.70	0.00	0.90	0.00	2.60
	Fulmar Ward.	Forensics MH	8.10	8.20	15.30	15.00	8.10	8.20	15.30	14.20	0.00	0.00	0.00	-0.80
	Lark	Forensics MH	8.10	7.40	13.20	11.00	8.10	7.40	13.20	14.00	0.00	0.00	0.00	3.00
	Kirkdale Ward	Forensics MH	8.10	7.90	15.30	13.90	8.10	7.80	15.30	14.90	0.00	-0.10	0.00	1.00
	Mallard Ward	Forensics MH	8.10	7.60	15.30	16.40	8.10	6.60	15.30	16.50	0.00	-1.00	0.00	0.10
	Mandarin	Forensics MH	8.10	9.00	13.20	12.40	8.10	9.00	13.20	13.40	0.00	0.00	0.00	1.00
	Nightingale Ward	Forensics MH	8.10	7.00	13.20	12.70	8.10	7.00	13.20	13.70	0.00	0.00	0.00	1.00
	Linnet Ward	Forensics MH	8.10	4.90	13.20	13.80	8.10	5.90	11.20	14.00	0.00	1.00	-2.00	0.20
	Newtondale Ward	Forensics MH	10.70	8.00	17.90	16.70	10.70	8.00	17.90	18.60	0.00	0.00	0.00	1.90
North Yorkshire	Abdale House (The Orchards)	Adults	10.70	9.70	5.60	5.50	10.70	10.80	5.40	5.60	0.00	1.10	-0.20	0.10
	Ayckbourn Unit Danby Ward	Adults	9.10	7.00	10.70	10.00	8.10	4.00	10.70	12.00	-1.00	-3.00	0.00	2.00
	Ayckbourn Unit Esk Ward	Adults	9.10	8.40	10.70	11.60	10.10	7.40	10.70	11.60	1.00	-1.00	0.00	0.00
	Ward 15 Friarage	Adults	9.10	8.00	10.70	11.60	9.10	8.00	10.70	11.50	0.00	0.00	0.00	-0.10
	Cedar Ward (NY)	Adults	9.10	10.00	15.20	13.60	9.10	7.30	15.20	12.00	0.00	-2.70	0.00	-1.60
	Ward 14	MHSOP	9.10	8.40	10.00	10.40	8.10	7.80	10.00	10.40	-1.00	-0.60	0.00	0.00
	Rowan Ward	MHSOP	9.10	9.30	10.70	9.60	8.10	8.60	10.70	11.30	-1.00	-0.70	0.00	1.70
	Springwood Community Unit	MHSOP	9.10	8.00	12.50	11.40	8.10	7.00	12.50	12.00	-1.00	-1.00	0.00	0.60
	Rowan Lea	MHSOP	9.10	7.40	17.90	18.40	8.10	8.40	17.90	19.40	-1.00	1.00	0.00	1.00
Teesside	Bedale Ward	Adults	8.20	8.00	13.70	13.70	8.20	7.00	13.70	13.70	0.00	-1.00	0.00	0.00
	Bilsdale Ward	Adults	8.20	9.00	11.00	10.20	8.20	7.80	11.00	10.70	0.00	-1.20	0.00	0.50
	Bransdale Ward	Adults	8.20	6.80	10.00	9.80	8.20	8.80	10.00	8.00	0.00	2.00	0.00	-1.80
	Overdale Ward	Adults	8.20	8.60	11.00	12.00	8.20	8.60	11.00	9.80	0.00	0.00	0.00	-2.20

	Stockdale Ward	Adults	8.20	7.60	11.00	11.50	8.20	7.60	11.00	8.60	0.00	0.00	0.00	-2.90
	Lincoln Ward	Adults	9.40	10.30	11.90	13.30	9.70	9.40	11.90	13.90	0.30	-0.90	0.00	0.60
	Lustrum Vale	Adults	10.30	11.00	11.00	13.00	10.30	11.00	11.00	10.30	0.00	0.00	0.00	-2.70
	Baysdale	CYPS	6.70	7.10	12.70	12.50	6.70	7.10	12.70	12.50	0.00	0.00	0.00	0.00
	Newberry Centre	CYPS	12.70	15.40	15.20	16.80	12.70	14.50	15.20	16.60	0.00	-0.90	0.00	-0.20
	The Evergreen Centre	CYPS	13.50	14.00	18.30	19.60	13.50	17.10	18.30	19.90	0.00	3.10	0.00	0.30
	Westwood Centre	CYPS	14.70	13.80	16.50	16.00	14.70	15.40	16.50	16.90	0.00	1.60	0.00	0.90
	Thornaby Road	LD	3.40	3.40	10.30	9.40	3.40	3.60	10.30	9.70	0.00	0.20	0.00	0.30
	Aysgarth	LD	6.00	5.40	11.50	9.40	6.00	5.40	11.50	9.50	0.00	0.00	0.00	0.10
	Bankfields Court Unit 2	LD	6.60	8.00	9.50	7.70	6.60	7.80	9.50	7.80	0.00	-0.20	0.00	0.10
	Bankfields Court	LD	14.30	17.20	58.30	47.40	14.30	18.10	58.30	45.20	0.00	0.90	0.00	-2.20
	Wingfield Ward	MHSOP	8.10	7.80	10.00	11.40	8.80	7.80	9.10	9.70	0.70	0.00	-0.90	-1.70
	Westerdale South	MHSOP	8.20	8.50	11.00	12.00	8.20	10.40	11.00	12.60	0.00	1.90	0.00	0.60
	Westerdale North	MHSOP	8.20	8.20	11.00	11.40	8.20	9.20	11.00	11.40	0.00	1.00	0.00	0.00
York & Selby	Ebor Ward	Adults	0.00	0.00	0.00	0.00	9.40	6.50	11.70	8.50	9.40	6.50	11.70	8.50
	Minster Ward	Adults	0.00	0.00	0.00	0.00	9.40	8.80	11.70	5.40	9.40	8.80	11.70	5.40
	Cherry Tree House	MHSOP	14.00	5.00	15.00	12.00	11.20	10.80	15.00	12.20	-2.80	5.80	0.00	0.20
	Oak Rise	ALD	9.90	12.10	10.20	20.60	9.40	11.50	21.20	20.20	-0.50	-0.60	11.00	-0.40
	Worsley Court	MHSOP	9.00	6.60	13.50	18.40	9.00	6.60	13.50	17.10	0.00	0.00	0.00	-1.30
	Meadowfields	MHSOP	9.30	9.80	13.50	21.50	9.30	6.20	13.50	14.80	0.00	-3.60	0.00	-6.70

Average fill rate covering the period of 1st June 2016 to 30th November 2016

Appendix 3

Ward Name	Locality	Speciality	Bed Numbers (NOV)	6 Months - 1st June 2016 - 30th November 2016					
				Registered Average %		Unregistered Average %		Bank Usage vs Actual Hours	
				Day	Night	Day	Night	Hours	% against Actual Hours
Cedar	Durham & Darlington	AMH	10	105.7%	101.8%	166.5%	149.7%	8777.22	36.8%
Elm Ward	Durham & Darlington	AMH	20	105.4%	104.4%	106.1%	111.9%	2119.49	12.6%
Farnham Ward	Durham & Darlington	AMH	20	121.9%	101.1%	100.4%	105.0%	1551.17	9.2%
Maple	Durham & Darlington	AMH	20	99.1%	100.0%	98.7%	100.8%	2467.58	15.2%
Primrose Lodge	Durham & Darlington	AMH	15	58.0%	96.2%	137.8%	99.5%	756.00	4.8%
Tunstall Ward	Durham & Darlington	AMH	20	106.2%	104.4%	106.8%	104.2%	607.67	3.6%
Willow Ward	Durham & Darlington	AMH	15	90.8%	100.0%	160.3%	101.7%	361.33	2.1%
Holly	Durham & Darlington	CYPS	4	131.6%	114.2%	146.3%	166.0%	773.41	8.2%
Birch Ward	Durham & Darlington	ED	15	85.4%	100.7%	107.8%	131.8%	4137.02	21.9%
Bek-Ramsey Wards	Durham & Darlington	LD	11	94.0%	100.0%	111.6%	101.5%	648.67	2.5%
Ceddesfeld	Durham & Darlington	MHSOP	15	89.3%	100.4%	132.4%	100.8%	1117.82	6.3%
Hamsterley	Durham & Darlington	MHSOP	15	85.1%	102.1%	155.8%	123.9%	2721.51	14.6%
Oak Ward	Durham & Darlington	MHSOP	12	96.6%	100.0%	95.3%	102.0%	564.06	3.6%
Picktree	Durham & Darlington	MHSOP		76.1%	91.5%	107.1%	95.6%	1347.69	24.9%
Roseberry Wards	Durham & Darlington	MHSOP	15	90.2%	100.0%	96.0%	100.7%	2233.33	13.4%
Clover / Ivy	Forensics	Forensic LD	12	94.2%	100.0%	115.7%	150.5%	5343.82	22.9%
Eagle / Osprey	Forensics	Forensic LD	10	88.0%	100.0%	94.5%	102.4%	2117.57	11.2%
Harrier / Hawk	Forensics	Forensic LD	10	76.6%	90.3%	108.2%	134.5%	2717.24	11.6%
Kestrel / Kite.	Forensics	Forensic LD	16	85.0%	87.4%	121.5%	134.2%	6654.93	24.8%
Robin	Forensics	Forensic LD		67.4%	95.0%	126.2%	99.2%	3743.80	27.6%
Langley	Forensics	Forensic LD	10	84.9%	102.3%	137.3%	202.4%	3144.17	18.7%
Northdale Centre	Forensics	Forensic LD	12	71.3%	96.7%	110.9%	108.9%	4802.32	17.0%
Oakwood	Forensics	Forensic LD	8	80.2%	94.6%	193.3%	102.3%	780.50	6.5%
Thistle	Forensics	Forensic LD	5	78.3%	97.8%	114.0%	103.0%	1560.75	8.6%
Brambling	Forensics	Forensic MH	13	79.5%	97.5%	111.1%	98.1%	2406.75	14.4%
Jay Ward	Forensics	Forensic MH	5	73.7%	105.7%	114.0%	105.8%	2901.00	17.0%
Lark	Forensics	Forensic MH	15	85.4%	99.6%	110.6%	99.4%	2567.16	15.2%
Linnet Ward	Forensics	Forensic MH	17	75.4%	101.1%	125.3%	102.9%	3872.58	22.0%
Mallard	Forensics	Forensic MH	16	87.5%	101.2%	111.0%	143.5%	3702.65	17.8%
Mandarin	Forensics	Forensic MH	16	74.0%	103.0%	130.0%	120.1%	2996.50	16.1%

Merlin	Forensics	Forensic MH	10	97.1%	87.8%	130.3%	179.5%	8064.75	31.2%
Newtondale	Forensics	Forensic MH	20	84.7%	78.4%	101.5%	104.6%	1901.94	8.9%
Nightingale	Forensics	Forensic MH	16	86.7%	114.1%	103.5%	97.8%	1991.70	11.7%
Sandpiper Ward	Forensics	Forensic MH	8	90.8%	77.0%	107.7%	134.2%	4431.75	18.8%
Swift Ward	Forensics	Forensic MH	10	81.7%	104.1%	129.3%	148.5%	4974.75	22.4%
Fulmar Ward	Forensics	Locked Rehab	12	75.1%	101.3%	101.5%	104.5%	2487.08	13.9%
The Orchards (NY)	North Yorkshire	AMH	10	96.7%	80.9%	83.8%	115.6%	140.00	1.1%
Ayckbourn Danby Ward	North Yorkshire	AMH	11	63.2%	96.4%	114.7%	94.3%	1812.23	12.4%
Ayckbourn Esk Ward	North Yorkshire	AMH	11	68.6%	99.6%	111.8%	92.7%	1439.50	9.5%
Cedar (NY)	North Yorkshire	AMH	18	99.0%	103.7%	99.1%	121.3%	1834.92	8.7%
Ward 15	North Yorkshire	AMH	14	81.2%	98.1%	128.3%	101.2%	2213.50	14.6%
Rowan Lea	North Yorkshire	MHSOP	20	91.5%	114.4%	113.6%	109.8%	1074.69	4.7%
Rowan Ward	North Yorkshire	MHSOP	16	90.6%	102.8%	131.0%	105.6%	2096.80	12.1%
Springwood	North Yorkshire	MHSOP	14	76.1%	107.3%	130.1%	137.1%	1046.94	5.5%
Ward 14	North Yorkshire	MHSOP	9	88.5%	103.0%	119.5%	108.2%	207.50	1.3%
Kirkdale	Teesside	Locked Rehab	16	91.5%	102.7%	100.9%	111.5%	1887.00	9.9%
Bedale Ward	Teesside	AMH	10	90.7%	115.0%	173.9%	131.1%	5359.25	23.8%
Bilsdale	Teesside	AMH	14	92.4%	100.8%	116.5%	101.5%	1529.50	9.7%
Bransdale	Teesside	AMH	14	77.5%	94.4%	125.9%	101.2%	3153.25	20.3%
Lincoln Ward	Teesside	AMH	20	106.0%	94.7%	98.0%	110.1%	1643.42	8.6%
Overdale	Teesside	AMH	18	92.1%	106.0%	105.4%	98.2%	1313.50	8.4%
Stockdale	Teesside	AMH	18	98.9%	102.8%	107.8%	96.7%	4278.05	25.7%
Baysdale	Teesside	CYPS	6	118.8%	103.5%	105.4%	101.4%	691.38	4.4%
Newberry Centre	Teesside	CYPS	14	81.2%	108.7%	115.8%	109.9%	1682.23	7.9%
The Evergreen Centre	Teesside	CYPS	16	94.7%	106.7%	133.4%	127.2%	3617.20	11.4%
Westwood Centre	Teesside	CYPS	12	100.0%	98.8%	164.3%	203.3%	8335.92	24.3%
Aysgarth	Teesside	LD	6	113.2%	101.3%	139.7%	100.4%	2414.33	17.2%
Bankfields Court	Teesside	LD	19	81.4%	95.0%	100.9%	98.7%	2429.56	5.1%
Bankfields Court Unit 2	Teesside	LD	5	124.1%	100.8%	100.0%	112.4%	2099.65	15.2%
Lustrum Vale	Teesside	MHSOP	20	97.3%	102.4%	103.4%	103.5%	1645.00	9.7%
Westerdale North	Teesside	MHSOP	18	96.2%	101.2%	128.9%	103.3%	863.50	5.3%
Westerdale South	Teesside	MHSOP	14	114.4%	99.3%	277.8%	227.3%	13145.96	45.0%
Wingfield	Teesside	MHSOP	10	77.8%	104.1%	129.6%	112.9%	1966.00	12.6%
Ebor Ward	York & Selby	AMH	12	91.5%	86.4%	76.5%	95.8%	524.00	10.9%
Minster Ward	York & Selby	AMH	12	103.3%	95.5%	67.3%	96.8%	709.00	13.7%

Oak Rise	York & Selby	LD	8	**132.3%**	**99.7%**	**82.4%**	**99.9%**	1282.85	**5.2%**
Meadowfields	York & Selby	MHSOP	14	**80.8%**	**86.6%**	**101.9%**	**111.5%**	2309.40	**12.1%**
Worsley Court	York & Selby	MHSOP	14	**82.0%**	**109.7%**	**109.7%**	**169.1%**	525.17	**2.5%**
Cherry Tree House	York & Selby	MHSOP	18	**94.0%**	**95.8%**	**99.7%**	**160.4%**	1741.00	**8.3%**

Absence Factors and Additional Staffing Usage **Appendix 4**

Ward Name	Locality	Speciality	Overtime		Agency		Bank		Maternity		Sickness		Vacancies	
			Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours
Cedar	Durham & Darlington	AMH	413.14	1.73%	0	0.0%	8777.2	36.8%	51.0	0.2%	2743.5	11.5%	251.3	1.1%
Elm Ward	Durham & Darlington	AMH	999.69	5.94%	0	0.0%	2119.5	12.6%	1359.0	8.1%	1938.5	11.5%	450.0	2.7%
Farnham Ward	Durham & Darlington	AMH	671.25	3.97%	0	0.0%	1551.2	9.2%	0.0	0.0%	964.0	5.7%	352.5	2.1%
Maple	Durham & Darlington	AMH	772.37	4.75%	0	0.0%	2467.6	15.2%	0.0	0.0%	1666.0	10.3%	322.5	2.0%
Primrose Lodge	Durham & Darlington	AMH	108	0.69%	0	0.0%	756.0	4.8%	0.0	0.0%	2595.0	16.6%	41.3	0.3%
Tunstall Ward	Durham & Darlington	AMH	1089.8	6.45%	0	0.0%	607.7	3.6%	0.0	0.0%	2240.0	13.3%	341.3	2.0%
Willow Ward	Durham & Darlington	AMH	302.67	1.73%	0	0.0%	361.3	2.1%	0.0	0.0%	3043.1	17.4%	112.5	0.6%
Holly	Durham & Darlington	CYPS	1036.33	10.93%	0	0.0%	773.4	8.2%	0.0	0.0%	709.7	7.5%	60.0	0.6%
Birch Ward	Durham & Darlington	ED	1086.07	5.74%	0	0.0%	4137.0	21.9%	0.0	0.0%	2149.8	11.4%	1908.8	10.1%
Bek-Ramsey Wards	Durham & Darlington	LD	2081.98	8.18%	0	0.0%	648.7	2.5%	0.0	0.0%	1671.0	6.6%	682.5	2.7%
Ceddesfeld	Durham & Darlington	MHSOP	256	1.43%	0	0.0%	1117.8	6.3%	0.0	0.0%	1527.0	8.5%	240.0	1.3%
Hamsterley	Durham & Darlington	MHSOP	711.31	3.80%	0	0.0%	2721.5	14.6%	397.5	2.1%	1793.0	9.6%	285.0	1.5%
Oak Ward	Durham & Darlington	MHSOP	352.69	2.23%	0	0.0%	564.1	3.6%	0.0	0.0%	831.0	5.2%	67.5	0.4%
Picktree	Durham & Darlington	MHSOP	133.16	2.46%	0	0.0%	1347.7	24.9%	0.0	0.0%	1068.0	19.7%	885.0	16.4%
Roseberry Wards	Durham & Darlington	MHSOP	360.52	2.16%	0	0.0%	2233.3	13.4%	786.0	4.7%	1295.7	7.8%	281.3	1.7%
Clover / Ivy	Forensics	Forensic LD	1705.51	7.31%	0	0.0%	5343.8	22.9%	976.0	4.2%	641.3	2.7%	1451.3	6.2%
Eagle / Osprey	Forensics	Forensic LD	915.36	4.86%	0	0.0%	2117.6	11.2%	1376.3	7.3%	3082.3	16.4%	637.5	3.4%
Harrier / Hawk	Forensics	Forensic LD	1152.12	4.91%	810	3.5%	2717.2	11.6%	615.0	2.6%	1080.0	4.6%	1597.5	6.8%
Kestrel / Kite.	Forensics	Forensic LD	885.75	3.30%	135	0.5%	6654.9	24.8%	1447.5	5.4%	2076.3	7.7%	1368.8	5.1%
Robin	Forensics	Forensic LD	431.59	3.19%	67.5	0.5%	3743.8	27.6%	2066.3	15.3%	1036.0	7.6%	1316.3	9.7%
Langley	Forensics	Forensic LD	685.75	4.07%	0	0.0%	3144.2	18.7%	0.0	0.0%	1112.8	6.6%	461.3	2.7%
Northdale Centre	Forensics	Forensic LD	1471.42	5.22%	618.75	2.2%	4802.3	17.0%	108.8	0.4%	704.8	2.5%	1432.5	5.1%
Oakwood	Forensics	Forensic LD	275	2.27%	372.45	3.1%	780.5	6.5%	678.8	5.6%	1203.8	10.0%	206.3	1.7%
Thistle	Forensics	Forensic LD	1278.09	7.08%	11.15	0.1%	1560.8	8.6%	0.0	0.0%	0.0	0.0%	2336.3	12.9%
Brambling	Forensics	Forensic MH	213.9	1.28%	0	0.0%	2406.8	14.4%	903.0	5.4%	1838.0	11.0%	1421.3	8.5%
Jay Ward	Forensics	Forensic MH	610.25	3.58%	0	0.0%	2901.0	17.0%	0.0	0.0%	1416.1	8.3%	2321.3	13.6%
Lark	Forensics	Forensic MH	289.75	1.71%	0	0.0%	2567.2	15.2%	794.3	4.7%	1184.8	7.0%	1267.5	7.5%
Linnet Ward	Forensics	Forensic MH	437.35	2.49%	0	0.0%	3872.6	22.0%	1035.0	5.9%	1041.3	5.9%	2381.3	13.5%

Mallard	Forensics	Forensic MH	423.75	2.04%	0	0.0%	3702.7	17.8%	228.8	1.1%	1217.0	5.9%	1226.3	5.9%
Mandarin	Forensics	Forensic MH	702.5	3.77%	0	0.0%	2996.5	16.1%	986.3	5.3%	1632.3	8.8%	2396.3	12.9%
Merlin	Forensics	Forensic MH	631.23	2.44%	0	0.0%	8064.8	31.2%	106.8	0.4%	1141.0	4.4%	2418.8	9.4%
Newtondale	Forensics	Forensic MH	729.5	3.41%	0	0.0%	1901.9	8.9%	0.0	0.0%	683.7	3.2%	2227.5	10.4%
Nightingale	Forensics	Forensic MH	299.75	1.77%	0	0.0%	1991.7	11.7%	915.0	5.4%	535.1	3.2%	1706.3	10.1%
Sandpiper Ward	Forensics	Forensic MH	539.92	2.30%	0	0.0%	4431.8	18.8%	821.3	3.5%	1323.5	5.6%	1387.5	5.9%
Swift Ward	Forensics	Forensic MH	448.91	2.02%	0	0.0%	4974.8	22.4%	540.0	2.4%	388.3	1.7%	1297.5	5.8%
Fulmar Ward	Forensics	Locked Rehab	170	0.95%	0	0.0%	2487.1	13.9%	1331.3	7.4%	356.3	2.0%	870.0	4.9%
The Orchards (NY)	North Yorkshire	AMH	1615	12.53%	0	0.0%	140.0	1.1%	454.5	3.5%	1195.5	9.3%	708.8	5.5%
Ayckbourn Danby Ward	North Yorkshire	AMH	465.33	3.18%	0	0.0%	1812.2	12.4%	0.0	0.0%	1439.0	9.8%	1481.3	10.1%
Ayckbourn Esk Ward	North Yorkshire	AMH	616.75	4.09%	0	0.0%	1439.5	9.5%	982.5	6.5%	812.5	5.4%	1451.3	9.6%
Cedar (NY)	North Yorkshire	AMH	1591.32	7.50%	974.7	4.6%	1834.9	8.7%	330.0	1.6%	1186.8	5.6%	2651.3	12.5%
Ward 15	North Yorkshire	AMH	308.6	2.03%	0	0.0%	2213.5	14.6%	0.0	0.0%	1063.6	7.0%	446.3	2.9%
Rowan Lea	North Yorkshire	MHSOP	2162.21	9.44%	0	0.0%	1074.7	4.7%	1905.0	8.3%	556.7	2.4%	405.0	1.8%
Rowan Ward	North Yorkshire	MHSOP	1108.6	6.38%	1279	7.4%	2096.8	12.1%	1032.5	5.9%	669.0	3.9%	682.5	3.9%
Springwood	North Yorkshire	MHSOP	1618.9	8.45%	1816	9.5%	1046.9	5.5%	0.0	0.0%	1329.6	6.9%	963.8	5.0%
Ward 14	North Yorkshire	MHSOP	875.81	5.66%	80.5	0.5%	207.5	1.3%	0.0	0.0%	258.3	1.7%	243.8	1.6%
Kirkdale	Teesside		475.78	2.51%	0	0.0%	1887.0	9.9%	0.0	0.0%	1208.5	6.4%	1946.3	10.3%
Bedale Ward	Teesside	AMH	1183.73	5.25%		0.0%	5359.3	23.8%	0.0	0.0%	301.5	1.3%	1425.0	6.3%
Bilsdale	Teesside	AMH	693.25	4.39%	0	0.0%	1529.5	9.7%	0.0	0.0%	927.0	5.9%	2190.0	13.9%
Bransdale	Teesside	AMH	328.44	2.11%	0	0.0%	3153.3	20.3%	75.0	0.5%	1709.3	11.0%	1871.3	12.0%
Lincoln Ward	Teesside	AMH	325.78	1.71%	0	0.0%	1643.4	8.6%	0.0	0.0%	831.5	4.4%	1687.5	8.9%
Overdale	Teesside	AMH	311.8	2.00%	0	0.0%	1313.5	8.4%	532.5	3.4%	1694.0	10.9%	405.0	2.6%
Stockdale	Teesside	AMH	1107.74	6.64%	0	0.0%	4278.1	25.7%	1257.0	7.5%	2321.0	13.9%	1080.0	6.5%
Baysdale	Teesside	CYPS	1705.73	10.76%	0	0.0%	691.4	4.4%	562.5	3.5%	480.5	3.0%	521.3	3.3%
Newberry Centre	Teesside	CYPS	860.87	4.03%	0	0.0%	1682.2	7.9%	900.0	4.2%	2830.7	13.2%	416.3	1.9%
The Evergreen Centre	Teesside	CYPS	1140.05	3.60%	0	0.0%	3617.2	11.4%	982.5	3.1%	1208.2	3.8%	596.3	1.9%
Westwood Centre	Teesside	CYPS	3175.94	9.27%	0	0.0%	8335.9	24.3%	544.5	1.6%	986.5	2.9%	1683.8	4.9%
Aysgarth	Teesside	LD	696.53	4.98%	0	0.0%	2414.3	17.2%	787.5	5.6%	688.0	4.9%	600.0	4.3%
Bankfields Court	Teesside	LD	1126.17	2.37%	0	0.0%	2429.6	5.1%	3187.5	6.7%	3385.1	7.1%	5647.5	11.9%
Bankfields Court Unit 2	Teesside	LD	904.85	6.55%	0	0.0%	2099.7	15.2%	1050.0	7.6%	340.8	2.5%	682.5	4.9%
Lustrum Vale	Teesside	MHSOP	77.2	0.45%	0	0.0%	1645.0	9.7%	7.5	0.0%	1796.5	10.6%	1203.8	7.1%
Westerdale North	Teesside	MHSOP	677.75	4.16%	0	0.0%	863.5	5.3%	908.5	5.6%	997.5	6.1%	476.3	2.9%
Westerdale South	Teesside	MHSOP	140.5	0.48%	34.5	0.1%	13146.0	45.0%	915.0	3.1%	796.7	2.7%	401.3	1.4%
Wingfield	Teesside	MHSOP	410.5	2.64%	0	0.0%	1966.0	12.6%	45.5	0.3%	1058.5	6.8%	1031.3	6.6%
Ebor Ward	York & Selby	AMH	131.3	2.73%	459.5	9.6%	524.0	10.9%	0.0	0.0%	468.5	9.8%	678.8	14.1%
Minster Ward	York & Selby	AMH	283.5	5.47%	287.5	5.5%	709.0	13.7%	206.3	4.0%	256.0	4.9%	626.3	12.1%

Oak Rise	York & Selby	LD	311.58	1.26%	11	0.0%	1282.9	5.2%	0.0	0.0%	2935.1	11.9%	82.5	0.3%
Meadowfields	York & Selby	MHSOP	190.33	1.00%	1068.5	5.6%	2309.4	12.1%	1369.5	7.2%	2420.5	12.7%	926.3	4.8%
Worsley Court	York & Selby	MHSOP	188.5	0.88%	5829	27.3%	525.2	2.5%	7.5	0.0%	1831.0	8.6%	1353.8	6.3%
Cherry Tree House	York & Selby	MHSOP	1135.5	5.40%	668	3.2%	1741.0	8.3%	0.0	0.0%	2007.5	9.5%	1601.3	7.6%

	Green	Amber	Red
Agency	0 - 2.9%	3- 3.9%	4% and over
Bank Usage	0 - 19.9%	20 - 39.9%	40% and over
Maternity	0 - 1.9%	2 - 4.9%	5% and over
Sickness	0 - 1.9%	2 - 4.9%	5% and over
Vacancies	0 - 4.9%	5 - 9.9%	10% and over

Quality Indicators - 6 Month Total

Appendix 5

Ward Name	Locality	Speciality	Bed Numbers (NOV)	Bank Usage vs Actual Hours		Quality Indicators					Incidents of Restraints				Registered Average %		Unregistered Average %	
				Hours	% against Actual Hours	Number of SUIs	Number of Level 4 Incidents	Number of Level 3 (Self-Harm) Incidents	Number of Complaints	Number of PALS	Number of Incidents	Number of PRO Restraints Used	Number of Other Restraints Used	Total Number of Restraints Used	Day	Night	Day	Night
Cedar	Durham & Darlington	AMH	10	8777.2	36.8%		1	3	1	8	101	12	178	190	105.7%	101.8%	166.5%	149.7%
Elm Ward	Durham & Darlington	AMH	20	2119.5	12.6%	2	1	3	1	10	25	3	34	37	105.4%	104.4%	106.1%	111.9%
Farnham Ward	Durham & Darlington	AMH	20	1551.2	9.2%	1			1	7	15	1	19	20	121.9%	101.1%	100.4%	105.0%
Maple	Durham & Darlington	AMH	20	2467.6	15.2%			3		2	18		22	22	99.1%	100.0%	98.7%	100.8%
Primrose Lodge	Durham & Darlington	AMH	15	756.0	4.8%										58.0%	96.2%	137.8%	99.5%
Tunstall Ward	Durham & Darlington	AMH	20	607.7	3.6%			2	2	9	5		6	6	106.2%	104.4%	106.8%	104.2%
Willow Ward	Durham & Darlington	AMH	15	361.3	2.1%					2	2		3	3	90.8%	100.0%	160.3%	101.7%
Holly	Durham & Darlington	CYPS	4	773.4	8.2%						28		61	61	131.6%	114.2%	146.3%	166.0%
Birch Ward	Durham & Darlington	ED	15	4137.0	21.9%				1		4		4	4	85.4%	100.7%	107.8%	131.8%
Bek-Ramsey Wards	Durham & Darlington	LD	11	648.7	2.5%						44	7	65	72	94.0%	100.0%	111.6%	101.5%
Ceddesfeld	Durham & Darlington	MHSOP	15	1117.8	6.3%	1	1		1	1	23		40	40	89.3%	100.4%	132.4%	100.8%
Hamsterley	Durham & Darlington	MHSOP	15	2721.5	14.6%	1	1			1	9		9	9	85.1%	102.1%	155.8%	123.9%
Oak Ward	Durham & Darlington	MHSOP	12	564.1	3.6%										96.6%	100.0%	95.3%	102.0%
Picktree	Durham & Darlington	MHSOP		1347.7	24.9%						7		8	8	76.1%	91.5%	107.1%	95.6%
Roseberry Wards	Durham & Darlington	MHSOP	15	2233.3	13.4%	1	2		2	1	14		14	14	90.2%	100.0%	96.0%	100.7%
Clover / Ivy	Forensics	Forensic LD	12	5343.8	22.9%			1		7	32	2	69	71	94.2%	100.0%	115.7%	150.5%
Eagle / Osprey	Forensics	Forensic LD	10	2117.6	11.2%				1	5	2		2	2	88.0%	100.0%	94.5%	102.4%
Harrier / Hawk	Forensics	Forensic LD	10	2717.2	11.6%					7	8		10	10	76.6%	90.3%	108.2%	134.5%
Kestrel / Kite.	Forensics	Forensic LD	16	6654.9	24.8%				1	7	110	1	217	218	85.0%	87.4%	121.5%	134.2%
Robin	Forensics	Forensic LD		3743.8	27.6%					4					67.4%	95.0%	126.2%	99.2%
Langley	Forensics	Forensic LD	10	3144.2	18.7%		1		1	14	4		8	8	84.9%	102.3%	137.3%	202.4%
Northdale Centre	Forensics	Forensic LD	12	4802.3	17.0%			1		7	22		43	43	71.3%	96.7%	110.9%	108.9%
Oakwood	Forensics	Forensic LD	8	780.5	6.5%										80.2%	94.6%	193.3%	102.3%
Thistle	Forensics	Forensic LD	5	1560.8	8.6%				1	6	25		48	48	78.3%	97.8%	114.0%	103.0%
Brambling	Forensics	Forensic MH	13	2406.8	14.4%			3		2	10	1	17	18	79.5%	97.5%	111.1%	98.1%
Jay Ward	Forensics	Forensic MH	5	2901.0	17.0%						12	1	20	21	73.7%	105.7%	114.0%	105.8%
Lark	Forensics	Forensic MH	15	2567.2	15.2%					2					85.4%	99.6%	110.6%	99.4%

Linnet Ward	Forensics	Forensic MH	17	3872.6	22.0%					6	19		28	28	75.4%	101.1%	125.3%	102.9%
Mallard	Forensics	Forensic MH	16	3702.7	17.8%				1	4	17		22	22	87.5%	101.2%	111.0%	143.5%
Mandarin	Forensics	Forensic MH	16	2996.5	16.1%					7	11		18	18	74.0%	103.0%	130.0%	120.1%
Merlin	Forensics	Forensic MH	10	8064.8	31.2%					2	28	3	55	58	97.1%	87.8%	130.3%	179.5%
Newtondale	Forensics	Forensic MH	20	1901.9	8.9%					2	2		3	3	84.7%	78.4%	101.5%	104.6%
Nightingale	Forensics	Forensic MH	16	1991.7	11.7%					3					86.7%	114.1%	103.5%	97.8%
Sandpiper Ward	Forensics	Forensic MH	8	4431.8	18.8%			2	1	5	323	33	870	903	90.8%	77.0%	107.7%	134.2%
Swift Ward	Forensics	Forensic MH	10	4974.8	22.4%					1	76	1	137	138	81.7%	104.1%	129.3%	148.5%
Fulmar Ward	Forensics	Locked Rehab	12	2487.1	13.9%			1		2	11		13	13	75.1%	101.3%	101.5%	104.5%
The Orchards (NY)	North Yorkshire	AMH	10	140.0	1.1%										96.7%	80.9%	83.8%	115.6%
Ayckbourn Danby Ward	North Yorkshire	AMH	11	1812.2	12.4%	1	1		2	4	18	1	29	30	63.2%	96.4%	114.7%	94.3%
Ayckbourn Esk Ward	North Yorkshire	AMH	11	1439.5	9.5%			3	1	7	55	1	76	77	68.6%	99.6%	111.8%	92.7%
Cedar (NY)	North Yorkshire	AMH	18	1834.9	8.7%			12		12	45		73	73	99.0%	103.7%	99.1%	121.3%
Ward 15	North Yorkshire	AMH	14	2213.5	14.6%				2	5	10		10	10	81.2%	98.1%	128.3%	101.2%
Rowan Lea	North Yorkshire	MHSOP	20	1074.7	4.7%			1		7	88		147	147	91.5%	114.4%	113.6%	109.8%
Rowan Ward	North Yorkshire	MHSOP	16	2096.8	12.1%	1	1		1	1	36		50	50	90.6%	102.8%	131.0%	105.6%
Springwood	North Yorkshire	MHSOP	14	1046.9	5.5%						209		236	236	76.1%	107.3%	130.1%	137.1%
Ward 14	North Yorkshire	MHSOP	9	207.5	1.3%						15		23	23	88.5%	103.0%	119.5%	108.2%
Kirkdale	Teesside	Locked Rehab	16	1887.0	9.9%					1	6	1	5	6	91.5%	102.7%	100.9%	111.5%
Bedale Ward	Teesside	AMH	10	5359.3	23.8%			1		3	130	6	208	214	90.7%	115.0%	173.9%	131.1%
Bilsdale	Teesside	AMH	14	1529.5	9.7%			1		2	6		13	13	92.4%	100.8%	116.5%	101.5%
Bransdale	Teesside	AMH	14	3153.3	20.3%			6	2	3	19		28	28	77.5%	94.4%	125.9%	101.2%
Lincoln Ward	Teesside	AMH	20	1643.4	8.6%			1		1	10		12	12	106.0%	94.7%	98.0%	110.1%
Overdale	Teesside	AMH	18	1313.5	8.4%			2		9	26		34	34	92.1%	106.0%	105.4%	98.2%
Stockdale	Teesside	AMH	18	4278.1	25.7%				1	8	31	4	44	48	98.9%	102.8%	107.8%	96.7%
Baysdale	Teesside	CYPS	6	691.4	4.4%										118.8%	103.5%	105.4%	101.4%
Newberry Centre	Teesside	CYPS	14	1682.2	7.9%			12	2	1	196	2	314	316	81.2%	108.7%	115.8%	109.9%
The Evergreen Centre	Teesside	CYPS	16	3617.2	11.4%			2	1	5	439		722	722	94.7%	106.7%	133.4%	127.2%
Westwood Centre	Teesside	CYPS	12	8335.9	24.3%			7	1	3	390	9	694	703	100.0%	98.8%	164.3%	203.3%
Aysgarth	Teesside	LD	6	2414.3	17.2%						1		1	1	113.2%	101.3%	139.7%	100.4%
Bankfields Court	Teesside	LD	19	2429.6	5.1%					1	155		242	242	81.4%	95.0%	100.9%	98.7%
Bankfields Court Unit 2	Teesside	LD	5	2099.7	15.2%						2		6	6	124.1%	100.8%	100.0%	112.4%
Lustrum Vale	Teesside	MHSOP	20	1645.0	9.7%				2	1	8		9	9	97.3%	102.4%	103.4%	103.5%
Westerdale North	Teesside	MHSOP	18	863.5	5.3%	1	1				18		21	21	96.2%	101.2%	128.9%	103.3%
Westerdale South	Teesside	MHSOP	14	13146.0	45.0%	1	1			1	22		28	28	114.4%	99.3%	277.8%	227.3%
Wingfield	Teesside	MHSOP	10	1966.0	12.6%					1	2		2	2	77.8%	104.1%	129.6%	112.9%
Ebor Ward	York & Selby	AMH	12	524.0	10.9%					2	18		29	29	91.5%	86.4%	76.5%	95.8%

Minster Ward	York & Selby	AMH	12	709.0	13.7%					1	3	1	3	4	103.3%	95.5%	67.3%	96.8%
Oak Rise	York & Selby	LD	8	1282.9	5.2%						12		16	16	132.3%	99.7%	82.4%	99.9%
Meadowfields	York & Selby	MHSOP	14	2309.4	12.1%					2	23		26	26	80.8%	86.6%	101.9%	111.5%
Worsley Court	York & Selby	MHSOP	14	525.2	2.5%	1	2			3	36		47	47	82.0%	109.7%	109.7%	169.1%
Cherry Tree House	York & Selby	MHSOP	18	1741.0	8.3%	1	1		2	3	46		60	60	94.0%	95.8%	99.7%	160.4%

Quality Indicators - 6 Month Total

Appendix 6

Ward Name	Locality	Speciality	Bed Numbers (NOV)	Safe Nursing Indicators											
				Falls resulting in significant harm	Pressure Ulcers	Medication Errors	Missed Breaks	Staffing Fill Rate - Day - Registered Nurses	Staffing Fill Rate - Night - Registered Nurses	Staffing Fill Rate - Day - Unregistered Nurses	Staffing Fill Rate - Night - Unregistered Nurses	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours	Mandatory Training (Nov 16)
Cedar	Durham & Darlington	AMH	10			6	4	105.7%	101.8%	166.5%	149.7%	36.8%	0.0%	1.7%	89.01%
Elm Ward	Durham & Darlington	AMH	20			16	15	105.4%	104.4%	106.1%	111.9%	12.6%	0.0%	5.9%	79.43%
Farnham Ward	Durham & Darlington	AMH	20			9	16	121.9%	101.1%	100.4%	105.0%	9.2%	0.0%	4.0%	87.50%
Maple	Durham & Darlington	AMH	20			9	29	99.1%	100.0%	98.7%	100.8%	15.2%	0.0%	4.8%	88.96%
Primrose Lodge	Durham & Darlington	AMH	15			3		58.0%	96.2%	137.8%	99.5%	4.8%	0.0%	0.7%	87.30%
Tunstall Ward	Durham & Darlington	AMH	20			3	65	106.2%	104.4%	106.8%	104.2%	3.6%	0.0%	6.4%	88.46%
Willow Ward	Durham & Darlington	AMH	15			6	3	90.8%	100.0%	160.3%	101.7%	2.1%	0.0%	1.7%	90.62%
Holly	Durham & Darlington	CYPS	4			3	140	131.6%	114.2%	146.3%	166.0%	8.2%	0.0%	10.9%	87.91%
Birch Ward	Durham & Darlington	ED	15			7	5	85.4%	100.7%	107.8%	131.8%	21.9%	0.0%	5.7%	90.00%
Bek-Ramsey Wards	Durham & Darlington	LD	11			3	3	94.0%	100.0%	111.6%	101.5%	2.5%	0.0%	8.2%	91.56%
Ceddesfeld	Durham & Darlington	MHSOP	15	1		3	2	89.3%	100.4%	132.4%	100.8%	6.3%	0.0%	1.4%	94.29%
Hamsterley	Durham & Darlington	MHSOP	15		4	2	50	85.1%	102.1%	155.8%	123.9%	14.6%	0.0%	3.8%	90.31%
Oak Ward	Durham & Darlington	MHSOP	12			6	8	96.6%	100.0%	95.3%	102.0%	3.6%	0.0%	2.2%	92.55%
Picktree	Durham & Darlington	MHSOP						76.1%	91.5%	107.1%	95.6%	24.9%	0.0%	2.5%	
Roseberry Wards	Durham & Darlington	MHSOP	15	1		5	36	90.2%	100.0%	96.0%	100.7%	13.4%	0.0%	2.2%	94.51%
Clover / Ivy	Forensics	Forensic LD	12			1	33	94.2%	100.0%	115.7%	150.5%	22.9%	0.0%	7.3%	92.63%
Eagle / Osprey	Forensics	Forensic LD	10			5	21	88.0%	100.0%	94.5%	102.4%	11.2%	0.0%	4.9%	89.05%
Harrier / Hawk	Forensics	Forensic LD	10			2	30	76.6%	90.3%	108.2%	134.5%	11.6%	3.5%	4.9%	90.95%
Kestrel / Kite.	Forensics	Forensic LD	16			6	18	85.0%	87.4%	121.5%	134.2%	24.8%	0.5%	3.3%	87.26%
Robin	Forensics	Forensic LD				2	14	67.4%	95.0%	126.2%	99.2%	27.6%	0.5%	3.2%	
Langley	Forensics	Forensic LD	10			4	73	84.9%	102.3%	137.3%	202.4%	18.7%	0.0%	4.1%	87.30%
Northdale Centre	Forensics	Forensic LD	12			5	81	71.3%	96.7%	110.9%	108.9%	17.0%	2.2%	5.2%	92.00%
Oakwood	Forensics	Forensic LD	8			5	10	80.2%	94.6%	193.3%	102.3%	6.5%	3.1%	2.3%	90.23%
Thistle	Forensics	Forensic LD	5			1	25	78.3%	97.8%	114.0%	103.0%	8.6%	0.1%	7.1%	90.26%

Brambling	Forensics	Forensic MH	13			8	25	79.5%	97.5%	111.1%	98.1%	14.4%	0.0%	1.3%	93.17%
Jay Ward	Forensics	Forensic MH	5			6	23	73.7%	105.7%	114.0%	105.8%	17.0%	0.0%	3.6%	94.81%
Lark	Forensics	Forensic MH	15			7	22	85.4%	99.6%	110.6%	99.4%	15.2%	0.0%	1.7%	82.99%
Linnet Ward	Forensics	Forensic MH	17			33	22	75.4%	101.1%	125.3%	102.9%	22.0%	0.0%	2.5%	93.63%
Mallard	Forensics	Forensic MH	16			11	31	87.5%	101.2%	111.0%	143.5%	17.8%	0.0%	2.0%	89.14%
Mandarin	Forensics	Forensic MH	16			6	13	74.0%	103.0%	130.0%	120.1%	16.1%	0.0%	3.8%	89.88%
Merlin	Forensics	Forensic MH	10			15	31	97.1%	87.8%	130.3%	179.5%	31.2%	0.0%	2.4%	92.31%
Newtondale	Forensics	Forensic MH	20			9	20	84.7%	78.4%	101.5%	104.6%	8.9%	0.0%	3.4%	91.90%
Nightingale	Forensics	Forensic MH	16			8	14	86.7%	114.1%	103.5%	97.8%	11.7%	0.0%	1.8%	98.46%
Sandpiper Ward	Forensics	Forensic MH	8			11	35	90.8%	77.0%	107.7%	134.2%	18.8%	0.0%	2.3%	83.43%
Swift Ward	Forensics	Forensic MH	10			20	31	81.7%	104.1%	129.3%	148.5%	22.4%	0.0%	2.0%	88.00%
Fulmar Ward	Forensics	Locked Rehab	12			1	30	75.1%	101.3%	101.5%	104.5%	13.9%	0.0%	1.0%	97.62%
The Orchards (NY)	North Yorkshire	AMH	10				19	96.7%	80.9%	83.8%	115.6%	1.1%	0.0%	12.5%	89.12%
Ayckbourn Danby Ward	North Yorkshire	AMH	11			7		63.2%	96.4%	114.7%	94.3%	12.4%	0.0%	3.2%	86.47%
Ayckbourn Esk Ward	North Yorkshire	AMH	11			2	6	68.6%	99.6%	111.8%	92.7%	9.5%	0.0%	4.1%	91.16%
Cedar (NY)	North Yorkshire	AMH	18			8	4	99.0%	103.7%	99.1%	121.3%	8.7%	4.6%	7.5%	74.19%
Ward 15	North Yorkshire	AMH	14			4	33	81.2%	98.1%	128.3%	101.2%	14.6%	0.0%	2.0%	93.51%
Rowan Lea	North Yorkshire	MHSOP	20		2	1	145	91.5%	114.4%	113.6%	109.8%	4.7%	0.0%	9.4%	89.61%
Rowan Ward	North Yorkshire	MHSOP	16	1		2	3	90.6%	102.8%	131.0%	105.6%	12.1%	7.4%	6.4%	85.71%
Springwood	North Yorkshire	MHSOP	14					76.1%	107.3%	130.1%	137.1%	5.5%	9.5%	8.5%	85.19%
Ward 14	North Yorkshire	MHSOP	9		2	1	37	88.5%	103.0%	119.5%	108.2%	1.3%	0.5%	5.7%	82.86%
Kirkdale	Teesside	Locked Rehab	16			8	58	91.5%	102.7%	100.9%	111.5%	9.9%	0.0%	2.5%	97.14%
Bedale Ward	Teesside	AMH	10			6	117	90.7%	115.0%	173.9%	131.1%	23.8%	0.0%	5.2%	93.79%
Bilsdale	Teesside	AMH	14			2	20	92.4%	100.8%	116.5%	101.5%	9.7%	0.0%	4.4%	94.29%
Bransdale	Teesside	AMH	14		1	10	48	77.5%	94.4%	125.9%	101.2%	20.3%	0.0%	2.1%	84.13%
Lincoln Ward	Teesside	AMH	20			4	21	106.0%	94.7%	98.0%	110.1%	8.6%	0.0%	1.7%	98.57%
Overdale	Teesside	AMH	18			5	17	92.1%	106.0%	105.4%	98.2%	8.4%	0.0%	2.0%	92.86%
Stockdale	Teesside	AMH	18			6	63	98.9%	102.8%	107.8%	96.7%	25.7%	0.0%	6.6%	95.80%
Baysdale	Teesside	CYPS	6			12	264	118.8%	103.5%	105.4%	101.4%	4.4%	0.0%	10.8%	89.80%
Newberry Centre	Teesside	CYPS	14			5	400	81.2%	108.7%	115.8%	109.9%	7.9%	0.0%	4.0%	84.01%
The Evergreen Centre	Teesside	CYPS	16		1	11	209	94.7%	106.7%	133.4%	127.2%	11.4%	0.0%	3.6%	91.56%
Westwood Centre	Teesside	CYPS	12			6	177	100.0%	98.8%	164.3%	203.3%	24.3%	0.0%	9.3%	87.71%
Aysgarth	Teesside	LD	6			5		113.2%	101.3%	139.7%	100.4%	17.2%	0.0%	5.0%	96.24%
Bankfields Court	Teesside	LD	19			2	102	81.4%	95.0%	100.9%	98.7%	5.1%	0.0%	2.4%	88.19%
Bankfields Court Unit 2	Teesside	LD	5			1	794	124.1%	100.8%	100.0%	112.4%	15.2%	0.0%	6.5%	87.58%

Lustrum Vale	Teesside	MHSOP	20			22	58	97.3%	102.4%	103.4%	103.5%	9.7%	0.0%	0.5%	95.24%
Westerdale North	Teesside	MHSOP	18	1		15	58	96.2%	101.2%	128.9%	103.3%	5.3%	0.0%	4.2%	89.16%
Westerdale South	Teesside	MHSOP	14	1	1	10	47	114.4%	99.3%	277.8%	227.3%	45.0%	0.1%	0.5%	87.56%
Wingfield	Teesside	MHSOP	10			7	65	77.8%	104.1%	129.6%	112.9%	12.6%	0.0%	2.6%	97.28%
Ebor Ward	York & Selby	AMH	12			1	8	91.5%	86.4%	76.5%	95.8%	10.9%	9.6%	2.7%	76.19%
Minster Ward	York & Selby	AMH	12				25	103.3%	95.5%	67.3%	96.8%	13.7%	5.5%	5.5%	66.67%
Oak Rise	York & Selby	LD	8					132.3%	99.7%	82.4%	99.9%	5.2%	0.0%	1.3%	68.50%
Meadowfields	York & Selby	MHSOP	14			7	117	80.8%	86.6%	101.9%	111.5%	12.1%	5.6%	1.0%	72.73%
Worsley Court	York & Selby	MHSOP	14			12	3	82.0%	109.7%	109.7%	169.1%	2.5%	27.3%	0.9%	54.76%
Cherry Tree House	York & Selby	MHSOP	18	1		19	6	94.0%	95.8%	99.7%	160.4%	8.3%	3.2%	5.4%	67.49%

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

FOR GENERAL RELEASE **ITEM 8**

Board of Directors

DATE:	**31st January 2017**
TITLE:	**Proposed Recovery and Wellbeing Strategy 2017-2020**
REPORT OF:	**Brent Kilmurray, Chief Operating Officer**
REPORT FOR:	**Agreement and Formal sign off**

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:

At their meeting on 25th October, the Trust Board confirmed that Recovery remains one of TEWV's 6 Strategic Priorities. As the three year, 2013-2016 Recovery and Wellbeing strategy is due to conclude in March 2017, there is a requirement to have a new strategy in place.

Over the past five months, work has been conducted to refresh the 2013-2016 Recovery and Wellbeing strategy. A proposed Recovery and Wellbeing Strategy 2017-2020 has been developed and that was informed by a series of engagement events with service users, carers, recovery Experts by Experience group members, staff and governors.

The purpose of this report is to present the proposed Recovery and Wellbeing Strategy 2017-2020 and to request Board approval and sign off.

It is proposed that the strategy will be supported via a range of different delivery mechanisms and details of this are provided within the strategy and appendix 2 of this report.

Recommendations:

The Trust Board are being requested to approve and sign off the Recovery and Wellbeing Strategy 2017-2020

MEETING OF:	**Trust Board**
DATE:	**31st January 2017**
TITLE:	**Draft Recovery and Wellbeing Strategy 2017-2020**

1. INTRODUCTION & PURPOSE:

1.1 This paper presents the proposed Recovery and Wellbeing strategy 2017-2020 and proposed mechanisms for delivery.

1.2 The purpose of this report is to gain Trust Board approval and sign off of the proposed strategy

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Trust Board confirmed at their 25th October meeting that Recovery remains one of TEWV's 6 Strategic Priorities.

2.2 Phase one recovery developments are progressing as planned and are due to conclude in March 2017.

2.3 Over the last five months work has been conducted to refresh the Recovery and Wellbeing strategy and to produce a 2017-2020 strategy. This work has included a series of engagement workshops with service users, carers, staff and governors which have informed the strategy objectives.

3. KEY ISSUES:

3.1 The strategy is currently in draft form and requires agreement and sign off by the Trust Board (See appendix 1 for draft strategy).

3.2 The delivery of the strategy will require a complex programme of work which requires delivery via a range of mechanisms across a range of different programmes.

3.3 The strategy scorecard is currently under development and will require final agreement and sign off by end of March 2017 by EMT.

3.4 A Recovery Programme Board has been approved by the EMT and is now established. This Programme Board has responsibility for overseeing and ensuring the strategy is successfully implemented.

3.5 A central Recovery Team business case and resource for other key pieces of work has been approved by EMT.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
The Recovery strategy will help us to deliver the person-centred care, dignity & respect and staffing fundamental standards.

4.2 **Financial/Value for Money:** Recovery informed care is likely to be efficient because co-production of care eliminates non-value elements of care provision.

4.3 **Legal and Constitutional (including the NHS Constitution):**
No implications.

4.4 **Equality and Diversity:**
Equality and Diversity Implications will be identified in the individual work streams/projects. Each work-stream/project within the programme will have to undertake an Equality Assessment in line with the current Project Management Framework.

4.5 **Other implications: None**

5. RISKS:

5.1 Co-production, including the development of identified lived experience roles, is central to the success of the recovery strategy. There is a risk that there is insufficient lived experience resource to meet growing demand going forward.

5.2 The Trust is going though a period of transformational change with staff having to adapt and make significant changes to their practice. There is a risk that competing demands on staff at all levels of the organisation will have an inadvertent impact on the successful implementation of the recovery programme.

5.3 TEWV is relatively inexperienced in programme management (as opposed to project management) and this could adversely impact on the implementation of the strategy. To counter this risk, work is currently being conducted to agree an effective programme management approach. External expert consultation is being sought to guide this work

6. CONCLUSIONS:

Recovery is one of the Trust's Six Strategic Priorities. In order to progress this priority there is a requirement for the trust to have a cross-organisational Recovery and Wellbeing strategy for 2017-2020 in place by March 2017. The proposed strategy is being presented to the Trust Board for approval and sign off. A strategy scorecard is in development and will require agreement and sign off by EMT by March 2017. It is identified that in order to achieve the strategy objectives, a range of pieces of work and delivery mechanisms are required. A Recovery Programme Board has been set up with the role of ensuring the strategy is implemented successfully.

7. RECOMMENDATIONS:

The Trust Board is asked to review and approve the proposed Recovery and Wellbeing strategy 2017-2020, with the agreement that a scorecard will be in place by March 2017.

Author: Alison Brabban
Title: Clinical Lead, Recovery and Wellbeing Programme

Background Papers:

Recovery and Wellbeing Strategy 2013-2016 (Attached – Appendix 1)
Engagement Report
Recovery programme Board Paper and Terms of Reference

Appendix 1

DRAFT VERSION

Recovery and Wellbeing Strategy

2017-2020

Strategy Sponsor / Lead Director: Brent Kilmurray (Chief Operating Officer)		
Strategy Lead: Alison Brabban, Clinical Lead for Recovery		
Version: **STRAT-0030** **Version 2 Refresh**	**Date Completed:**	**Date of Next Review:** March 2020

making a difference together

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The Aim of the Strategy

Supporting the recovery and wellbeing of individuals is the core aim of the services we provide. In 2013 the Trust Board agreed a priority to 'embed a recovery focussed approach across all services'. A Recovery and Wellbeing strategy for 2013-2016 was agreed which recognised that cultivating the required change would take an iterative approach over many years. The Trust recognises that this remains a key priority.

Building on the progress achieved from the 2013-2016 strategy, this strategy sets out the direction for the further embedding of a recovery/wellbeing focussed approach within the organisation over the next three years.

The successful implementation of this strategy is central for the delivery of Trust Strategic Goal one, along with contributing to the delivery of the remaining Trust strategic goals.

Strategic Goal 1

To provide excellent services, working with the individual users of our services and their carers to promote recovery and wellbeing. This means that we make a positive difference to the lives of service users and carers by:

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

What do we mean by recovery and wellbeing?

In mental health and learning disability services the term 'recovery' is most frequently used to describe the personal lived experiences and journeys of people as they work towards living a meaningful and satisfying life. Recovery principles focus on the whole person in the context of their life, considering what makes that person thrive.

Evidence based interventions designed to minimise distressing and disabling symptoms are critical but with a range of interventions and support in place,

we recognise that people can have meaningful and satisfying lives often despite the presence of ongoing symptoms.

There are 5 key processes, referred to as CHIME factors, which have been identified as being central to individualised recovery and wellbeing.

CHIME factors

- **Connectedness** – being able to and /or having the opportunity to feel connected to something or other people
- **Hope** - having hope for the future or to feel hopeful that there can be better moments in what can be difficult times.
- **Identity** – maintaining or developing an identity beyond that of a mental health patient and/or diagnosis/someone with a learning disability
- **Meaning** – having meaning in life such as opportunities, roles and things to enjoy. This also includes finding meaning in the distressing experiences people are suffering.
- **Empowerment** – Having choice and control in your life and surrounding your care.

As a Trust we acknowledge that the word 'recovery' may not appear the most suitable term for some individuals, especially for individuals who are experiencing organic mental health problems or who have a learning disability but no mental health problems. However the principles and philosophy that lies behind the concept of a fulfilling life with meaning, remains valid and so this strategy will use the term recovery throughout. Individual specialities may develop more specific working definitions that best suit their client groups. The CHIME factors remain core to wellbeing and offering support in these areas is important for all service users groups accessing our services.

The Case for Change

National Context

- As evidenced in the Five Year Forward View for Mental Health (2016) there are a range of national drivers which require mental health services to offer interventions and approaches which support individuals to live meaningful and fulfilling lives. In order to deliver on these drivers there is a requirement for a co-production approach

working alongside individuals with lived experience of services, their families and carers.

- There is increasing demand on mental health and learning disability services at the same time there is a requirement to provide both efficient and effective services which meet the needs of individuals accessing our services.
- Future national arrangements for funding will increasingly require Trusts to demonstrate high quality outcomes and improvements in patient experience.

Local Context

- Our ability to sustain funding to deliver high quality services is not only reliant upon the clinical outcomes we achieve but will also be contingent on improvements in patient reported outcomes (PROMs) and improvements in service user experience. Embedding a recovery-based approach will play a central role in achieving positive outcomes.
- In the last three years we have conducted a significant amount of work to embed recovery principles and values within both our corporate and clinical services. An overview of the progress made can be found in appendix 1.
- Ensuring that individuals with lived experience have been involved in the design and delivery of core pieces of work has been fundamental to the progress made to date and is central to future developments in this area.
- The Trust is committed to implementing developments which eliminate non-value added activity within service delivery and we have a wealth of expertise within Quality Improvement Systems. There is an opportunity to further align our expertise in this area to support the delivery of more recovery focussed services. Understanding the views of service users and carers on what adds or does not add value to their recovery and wellbeing and co-producing improvements, is central to both QIS activity and broader approaches to developments.
- Engagement with service users, carers, our Experts by Experience group, staff and governors, highlights that while progress has been made, further work is required to embed recovery values and principles across **all** services.
- There is widespread support for the further embedding of this approach at all levels of the organisation and is reflected in Recovery remaining as a priority within the Trust business plan.

A Vision for the Future

Our vision is to deliver services to all service users and carers that are driven and underpinned by the values and principles of a recovery/wellbeing approach.

The core values and principles underpinning our vision are:

- We believe that everyone has the potential to lead a life that is fulfilling and meaningful to them, irrespective of symptoms and diagnosis.
- We recognise and acknowledge the many barriers to recovery that people can face, including social, environmental and economic factors. We offer support to minimise the impact of these on an individual's wellbeing and recovery.
- We don't just tell people what is best for them. We listen to service users and carers and try to understand what is important to them. We take their ideas, concerns and experiences seriously.
- We provide a service which values making shared decisions and seeks to explore options together with service users and provide meaningful choice wherever possible.
- We support people to feel empowered and take charge of their lives. We are aware of the power we hold and always look to share this as much as possible.
- We recognise the value in sitting with, listening and bearing witness to a person's emotional pain, we don't always try to fix people.
- We hold on to hope for people when they feel at their lowest, believing that there is hope for an individual's future and /or that that there can be better moments in what can be difficult times.
- We see the whole person, we see beyond their distress, beyond their 'symptoms' and 'diagnosis' recognising and respecting their individual interests, strengths and beliefs.
- We recognise that we have a lot of professional expertise to offer but equally we respect the expertise of those who have experienced mental distress and who have accessed our services.
- We value working alongside people with lived experience, as partners, at all levels of the organisation from coproduction of individual care plans through to strategic decisions about service design and delivery.
- We are mindful that our actions might harm a person's recovery e.g. losing identity, hope, sense of control. We acknowledge this and try to avoid it at all times. We take a harm minimisation approach.
- We appreciate that people's distress is often an understandable reaction to their life experiences, circumstances and beliefs and not merely symptoms of an illness.

- We acknowledge that many of our service users have experienced trauma and adversity in their lives. We ask about this and respond with compassion. We recognise that people's 'symptoms' and behaviours, while sometimes creating difficulties in their lives, are often creative attempts to survive intolerable situations.
- We support people to come to an understanding of their distress that is meaningful to them.

Objectives

In order to inform the strategy objectives we held a series of workshops with staff, governors, service users, carers and our recovery Experts by Experience group members. The outcomes of the engagement process has informed the strategy objectives and associated area of work. The timeframe for implementing each objective is March 2020.

Objective 1:

We will further embed recovery values and principles into the delivery of our services.

We will achieve this by:

- Building infrastructures to ensure that our leaders have the knowledge and skills to support transformational change and the implementation of the values and practices associated with a recovery and wellbeing approach. This will include the development of community demonstration sites, recovery for leaders training and a recovery accreditation scheme for services.
- Developing models of community and inpatient services which are underpinned by a recovery based approach via the Model Wards programme and the Purposeful, Productive Community Services programme and CPA.
- Ensuring that our Quality Improvement System aligns and supports recovery focussed developments.
- Ensuring key polices and projects support a recovery focussed approach.
- Adopting a consistent language which reflects a recovery focussed approach which is meaningful for different service user groups.
- Ensuring that recovery principles are embedded within the work of other core trust strategies and processes.
- Ensuring that a trauma informed approach is embedded within clinical services.

- Identifying community assets and resources that will support the delivery of recovery in our and partner organisations, and work with all organisations to encompass a recovery-based approach.
- Scoping options for enhancing employment support offered to individuals accessing our services who want support to access education and employment opportunities.

Objective 2

We will further embed infrastructures to support a model of 'co-production'

We will achieve this by:

- Determining how co-production is defined and implemented within TEWV in terms of an individual's own care, as well as service design, delivery and governance.
- Expanding the influence of the Trust's Recovery Experts by Experience programme, ensuring we include carers.
- Increasing the involvement of service users and carers in the recruitment of staff, building on current good practice.
- Increasing the number of unpaid Involvement Peer roles.
- Introducing paid peer roles into a wider range of clinical services.
- Identifying mechanisms to support our workforce to feel more comfortable being open about their own experiences of mental health difficulties.
- Ensuring our Quality Improvement work is informed by the priorities identified by individuals with lived experience and that a co-production approach is embedded within this work.

Objective 3

We will further embed a harm minimisation approach to support an individual's recovery, which engages service users and where appropriate, carers as partners in the process.

We will achieve this by:

- Embedding the Positive and Safe agenda to reduce the use of restrictive interventions and practices and promote the use of positive approaches.
- Reviewing how we approach core Nursing and Governance Directorate processes such as Patient Safety (Serious Incident enquiries / Learning lessons) and safeguarding, ensuring these are informed by a harm

minimisation approach and the views of individuals with lived experience.

- Ensuring staff have continued access to harm minimisation training and support.
- Ensuring that as part of the CPA process, we work with individuals to identify how threats to basic needs (e.g. housing and finances) could harm their recovery and wellbeing, offering support, advice and signposting.

Objective 4

We will have increased access to recovery training programmes which support recovery knowledge and self-management skills for staff, service users and carers

We will achieve this by:

- Consolidating delivery of physical recovery college provision where the Trust is commissioned to provide this.
- Working in partnership with Third Sector providers to support college delivery in locality areas where we do not have contracts to deliver physical recovery college provision.
- Delivering Recovery College Online as a new service. This will provide access to a wide range of self- management information and recovery focussed courses, which will be accessible to all locality areas and specialities.
- Ensuring that training needs analysis meets the aims of the strategy.
- Working to support post registration training for core professional groups being informed by recovery values and principles.

How will we implement this strategy?

Within these overarching objectives key elements will require implementation via a programme of work with the following delivery mechanisms:

- Core pieces of work delivered by a central recovery team and associated business case
- A range of other core business cases/projects which will directly report to recovery and the Recovery Programme Board (e.g. Trauma Informed Care, VRC)
- Ensuring that recovery principles are embedded within other key strategic programmes and projects managed outside of the Recovery Programme Board e.g. PPCS

- A range of business as usual developments led by a number of departments e.g. embedding Positive and Safe agenda

The objectives and deliverables within the strategy will be evaluated via a range of mechanisms including a score card, individual business case benefits realisation (PM4's) and other agreed mechanisms for business as usual developments.

Governance arrangements

It is proposed to establish a Recovery Programme Board to ensure the Recovery Strategy is implemented successfully. The diagram below describes how the different delivery mechanisms will report so that the Programme Board has assurance that the strategy objectives are being delivered. The Programme Board will also identify, agree and monitor the evaluation of strategy implementation.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Line of accountability ⟶ reporting Line for assurance of strategy delivery ⇢

Core PM3 Business cases

(Accountable to Programme Board – Report Monthly)

Trauma Informed Care
Virtual Recovery College

Central Recovery Team business case and Work streams

(Accountable to Programme Board – Report monthly)

Values / Culture work stream, EbyE,
Peer roles, Ensuring specialist consultation and influence into other programmes / BAU, Recovery Colleges

Other core strategic projects/ Programmes influencing embedding of recovery

(Accountable to project/ programme specific agreed board. Provide updates to Recovery programme Board to ensure these are being implemented in line with recovery principles and strategy

(Need to agree reporting processes)

PIPA/Model Wards, PPCS, Safe staffing, The 'TEWV Way'

RECOVERY PROGRAMME BOARD

(Accountable to EMT)

Core business as usual developments required to implement the Recovery strategy

Provide updates to Recovery programme Board to provide assurances that these are being implemented in line with recovery principles and strategy)

(Need to agree processes)

Harm minimisation, Positive and Safe, pre reg training, 3rd Sector Partnerships,

Executive Management team

Will receive monthly overall programme reports from the Recovery Programme Board with an overall programme RAG status and will hold Programme Board to account (need to set up and agree programme RAG and how this will be done)

Scorecard

The strategy score card needs to be agreed and developed as well as ensuring it is aligned with other strategy scorecards and core benefits identified within the key areas of work identified. The score card metrics will be discussed at the Recovery Programme Board and presented to EMT for approval before the strategy goes live in March 2017.

Related Strategies / Policies

- **Nursing Strategy 2017-2020**
- **Quality Strategy 2016-2019**
- **Harm Minimisation Policy http://flcintouch:35000/Docs/Documents/Policies/TEWV/Clinical/Harm%20Minimisation%20Policy.pdf**
- **Physical Health care policy** http://flcintouch:35000/Docs/Documents/Policies/TEWV/Clinical/Physical%20healthcare%20(inpatients)%20policy.pdf
- **CPA policy**

Appendix 1

What did we achieve through the implementation of the 2013-2016 Recovery and Well-being strategy?

Objective 1. Moving toward a Recovery focussed culture	
Area of work	**Benefits realised**
Training on Recovery	We have delivered a broad range of introductory recovery training including; Trust Induction, Model Line Teams, a range of other services, Trust Board Seminar, EMT; a range of Corporate Services. • 1268 slots have been attended at specific recovery training sessions / conference • 80% of staff completing evaluations reported an increased knowledge in recovery principles and values • 90 % staff identified 5-10 (on a scale of 1-10) that training would positively impact on their practice • In 2016/2017 100% of new staff have received an introduction to recovery values and principles as part of their trust induction (n=376) • We have recently embedded a recovery slot within the embedding values training • Delivery of team joint care planning workshops • We have trained staff and have rolled out recovery groups and courses across a range of MHSOP and adult community services • We have embedded recovery values and principles within the trust Equality and Diversity training and are currently working to embed principles within the mandatory CPA training
Shared Decision Making (in partnership with Newcastle University and The Health Foundation)	In addition to our original strategy deliverables we secured a bid to work with Newcastle University and the Health Foundation to begin to embed Shared Decision Making within our services. The project is called MAGIC (Making Good Decisions in Collaboration). We have: • Trained a core central group of trainers • Piloted training with two teams and 32 senior medical staff and psychologists. • Developed video training materials specific to mental health • Begun to adapt the MAGIC training programme to meet the needs of mental health provision • We are working to embed Shared Decision Making principles within the new medication optimisation

	mandatory training for nurses • We have designed a workshop for students at ARCH to pilot how we can engage service users
Embedding of Recovery principles in core trust projects an developments	• We embedded recovery principles within other core strategic projects for example the Model Lines psychosis project, the CPA project, Harm minimisation project, Force reduction project, • We have worked to embed recovery within pathways – Functional pathway for Mental Health Services for Older People and the psychosis pathway
Objective 2: To move towards a model of co-production where there are increased opportunities for individuals with lived experience to be involved in the design and delivery of services	
To develop an Expert By Experience Group to support training and project Delivery – (target 8 people)	We have developed adult services Recovery Expert by Experience Group whose input has been fundamental to the progress made to date. • We have trained 4 cohorts of Experts by Experience in storytelling and currently have 26 active members of the group (this group offer input via involvement and engagement processes) • We have created 5 paid expert by Experience Roles (Two posts to co-ordinate the experts group and three expert by Experience trainers) • We will be recruiting to and delivering a 5th Cohort of training by the end of March 2017 • We have plans to commence recovery training with carers to support carers input into the programme • The Expert by Experience group have co-delivered and delivered a broad range of recovery related training throughout phase one using story telling as a mechanism for supporting culture change. This aspect of training is always rated as most impactful overall • The group members have also been involved in consulting on and designing a wide range of service developments • The group has been short listed for a Royal College of Psychiatrists award for service user and carer involvement • We implemented two CQUIN targets in 2014/15 and 2015/16 which focussed in increasing opportunities for individuals with lived experience which secured an income of £360,500
Ensuring systems are in place for an increased	We have: • Reviewed and revised all processes for recruiting and supporting volunteers within the trust, with services now

number of volunteering opportunities for individuals with lived experience	taking increased responsibility for supporting this process • We have offered volunteering placements to 160 individuals who report having lived experience of mental health issues during the lifespan of the strategy.
To ensure lived experience representation on the recovery project steering group and work stream groups	We have had lived experience representation on a wide range of work stream groups examples include; The recovery steering committee; the peer role steering group; the Recovery College steering group; the Virtual Recovery College steering Group; The Harm minimisation steering group and training development groups; The Force Reduction Steering and work stream groups; the involvement in recruitment work stream group; the mindfulness project steering Group; the physical health project; the North Yorkshire recovery development group.
We will standardise practice for involving service users and carers in recruitment	We have conducted work to understand current good practice and models currently in use. We have reviewed reporting arrangements for capturing data on how frequently we are involving service users and carers in the interview process and identified actions for increasing involvement growing forward. Further work is required in phase 2 developments following the current review of recruitment processes within the trust.
To introduce unpaid peer role opportunities	We have set up a structure for Involvement Peer Roles which are managed through our Involvement and Engagement structures. These roles allow individuals, who have experience of a specific course or intervention, the opportunity to co-facilitate groups/ courses alongside paid staff. We have: • Introduced 36 Involvement peer roles across services and currently have 32 active • Introduced these roles into a wide range of services such as; ARCH Recovery College; a range of DBT skills groups; Mindfulness courses; Recovery the New me Courses running in a variety of community adult services; a Cognitive Stimulation Therapy group; the psychotherapy service within York; hearing voices groups; the forensic recovery college courses; a dual diagnosis inpatient support group. • Initial evaluation of roles these indicates that - 100% of staff would recommend these roles to other services and 88% would like to see expansion into paid peer roles being offered - 87% of service users receiving input found the input beneficial, with 73% reporting a positive impact on their recovery - 100% of Involvement peers responding reported the role as a positive experience which had a positive impact on their own recovery

To scope the introduction of Paid Peer roles within the trust	Work has been conducted to gain a greater understanding of how we can effectively introduce paid peer roles within The organisation. This has involved: • The introduction of 6 paid peer roles (2 peer trainers at ARCH, 3 Peer workers at the Discovery Hub York and 1 Peer Worker within the currency and outcomes department) • 10 individuals have received an introductory training course in peer support and 13 individuals have received an accredited Peer training course • Gaining an in-depth understanding of the training and support structures required to introduce a broader range of Peer Worker roles moving into phase 2
Objective 3: To establish a Recovery Education centre which is co-designed and delivered with staff, service users and partner organisations	
To Develop a Recovery College in Durham and Darlington Locality	ARCH recovery college was launched in September 2014 at St Margaret's Health Centre in Durham. It offers a wide range of self- management courses to staff, service users and carers. It is set up using a co-production approach and all courses are designed and delivered by an Expert by Experience and an Expert by Profession. Since the launch ARCH has: • Now offer 42 different courses/ workshops to students • Enrolled 372 students, with 99% of course evaluations to date indicating students are satisfied with the courses they have sat • 76% of students who complete a baseline and follow up recovery patient related outcome measure (QPR) report an overall improvement
Converge College York / Discovery Hub	Converge is a partnership between York St John University and the trust and delivers educational opportunities to people overcoming mental health difficulties: In contrast to ARCH recovery college the focus of converge is not on self-management courses but rather offering access to educational opportunities such as arts, music, textiles, creative writing, dance, theatre, sports and film within a University environment. Courses are taught by staff and university students. In 2015/2016 140 individuals completed courses and 85 University students were involved in delivering courses. Converge is delivered in partnership with the discovery hub which offers peer support to individuals to access community learning opportunities across the whole locality area

Forensic Services Recovery College	• Our Deputy Medical Director / Senior Clinical Director Forensic Services has been instrumental in setting a National CQUIN target for the development of recovery college provision with secure services. • We have piloted initial recovery college courses throughout 2016 and have recently launched a prospectus of recovery college courses within Ridgeway Forensic services which commenced in September 2016
Development of a Virtual Online Recovery College (recovery college online)	In 2015 the trust was successful in securing a bid for funds to develop a Virtual Recovery College site. We subsequently secured Academic Health Science Network funds to staff the development of initial content. We have now built the online college site which offers two functions 1. Access to a wide range of self-management resources 2. Access to online self-management courses We have recently agreed to fund the virtual recovery college as an innovative service within phase two of recovery developments. This will provide online access to a wide range of recovery resources and courses to staff, service users and carers across all our locality areas.
Objective 4: Transform the way the Trust approaches Risk Assessment and Management	
We will ensure that the Trust review and development of risk management and patient safety policies and frameworks are in line with recovery principles	• We have extended the concept of risk and harm to include experiences that inhibit recovery e.g. lack of autonomy, hopelessness, an identity solely linked to diagnosis, impoverished opportunities and introduced the language of a 'Harm Minimisation approach' to supporting safety • We have reviewed and re-written our risk management policy and now have a trust wide Harm Minimisation policy • We have reviewed our engagement and observation protocol and have a new ' Supportive Engagement and Observation protocol' in place
We will ensure that recovery principles are embedded within the Trust review and development of	• We have designed a face to face harm minimisation training programme for staff and are currently delivering this training to a wide range of clinical services / staff • We have employed 3 harm minimisation lived experience trainers who co-delver the face to face training with professional staff.

Risk Management Training.	• We are currently in the process of reviewing the current mandatory e-learning training on risk management, adapting this so that it encompasses a harm minimisation training approach. It is planned that this will be in place by April 2017

ITEM NO. 9

FOR GENERAL RELEASE

Board of Directors

DATE:	**31 January 2017**
TITLE:	**CYPS Management of Waiting Times Update**
REPORT OF:	**Brent Kilmurray**
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:

The Board has received previous reports regarding the work under way to address concerns about excessive waits within CAMHS services. This report includes an update from each locality and provides the position reported up to December 2016 together with a narrative regarding the key areas of action that have been completed and/or are under way.

Recommendations:

The Board is asked to receive this paper and give comment and direction as appropriate.

MEETING OF:	**Board of Directors**
DATE:	**31 January 2017**
TITLE:	**CYPS Management of Waiting Times Update**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to update the Trust Board on progress made in minimising waiting times for children & young people accessing our CAMHS services.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Board has received previous reports regarding the work under way to address concerns about excessive waits within CAMHS services. This report includes details from each locality and provides the position reported to December 2016 and a narrative regarding the key areas of action that have been completed and/or are under way.

2.2 To support further understanding of the context for performance in each Locality the Board has requested an analysis of the funding/investment in CAMHs services across the Trust. A summary table of waiting times and investment by Locality can be found in Appendix 1.

3. KEY ISSUES:

3.1 Durham & Darlington

3.1.1 The service fully implemented the overall recovery plan which was underpinned with QIS methodology and the phase one Purposeful & Productive Community Services tools. Key factors that influenced progress included: cells and huddles, caseload management, activity planning, daily lean management. There was also the introduction of the Single Point of Access (SPA) in August 2016. This was developed through an RPIW and has introduced: a single contact point for referrers; open access; choice of assessment type; telephone assessments on the day the referral is received; priority referrals are seen the same day as referral face to face; standard face to face assessment with SPA within 5 days; appointment with their local CAMHS team within 28 days.

3.1.2 As a result of the work completed aligned to the recovery plan, the service continues to achieve the 9 week waiting time KPI. All young people waiting will have had a telephone assessment which ensures we have considered risk and the young person is waiting for ongoing assessment and interventions at the right place.

3.1.3 The service is working with commissioners regarding commitments to Local Transformation Plans (LTPs), implemented in October 2015. These include the recognition that work needs to be undertaken to support the wider

children's workforce to reduce referrals to CAMHS (as outlined in Future in Minds). Within Durham & Darlington CAMHS there has been no reduction in the number of referrals received and there is recognition by commissioners that as part of the refreshed LTP more needs to be done. Details regarding referrals are shown in appendix 1.

3.1.4 Public Health has funded 5 resilience nurses to work into secondary schools in County Durham (commenced October 2016). It is expected that this resource will build resilience within schools to support young people with emotional difficulties and reduce inappropriate referrals into CAMHS.

3.1.5 Phase 6 of CYP-IAPT includes the development of Psychological Wellbeing Practioners (PWPs). The service is committed to including these roles within the skill mix of the service. The PWP role will enhance opportunities to deliver timely evidence based interventions within Tier 2, supporting timely interventions and recovery, which will increase productivity.

3.1.6 Although Durham & Darlington has made progress to ensure young people do not have to wait over 4 weeks for a face to face assessment, we recognise there is much work still to be done to continuously improve the current position and sustain this improvement and the resource to manage referrals is extremely tight. The % seen within 4 weeks declined in December due to staff sickness and an increase in referrals. In January we are seeing this improve (71.9%) as sickness rates improve and referrals rates level off. Using the daily lean management and PPCS tools this is monitored closely, with corrective actions taken if individual teams encounter difficulties.

Durham and Darlington waiting times:

	December	November 16	August 16	June 16	March 16
% seen in 4 wks	**68.72%**	**87.5%**	**77.04%**	**32.65%**	**31.25%**
Numbers waiting more than 4 wks	**67**	**43**	**51**	**232**	**519**

3.2 Teesside

3.2.1 The service has sustained the improved performance of time waiting from referral to initial appointment at target for over 6 months, this has improved further with the current position being 100% (December '16).

3.2.2 The support and leadership of the team managers has been pivotal to this success, with them managing and leading the plans/processes that were identified in the previous report.

3.2.3 The success of achieving and sustaining this improvement is as a direct result of the engagement and collaboration of the whole workforce who held a strong belief that the situation would improve.

3.2.4 The waiting times continue to be monitored through daily and weekly management processes (PPCS stage 1 tools).

3.2.5 The demand on CAMHS and referrals continue to increase, appendix 1.

3.2.6 However despite this increase in demand we have maintained the waiting time targets and also as we have improved access to the service we have seen a decrease in DNA – our current position with DNA is 7% (nationally 12 – 20%).

3.2.7 The service is now engaging with stage 2 of PPCS and looking at the whole system and clinical quality. This entails engaging with commissioners and CCGs alongside the children's workforce.

3.2.8 The vision of Future in Mind has helped the system begin to identify a co-ordinated way forward where children and young people's mental health is everyone's business.

3.2.9 The themes in Future in Mind are:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

3.2.10 Examples of developing new ways of working include:

- Tees CYPS have CAMHS staff co-located alongside colleges in Early Help hubs and Children's Hubs as one point of contact for that locality, where referrals (self and professional) are received and discussed within a multi-agency context and signposted appropriately.
- As a result this is increasing capacity and confidence in the workforce and promoting resilience, prevention and early intervention and reducing the need for CAMHS referral/ involvement.
- Phase 6 of CYP-IAPT includes the development of Psychological Wellbeing Practitioners (PWPs). This development is embedded within our business plan and the service is committed to including these roles within the skill mix of the service, thus providing high intensity work for low level difficulties

Tees waiting times:

	December '16	November '16	August '16	June '16	March '16
% seen in 4 wks	**100%**	**99.10%**	**97.92%**	**97.55%**	**59.01%**
Numbers waiting more than 4 wks	**0**	**3**	**2**	**4**	**75**

3.3 North Yorkshire

3.3.1 The service has developed a recovery plan to support improvement of waiting times across the locality with particular focus on the Scarborough and Harrogate teams. The plan is underpinned by embedding of phase one of the Purposeful & Productive Community Services programme. From 1 October 2016 a revised approach to daily lean management has been in place to support the review and monitoring of key performance indicators and facilitate proactive management of issues. This has been supported by the Assistant Corporate Performance Manager who has delivered dedicated IIC training to the team managers and team administration to support the revised daily management process. This has created a greater awareness of position against the key performance indicators and supports improvement in performance.

3.3.2 Staff vacancy levels, particularly in the Scarborough team, have had a significant impact on the ability to meet an increased demand. With the exception of one post all vacancies have been successfully recruited to with all post being filled by the end of January 2017.

3.3.3 As a result of implementing the action plan the service has made significant improvements and has achieved the 9 week waiting time KPI across all teams. The Northallerton team continue to improve and maintain performance of the 4 week waiting time KPI. The Scarborough team have made significant improvements with current average waiting times being 5 weeks. The number of complex patients on caseload and urgent responses during November continues to have an impact on the Harrogate service although improvements have been made. The Team Managers continue to realign diaries to plan capacity across the teams where possible to minimise the impact. All young people waiting will have had a telephone assessment within 24 hours via the Single Point of Access (SPA) which ensures we have considered risk and the young person is waiting for ongoing assessment and interventions at the right place.

3.3.4 Following a successful bid to access short term funding via national non-recurring monies the 3 local CCGs are supporting a GP early intervention pilot scheme to support the reduction of waiting lists. The monies are available from November 2016 to March 2017 and are subject to review in January 2017. The pilot will commence in December / January in GP surgeries from each CCG area. Practices have been identified based on referral patterns and all referrals from the identified practice, which do not present with significant risks, will be seen in a GP based clinic. Patients seen in the GP based clinic will receive a 30min face to face assessment from a CAMHS clinician. The outcome of the assessment will be either discharge; completion of a comprehensive assessment or invitation to a psychoeducational event. This work will further contribute to the reduction of waiting times.

3.3.5 The service is committed to the continued involvement in CYP IAPT. Phase 6 of CYP-IAPT includes the development of Psychological Wellbeing Practitioners (PWPs). The PWP role will enhance the opportunity to deliver timely evidence based interventions within Tier 2, supporting timely interventions and recovery, which will increase productivity. The service is committed to including these roles within the skill mix of the service.

3.3.6 Although North Yorkshire continues to make progress to ensure young people do not have to wait over 4 weeks for a face to face assessment we recognise there is work still to be done to continuously improve the current position and sustain this improvement to meet increasing demand. Using the daily lean management and PPCS tools this is monitored closely, with corrective actions taken if individual teams encounter difficulties.

North Yorkshire waiting times:

	December 2016	November 16	August 16	June 16	March 16
% seen in 4 wks	60.42%	60.38%	50.63%	53.15%	58.77%
Numbers waiting more than 4 wks	38	42	57	42	76

3.4 Vale of York

3.4.1 Whilst the performance against the 4 week target presents an improving picture there remain significant data quality issues which are a concern for York and Selby CAMHS. Further issues have been discovered following an external data request from the Partnership Commissioning Unit (PCU) in relation to new funding for children and young people's mental health.

3.4.2. Over recent weeks further validation of waiting lists and patient flow has been undertaken between the corporate and clinical services which has highlighted a number of issues and challenges. A brief update on this was given to the PCU and the CCG during the meeting on the 14th December 2016. The exercise has identified issues that are of relevance to all CAMHS services across the Trust and will be presented later in the report.

3.4.3 Work on the Service's Single Point of Access is well underway and has been running in shadow form since the beginning of November. The Primary Mental Health Worker (PMHW) team is running the telephone consultation and triage service provided from the SPA. Alongside this the wider clinical team are now offering Initial Comprehensive Assessments (ICA) rather than the PMHW team being responsible for the majority of initial assessments.

3.4.4 As part of the service redesign all Tier 3 CAMHS staff have engaged in a job planning exercise using PPCS tools and now have much clearer job plans based on the Trust's CAMHS clinical pathways. ICAs are allocated by the PMHW team to clinicians working on the pathways that seem most relevant

to the young person's clinical needs, as ascertained by the telephone consultation. This will lead to families experiencing fewer 'hand offs' between assessment and treatment appointments and should also improve the diagnostic conversion rates such as for Autistic Spectrum Condition (ASC), which is of significant interest to the Vale of York CCGs.

3.4.5 The service is currently involved in 2 waiting list iniatives, one funded internally by the Trust to address the ASC Waiting List and one funded by NHSE to address the Attention Deficit Hyperactivity Disorder and Low Mood and Anxiety Waiting Lists. The service is working with TEWV employees within the different CAMHS localities and with private and agency providers to address this. It is hoped that the timing of these initiatives and the establishment of the SPA will reduce the number of children waiting for these specialist assessments in the future.

3.4.6 Staff sickness in the service has increased from below 1% to over 4% over the last 2 months. Some is accounted for by physical ailments but 2 staff specifically report work related stress as a factor in their absence. Other staff have expressed concerns about the pace of change in the service and have written to QuAG to raise these. The management team are therefore mindful of the need to complete the changes described above to improve service delivery whilst also maintaining staff well being throughout the change process.

Vale of York waiting times:

	December 16	**November 16**	**August 16**	**June 16**	**April 16**
% seen in 4 wks	**31.1%**	**51.19%**	**17.38%**	**21.42%**	**34%**
Numbers waiting more than 4 wks	**198**	**124**	**390**	**429**	**406**

3.4.8 Following discussions in York and Selby it has become apparent that NHS England will be changing their expectations with regard to waiting times for children's services

3.4.9 The first key point to note is that in reality there are three points that patients wait in the pathway:

1. Wait for first appointment (this is a new referral to TEWV, where the patient is waiting to be seen for a first face to face appointment
2. Wait for second appointment (this is a new referral to TEWV, where the patient has had a first face to face appointment, but are waiting to be seen for a second face to face appointment (*this is the proxy being used by NHSE as the start of "treatment")
3. Wait for treatment (this is a new referral to TEWV, where the patient has had 1 or more face to face appointments, in order to determine the most appropriate form of treatment, but are waiting to be seen for the start of treatment).*

3.4.10 NHS England will focus more on the waiting list described in point 2; however we believe we need to develop waiting list reports for all 3 elements in order to ensure we continuously improve access and treatment in our service provision but also provide assurance initially to Vale of York CCG, but in all likelihood to other commssioners too in due course.

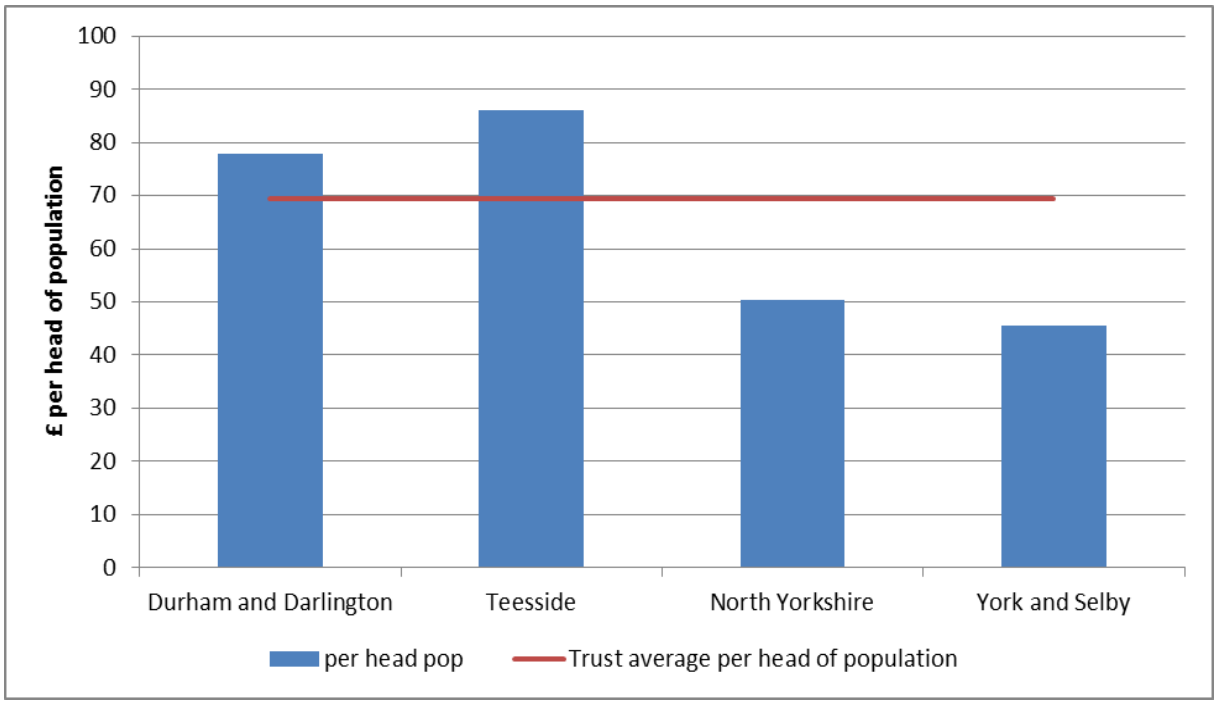
3.5 Funding

3.5.1 CAMHS funding for Locality and by funding source is summarised as follows:

Locality	16/17 CCG Investment	16/17 LA income	16/17 other income	16/17 Total investment	Population*	per head of population
	£	£	£	£		£
Durham and Darlington	9,422,168	127,757	332,084	9,882,009	126,896	77.87
Teesside	10,277,981	386,772	92,996	10,757,749	124,862	86.16
North Yorkshire	3,861,472	437,492	105,842	4,404,806	87,358	50.42
York and Selby	2,616,762	178,312	26,437	2,821,511	61,994	45.51
TRUST	**26,178,382**	**1,130,333**	**557,359**	**27,866,074**	**401,110**	**69.47**

*Population aged 0 to 17 years

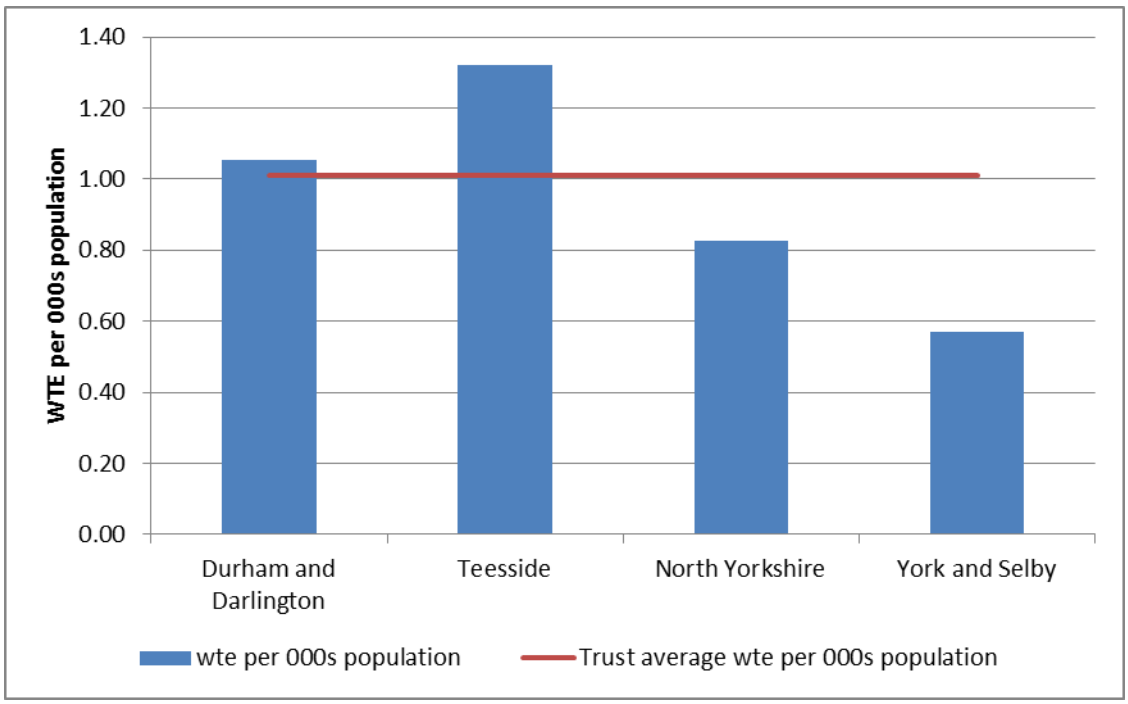
3.5.2 Values are for total funding and are also shown per head of GP population.



3.5.3 Values for CAMHS direct pay and non pay expenditure budgets are shown as follows:

Locality	16/17 Total investment	cost centre budgets (as at September 2016)		
	£	WTE	£	%
Durham and Darlington	9,882,009	133.52	7,587,403	77%
Teesside	10,757,749	164.88	7,604,581	71%
North Yorkshire	4,404,806	72.26	3,772,149	86%
York and Selby	2,821,511	35.25	2,070,908	73%
TRUST	**27,866,074**	**405.91**	**21,035,041**	

3.5.4 The following graph shows the WTE per 000s population



4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

There are no implications on Compliance with the CQC Fundamental Standards.

4.2 Financial/Value for Money:

There are no direct financial implications of this paper

4.3 Legal and Constitutional (including the NHS Constitution):

There are no legal or constitutional implications of this paper.

4.4 Equality and Diversity:

There are no equality or diversity implications of this paper.

4.4 Other implications:

There are no other implications of this paper.

5. RISKS:

These matters are covered within the locality risk registers.

6. CONCLUSIONS:

Waiting time pressures are a key priority for clinical teams across the Trust. The position within CAMHS services over the last year or so has been a significant cause for concern. Much effort has continues to be inveted into addressing these pressures to support a reduction in overall waiting times across the speciality.

7. RECOMMENDATIONS:

The Board is asked to receive this paper and give comment and direction as appropriate.

Brent Kilmurray
Chief Operating Officeer & Deputy Chief Executive
January 2017

Appendix 1

Locality	% seen in 4 weeks	Numbers waiting more than 4 wks	All referrals 2016 (inc internal referrals)	External T2 & T3 referrals (Jan – Nov)	Children's population	Finance (£)	Commissioned Services	WTE staff
Teesside	100 (Dec)	0 (Dec)	7914	2986	124,862	10,757,749	PMHWS Tier 2 CAMHS Tier 3 Enhanced Crisis Intensive Home Treatment CLD	164.88
Durham & Darlington	87.5% (Nov)	43 (Nov)	7958	3272	126,896	9,882,009	PMHWS Tier 2 CAMHS Tier 3 Enhanced Crisis Intensive Home Treatment CLD	133.52
North Yorkshire	60.38% (Nov)	42 (Nov)	2747	1365	87,358	4,404,806	PMHWS Tier 2 CAMHS Tier 3 LAC	72.26
York & Selby	51.19% (Nov)	124 (Nov)	2540	1314	61,994	2,821,511	PMHWS Tier 2 CAMHS Tier 3 CAMHS Liaison (A&E) CLD	35.25

Item 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31 January 2017**
TITLE:	**Finance Report for Period 1 April 2016 to 31 December 2016**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 December 2016 is a surplus of £9,596k, representing 3.8% of the Trust's turnover. The Trust is ahead of plan by £2,261k largely due to a refund of historic National Insurance payments linked to widening access trainees, confirmation of contract variations with commissioners, and vacancies. Recruitment to posts is ongoing.

Identified Cash Releasing Efficiency Savings at 31 December 2016 are in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

The Use of Resources Rating for the Trust is assessed as 1 for the period ending 31 December 2016 and is in line with plan.

Recommendations:

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

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

1. INTRODUCTION & PURPOSE

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

2. BACKGROUND INFORMATION

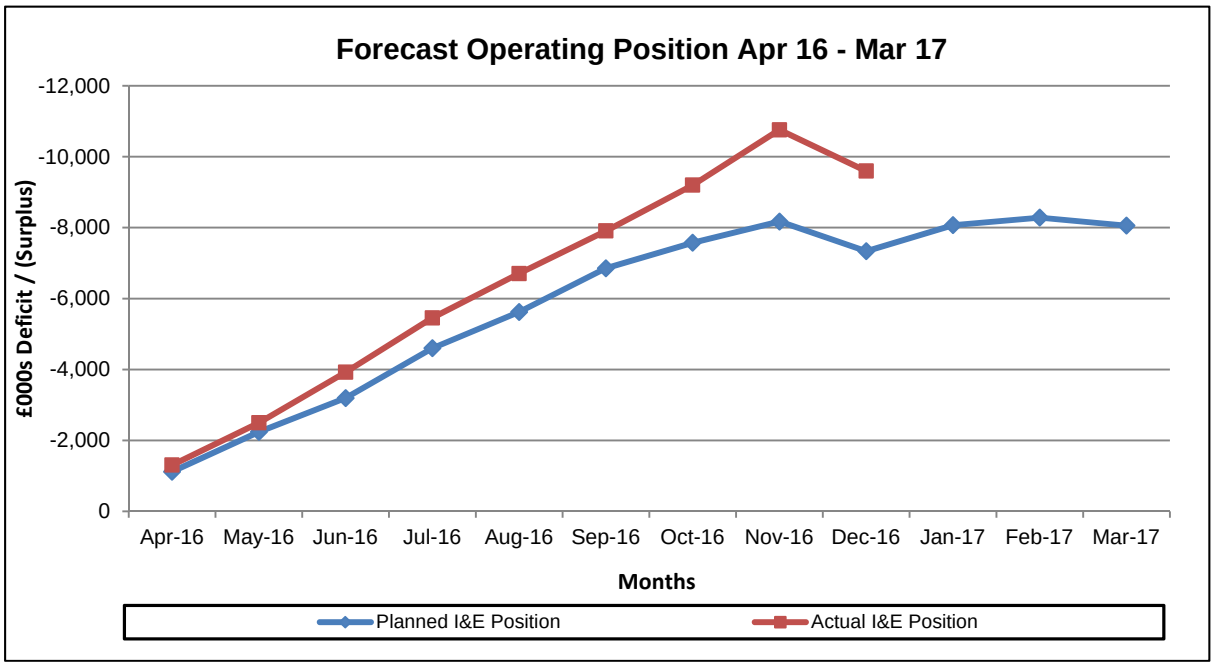
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

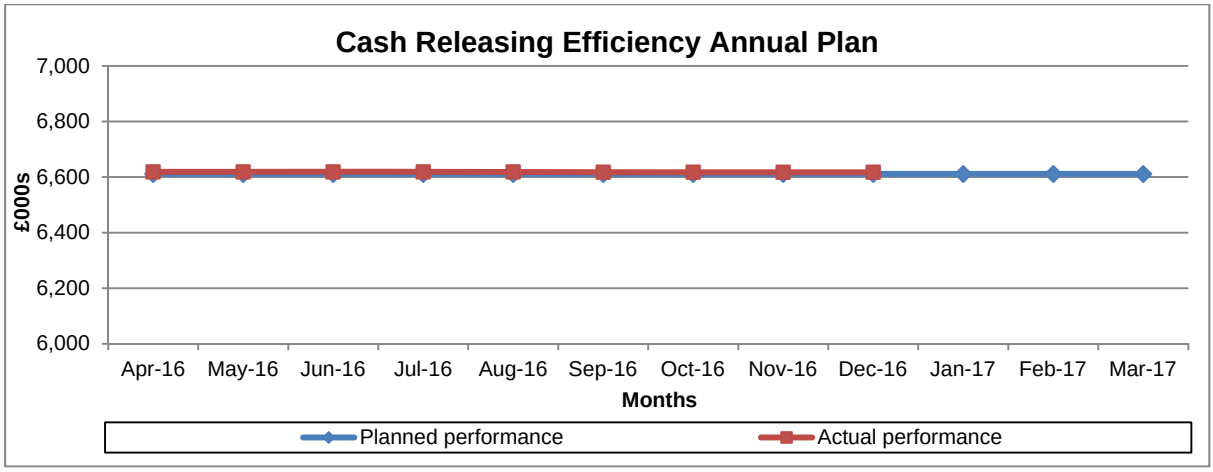
The comprehensive income outturn for the period ending 31 December 2016 is a surplus of £9,596k, representing 3.8% of the Trust's turnover. The Trust is ahead of plan by £2,261k largely due to a refund of historic National Insurance payments linked to widening access trainees, confirmation of contract variations with commissioners, and vacancies. Recruitment to posts is ongoing.

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

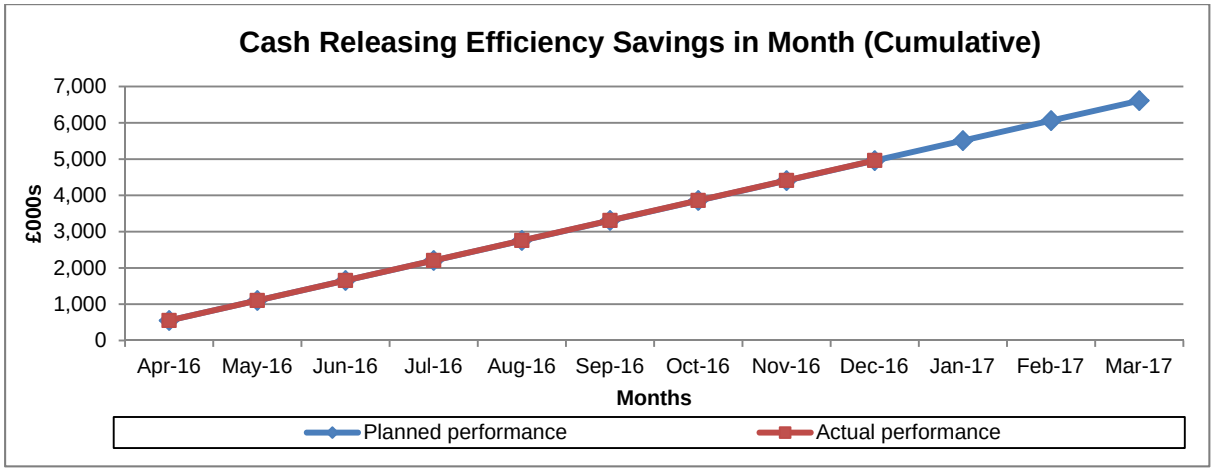


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 December 2016 is £6,617k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

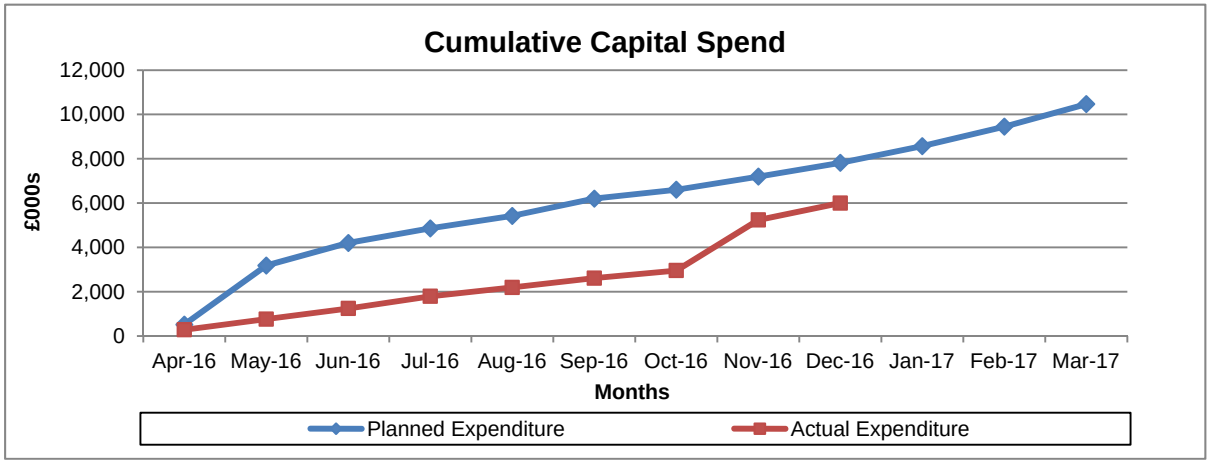


The monthly profile for CRES identified by Localities is shown below.



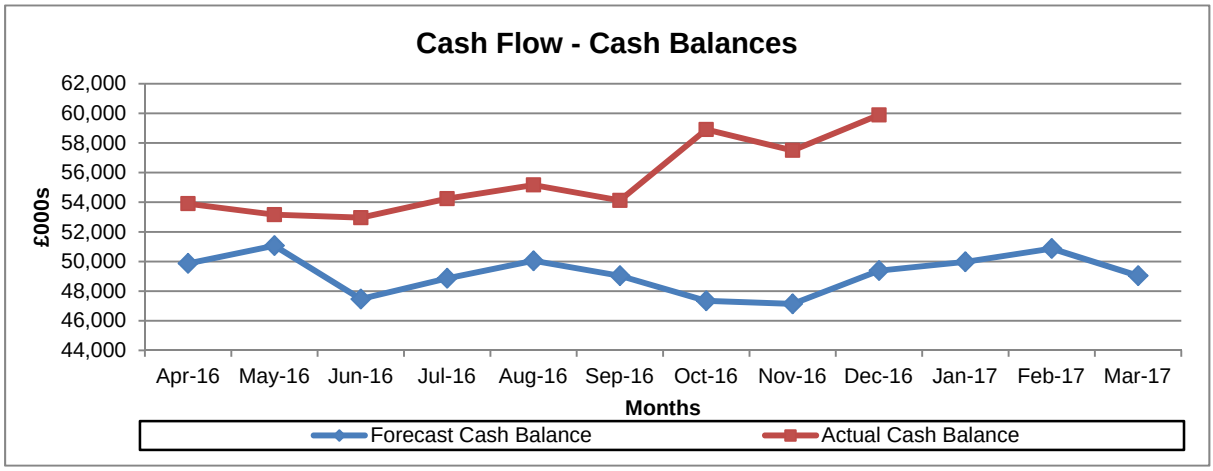
3.3 Capital Programme

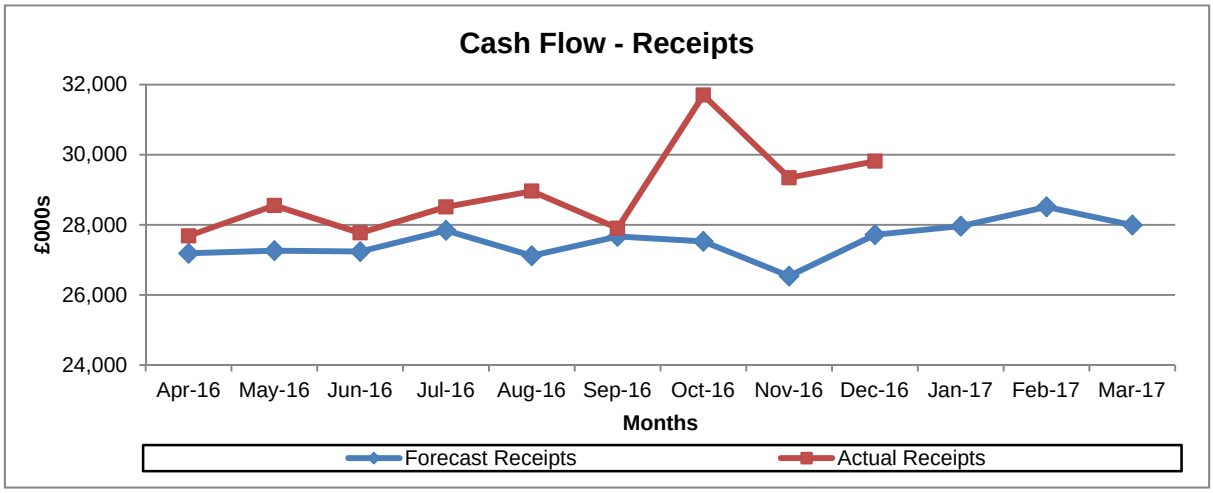
Capital expenditure to 31 December 2016 is £5,998k and is behind plan with schemes now progressing.

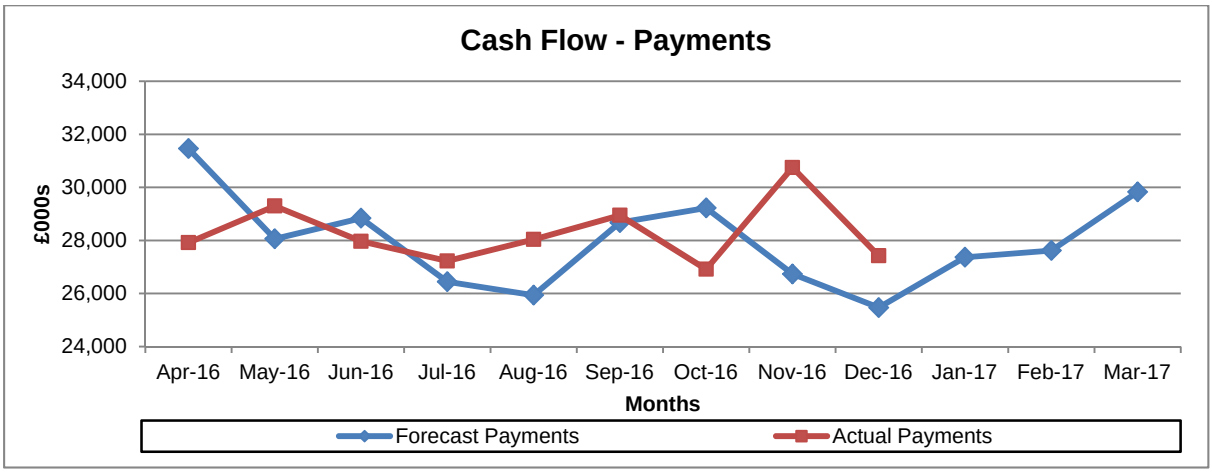


3.4 Cash Flow

Total cash at 31 December 2016 is £59,891k and is ahead of plan largely due to the Trusts surplus position, delays in the capital programme and unanticipated cash receipts related to projects.



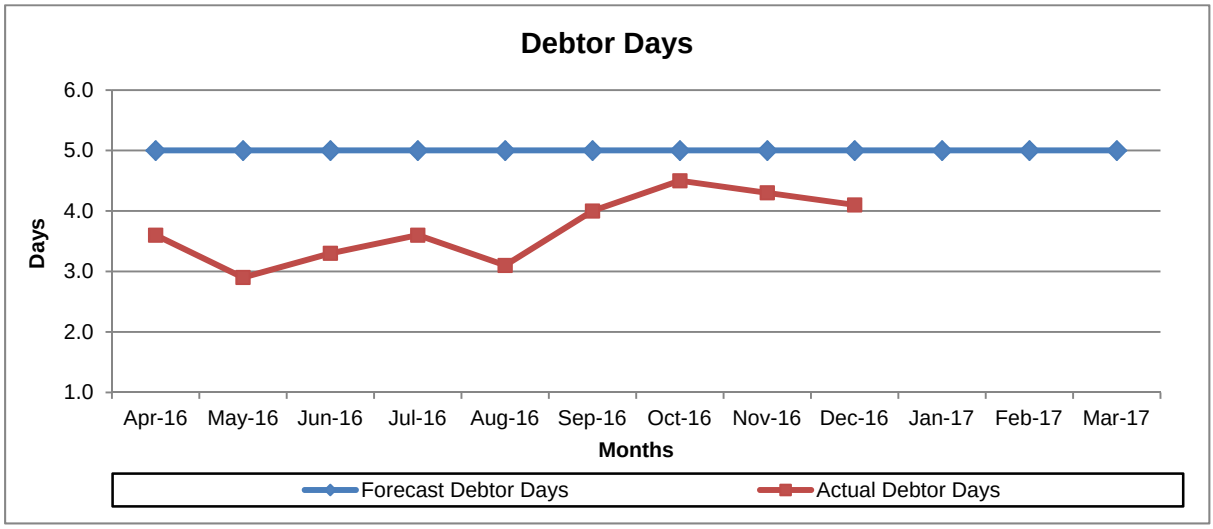




The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

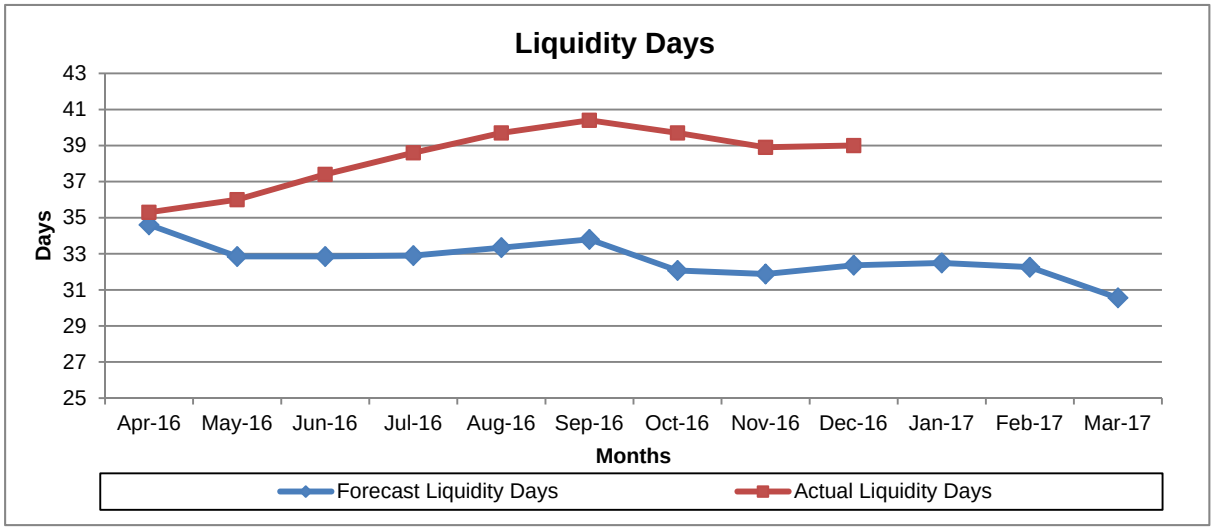
Working Capital ratios for period to 31 December 2016 are:

- Debtor Days of 4.1 days
- Liquidity of 39.0 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 96.40%
  Non NHS 30 Days – 97.84%



The Trust has a debtors' target of 5.0 days, and actual performance of 4.1 days for December 2016, which is ahead of plan.

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



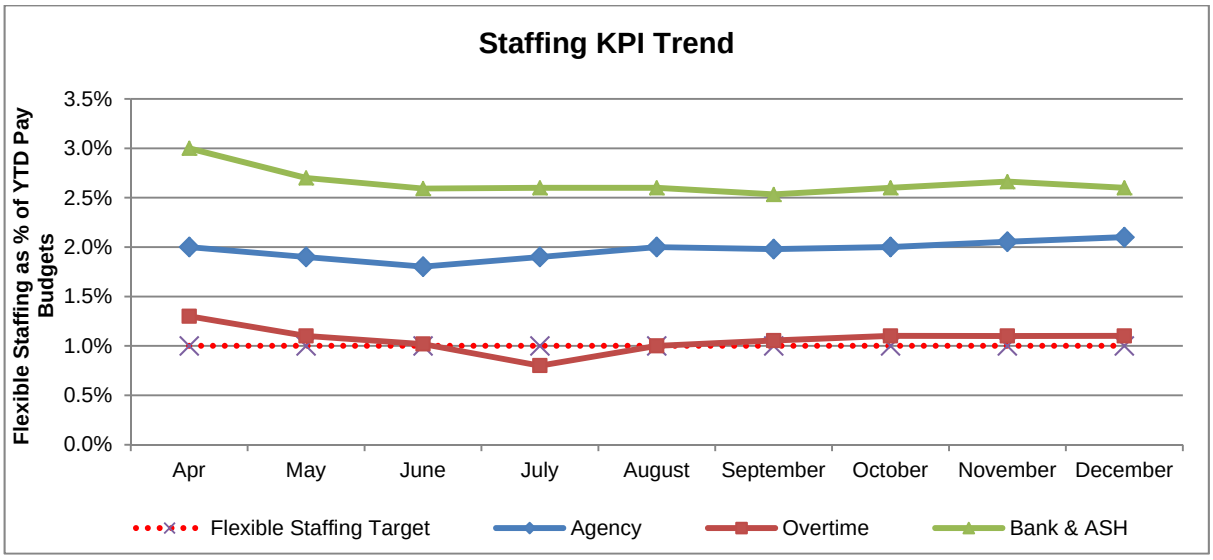
3.5 Financial Drivers

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

Tolerance	Jul	Aug	Sept	Oct	Nov	Dec
Agency (1%)	1.9%	2.0%	2.0%	2.0%	2.1%	2.1%
Overtime (1%)	0.8%	1.0%	1.1%	1.1%	1.1%	1.1%
Bank & ASH (flexed against establishment)	2.6%	2.6%	2.5%	2.6%	2.7%	2.6%
Establishment (90%-95%)	94.5%	94.6%	94.3%	94.6%	93.7%	93.7%
Total	**99.8%**	**100.2%**	**99.9%**	**100.3%**	**99.6%**	**99.5%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For December 2016 the tolerance for Bank and ASH is 4.3% of pay budgets.

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



Additional staffing expenditure is 5.8% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (54%), enhanced observations (18%) and sickness (12%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating is assessed as 1 at 31 December 2016, and is in line with plan.

3.6.2 Capital service capacity rating assesses the level of operating surplus generated, to ensure a Trust is able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.84x (can cover debt payments due 1.84 times), which is ahead of plan and rated as a 2.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 39.0 days, this is ahead of with plan and is rated as a 1.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 4.7% and is rated as a 1.

3.6.5 The variance from plan assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. The Trust surplus is 0.9% ahead of plan and is rated as a 1.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 18% less than the cap and is rated as a 1.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to reduce to a 3 a surplus decrease of £1,005k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £32,730k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £9,067k is required.
- I&E Margin variance from plan – to reduce to a 2 an operating surplus decrease of £2,198k is required.
- Agency Cap rating – to reduce to a 2 an increase in agency expenditure of £837k is required.

Use of Resource Rating at 31 December 2016

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

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.84x	2	1.62x	3	
Liquidity	39.0 days	1	34.1 days	1	
I&E margin	4.7%	1	3.8%	1	
I&E variance from plan	0.9%	1	0.0%	1	
Agency	£3,848k	1	£4,684k	1	
Overall Use of Resource Rating		**1**		**1**	

3.6.7 19.4% of total receivables (£746k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as £598k of debts are supported by an SLA and recent discussions to resolve debts are positive.

Excluding debts supported by an SLA the ratio reduces to 3.9%.

3.6.8 1.7% of total payables invoices (£180k) held for payment are over 90 days past their due date. This is below the 5% finance risk tolerance.

3.6.9 The cash balance at 31 December 2016 is £59,891k and represents 72.4 days of annualised operating expenses.

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

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 December 2016 is a surplus of £9,596k, representing 3.8% of the Trust's turnover. The Trust is ahead of plan by £2,261k largely due to a refund of historic National Insurance payments linked to widening access trainees, confirmation of contract variations with commissioners, and vacancies. Recruitment to posts is ongoing.

6.2 Total CRES identified at 31 December 2016 is £6,617k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

6.3 The Use of Resources Rating for the Trust is a 1 for the period ending 31 December 2016 which is in line with plan.

7. RECOMMENDATIONS:

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

7.2 The Board of Directors is requested to approve the submission of the NHS Improvement quarter 3 return in accordance with the results detailed in this report.

Drew Kendall
Interim Director of Finance and Information

Item 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31st January 2017**
TITLE:	**Board Dashboard as at 31st December 2016**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to provide the latest performance for the Board Dashboard as at 31st December 2016 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. The dashboard is now inclusive of performance relating to York and Selby.

As at the end of December 2016, 7 (37%) of the indicators reported are not achieving the expected levels and are red, which is the same as the figure reported in November. Of those red indicators, 3 are showing an improving trend over the previous 3 month period. There are a further 4 indicators which whilst not completely achieving the target levels are within the amber tolerance levels and 3 of those show an improving trend over the previous 3 months. The Year to Date position is slightly better with only 6 KPI being reported as red.

The key issues/risks are:

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

In respect of performance against the key NHSI indicators Q3 the Trust met all the indicators for the quarter. However we failed to hit one of the targets for the month of November (Admission via a crisis assessment) and one in December (CPA 7 day follow up).

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: 31	**st January 2017**
TITLE:	**Board Dashboard as at 31st December 2016**

1. INTRODUCTION & PURPOSE:

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

- As at the end of December 2016, 7 (37%) of the indicators reported are not achieving the expected levels and are red, which is the same as the figure reported in November. Of those red indicators, 3 are showing an improving trend over the previous 3 month period. There are a further 4 indicators which whilst not completely achieving the target levels are within the amber tolerance levels and 3 of these show an improving trend over the previous 3 months.

  In terms of the Year to Date position 6 indicators (32%) are reporting as not achieving the target set, with a further 6 (32%) being amber.

- For the whole of Quarter 3 the Trust met the operational performance metrics required by NHSI in the Standard Operating Framework. However we failed to achieve one of the targets in November and one in December as follows:

Indicator Target	%	Oct	Nov	Dec	Q3
Admissions should have assessment by crisis resolution team prior to admission	95	96.83	93.92	98.44	**96.27**
Patients on CPA who are discharged from acute ward should be followed up within 7 days	95	97.69	97.25	94.92	**96.62**

  This has been escalated to Directors of Operations for attention by the Director of Planning and Performance and Chief Operating Officer via the Operational Management Team Performance Report Out and the Performance Improvement Group.

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

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

2.2 The key risks are as follows:

- Bed Occupancy (KPI 3) – There has been a further improvement in the performance against this indicator with the December position at 89.49% showing the best performance since February 2016. This ongoing improvement reflects the impact that the opening of the additional adult beds within the York and Selby locality has had. It is proposed that if the level of occupancy moves even closer to the target of 85% in the month of January then this may no longer be an indicator that is highlighted as a significant key risk.

- Number of patients with a length of stay over 90 days – This indicator is being highlighted as a risk for the first time this month due to the Year to Date performance and the overall worsening position. The particular outlier is the York and Selby locality which is almost double its target. This reflects that there are and have been a number of delayed discharges within that patch. The locality is taking action to try to address this including monitoring this weekly on the locality visibility wall, rolling out PIPA onto the wards, and regularly raising the issue with the Partnership Commissioning Unit and Local Authority. It should be noted however that as the people with longer lengths of stay are discharged we would expect to see performance against this indicator decline further as length of stay is calculated at discharge. Indeed the closure of Worsley Court in December has resulted in a number of patients with long lengths of stay being discharged from Worsley Court which has contributed significantly to the 8 patients reported for the York and Selby locality having a Length of Stay greater than 90 days for the month of December.

- External Waiting Times (KPI 7) – Whilst the Trust remains below the target of 90% there has been a further improvement in performance in December such that performance is at its highest level in the past 3 years. It should be noted that Teesside and Forensic Services continue to exceed the target by a considerable margin. The main area of concern continues to be Children and Young Peoples services particularly in North Yorkshire and York and Selby with a significant deterioration, of 11 %age points, in the latter in December. However this reflects a concerted effort to reduce the number of patients that are experiencing long waiting times. The action plans in both localities continue to be implemented to the agreed timescales.

- Out of Locality Admissions (OoL) (KPI 9). Whilst not achieving the target in December performance did improve when compared to November and this has halted the increasing trend that we have seen since August 2016. The improvement seen in bed occupancy will have contributed to this position.

- Actual Number of Workforce in the Month KPI – Whilst this indicator is showing as amber it is highlighted as a risk for the first time this month due to the declining position, with performance being at it worse level since the beginning of the year. the localities of North Yorkshire and York and Selby are the main areas of concern and this reflects the number of vacancies that exists within these localities. Work continues to try improve the recruitment of permanent staff within these two localities including holding specific recruitment fairs and proactive discussions with student nurses.

- Appraisal (KPI 16) – Whilst the Trust is not achieving the target of 95% as at the end of December the position continues to be higher than the same time in previous years. As reported previously the inclusion of all those staff who transferred to the Trust's Electronic Staff Record in York and Selby on 1st November 2015 has had an impact on the Trust wide position. However the position in York and Selby has improved significantly from the 67.81% reported for November to the 74.18% reported for December. The new staff dashboard became available on the IIC in December which highlights to managers those staff reporting as non- compliant and also those who are due to be appraised within the coming three months. It is expected that this along with the roll out of regular operational management huddles to each localities will have a positive impact on future performance.

- %age Sickness Rate (KPI 18) – Performance against this KPI has seen a further deterioration in December (sickness that occurred in November) and was higher than that reported in the same month in the previous two years. All localities reported an increase in sickness rates with the exception of Teesside. North Yorkshire is the only locality that is achieving the target of 4.5%. The focussed work on staff experiencing 5 or more episodes of short terms sickness continues along with the maintained focus on the management of long term sickness.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Activity

	December 2016				April 2016 To December 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,793.00	7,522.00			69,133.00	73,968.00		91,759.00
2) Caseload Turnover	1.99%	-0.06%			1.99%	-0.06%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	89.49%			85.00%	94.58%		85.00%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	24.00	31.00			209.00	264.00		277.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.86%			15.00%	7.55%		15.00%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	21.00	20.00			179.00	218.66		237.00

Money

	December 2016				April 2016 To December 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	836,386.00	1,161,926.00			-7,335,169.00	-9,596,074.00		-4,784,000.00
20) CRES delivery	550,854.00	551,455.00			4,957,688.00	4,963,095.00		6,610,251.00
21) Cash against plan	49,385,000.00	59,891,000.00			440,214,000.00	59,891,000.00		49,036,000.00

Trust Dashboard Summary for TRUST

Quality

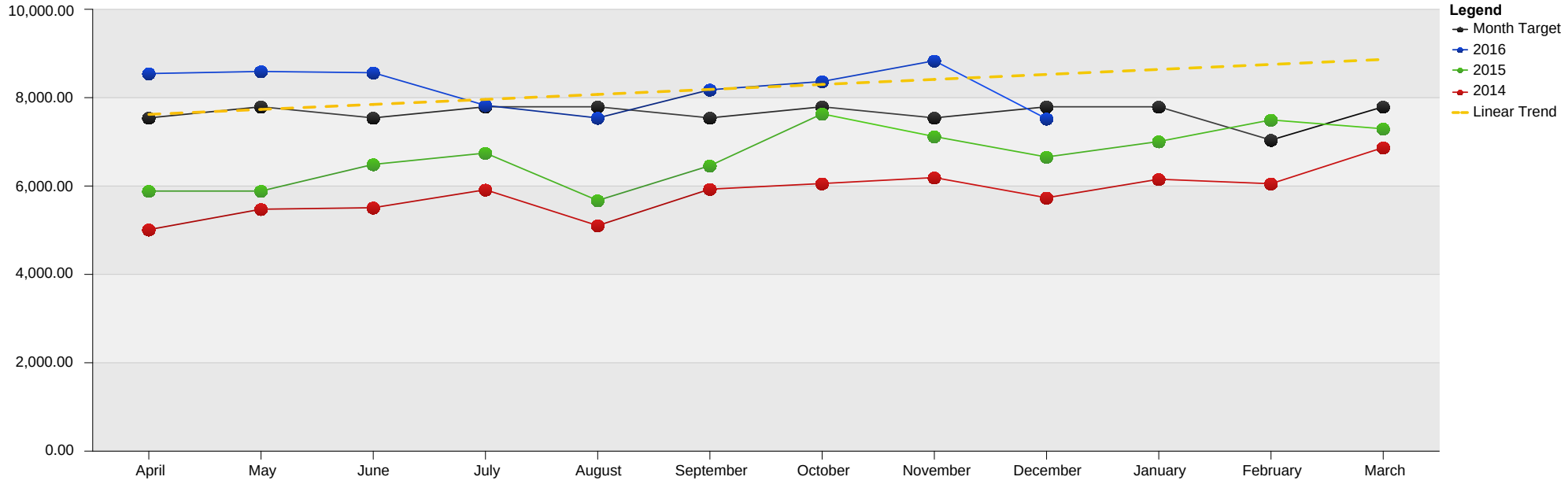
	December 2016				April 2016 To December 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	88.07%			90.00%	85.49%		90.00%
8) Percentage of appointments cancelled by the Trust	0.67%	0.71%			0.67%	0.74%		0.67%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	23.27%			15.00%	22.03%		15.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	93.22%			91.44%	92.16%		91.44%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.17			9.00	6.55		12.00

Workforce

	December 2016				April 2016 To December 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	92.74%			100.00%	92.74%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	12.31%			15.00%	17.00%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	87.10%			95.00%	87.10%		95.00%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	89.21%			95.00%	89.21%		95.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.63%			4.50%	4.92%		4.50%

Trust Dashboard Graphs for TRUST

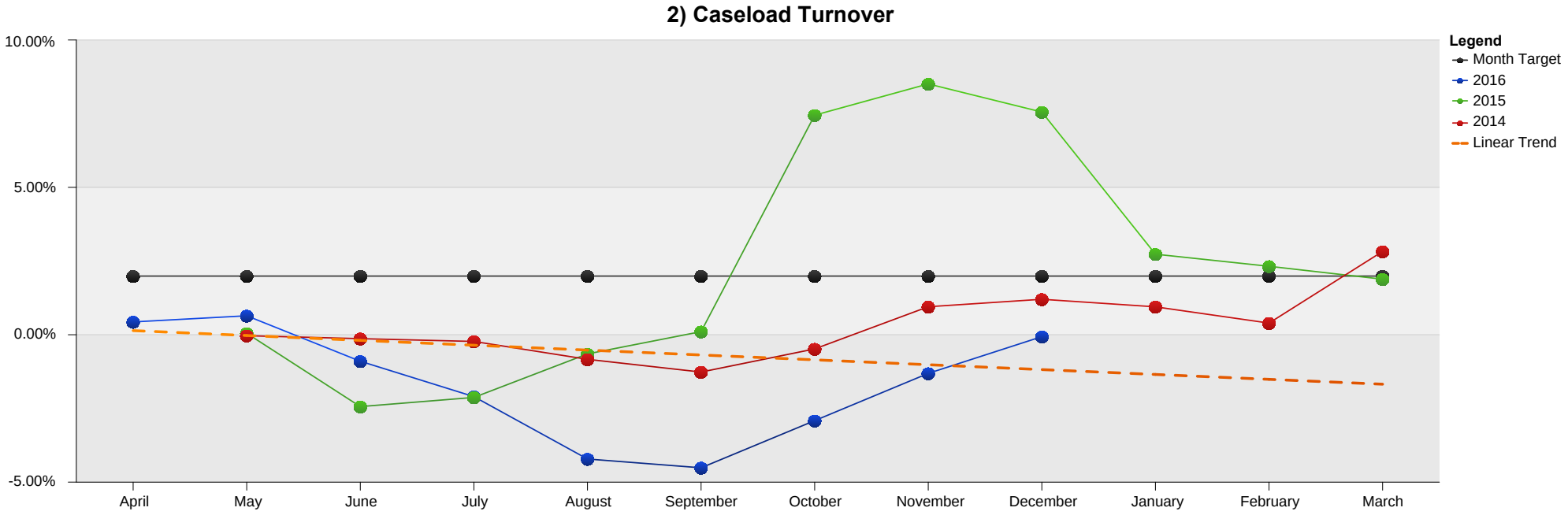
1) Total number of External Referrals into Trust Services



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Total number of External Referrals into Trust Services	7,522.00	73,968.00	1,801.00	17,746.00	1,714.00	17,248.00	1,901.00	18,239.00	505.00	5,301.00	1,599.00	15,415.00

Narrative
The Trust position for December 2016 is 7,522 which is within the Trust target of 7,793 and an improvement compared to that reported in November. A seasonal trend is noted in relation to the decrease in referrals with respect to the Christmas holiday period. The Trust position for the financial year to date is 73,968 which is 4,835 above target.Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 5921 which is lower compared to the same period last year of 6,392Based on the increasing trend reported it is anticipated that we will exceed the annual target of 91,759 referrals by more than 10%.

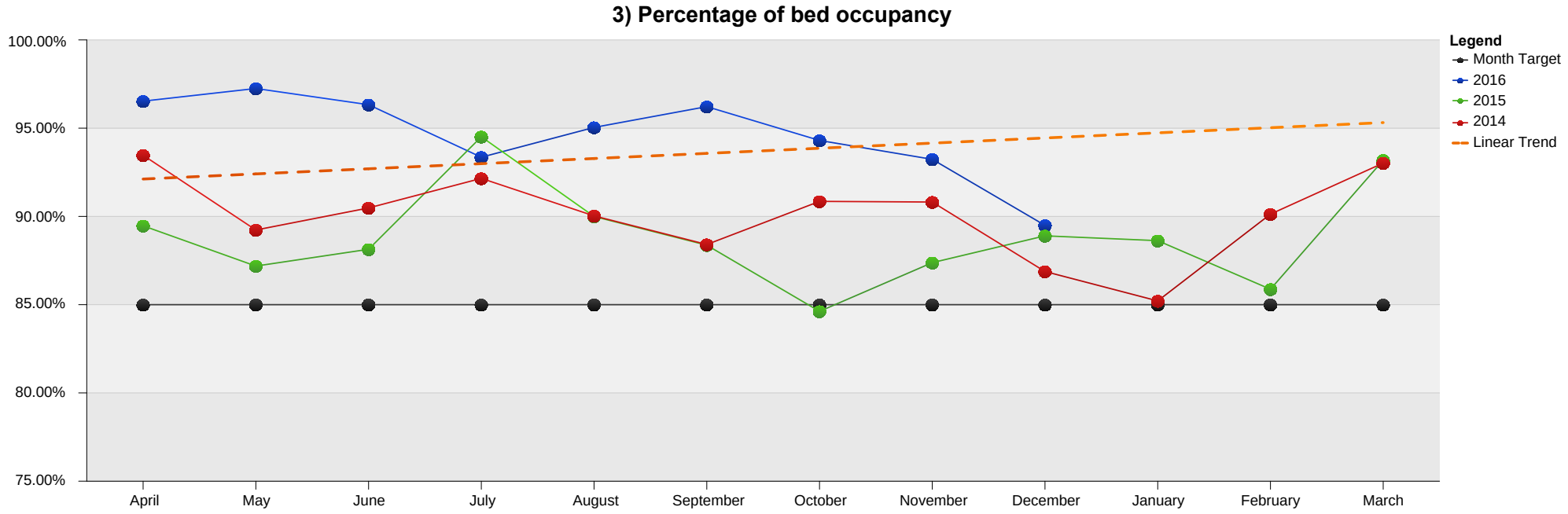
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Caseload Turnover	-0.06%	-0.06%	-0.72%	-0.72%	-0.03%	-0.03%	2.49%	2.49%	NA	NA	-1.86%	-1.86%

Narrative
The Trust position for December is -0.06% which is within target, however is a deterioration compared to that reported in November. All localities are achieving target with the exception of North YorkshireBased on the current trend it is likely we will achieve the annual target of 1.99%

Trust Dashboard Graphs for TRUST

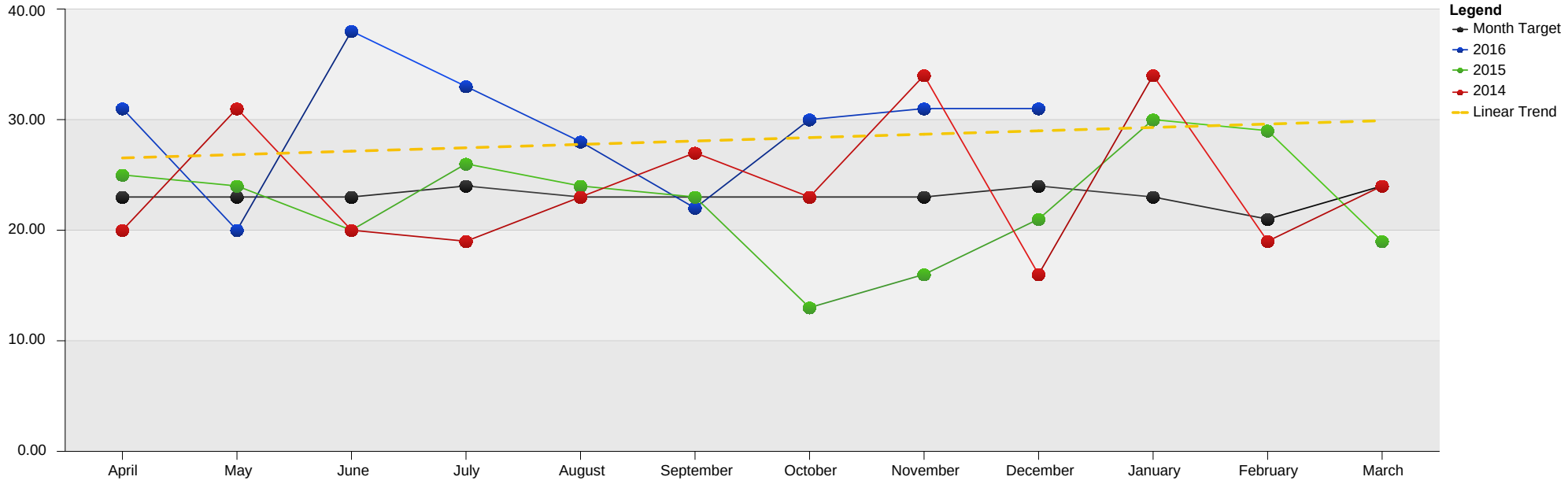


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	89.49%	94.58%	95.45%	92.98%	88.15%	96.63%	91.85%	96.10%	NA	NA	76.91%	90.74%

Narrative
The Trust position for December is 89.49% which is 4.49% over the Trust target of 85% but an improvement on the November position. This represents the 3rd consecutive month where performance has improved and is the best position in the year to date. All localities are exceeding the 85% target with the exception of York and Selby which had an occupancy level of 76.91% The Trust position for the financial year to date is 94.58%, which is 9.58% above target.A key factor that has been contributing to this high level of occupancy is linked to the placement of York Adult Mental Health patients requiring inpatient care into beds in other localities within the Trust. The Adult Mental Health beds re opened at Peppermill in York on 3rd October and now the unit is operational the levels of occupancy are moving closer to the target set. However it is recognised that there continues to be pressures in some localities.

Trust Dashboard Graphs for TRUST

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

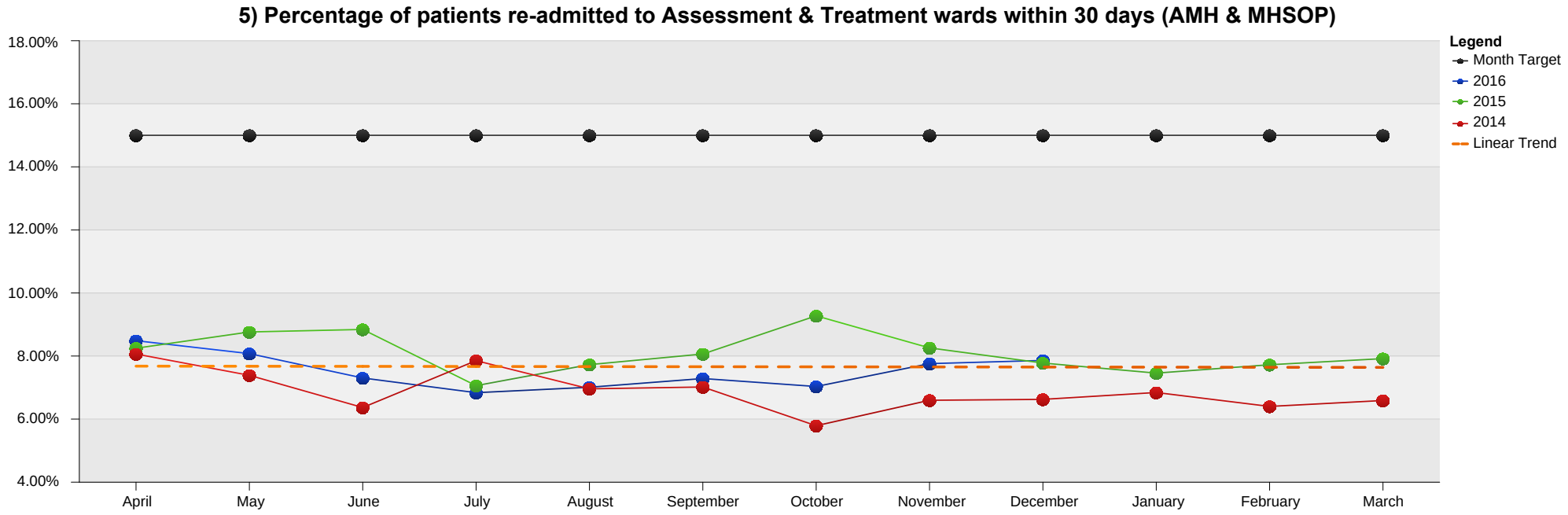


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	31.00	264.00	5.00	61.00	5.00	65.00	11.00	70.00	NA	NA	8.00	56.00

Narrative

The Trust position for December is 2016 is 31 which is worse that than the Trust target of 24 and the same as the November position. The Trust position for the financial year to date is 264 which is worse than the target of 209.Of the 31 admissions with a LoS greater than 90 days:* 11 (35%) were within North Yorkshire (4 AMH and 7 MHSOP) which is worse than target* 8 (26%) were within York & Selby (8 MHSOP) which is worse than target* 5 (16%) were within Durham & Darlington (2 AMH and 3 MHSOP) which is below target* 5 (16%) were within Teesside (1 AMH and 4 MHSOP) which is below target* 2 (6%) did not have the CCG recorded (1 MHSOP and 1 Adults)The position in York reflects the closure of Worsley Court where a number of people with long length of stays were discharged.Comparative data is now included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data given the indicator measurement is a number.Based on the current trend and performance it is unlikely we will achieve the annual target of 277.

Trust Dashboard Graphs for TRUST

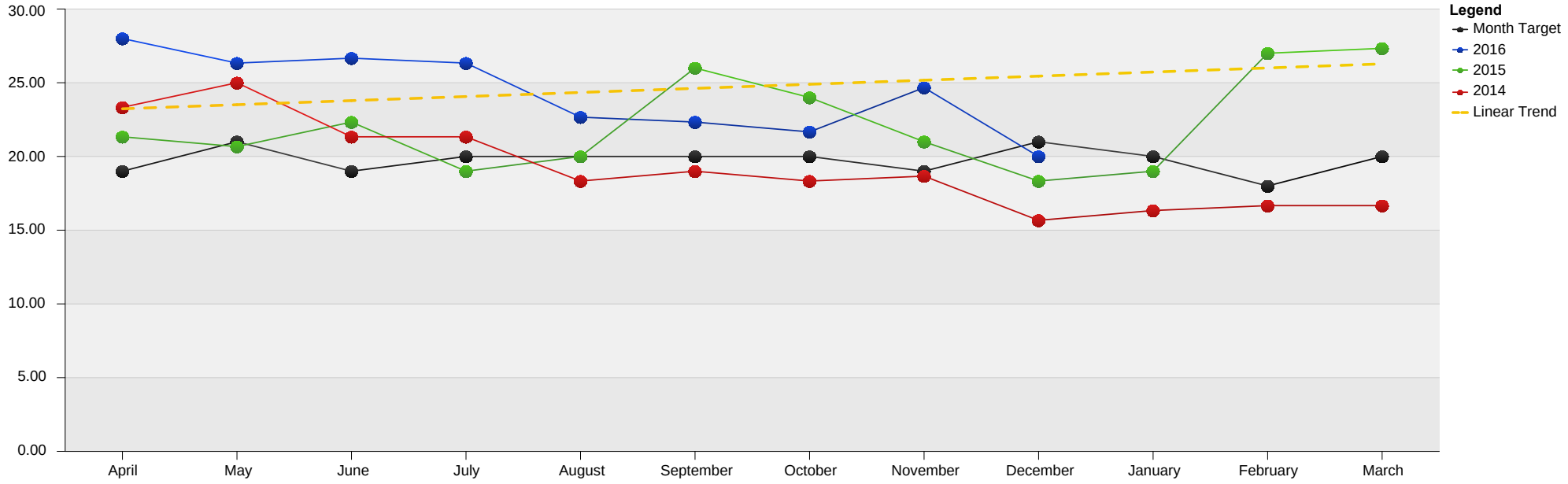


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	7.86%	7.55%	10.10%	6.94%	4.17%	7.41%	6.45%	7.22%	NA	NA	14.94%	11.23%

Narrative
The Trust rolling 3 month position ending December 2016 is.7.64%, which relates to 17.99 patients out of 229 that were readmitted within 30 days. This is better than the target of 15% and a slight improvement on the position reported in November 2016. The Trust position for the financial year to date is 7.52% which is better than the target of 15%. Of the 17.99 patients:* 6.66 (37%) were within Durham & Darlington (5.66 AMH and 0.99 MHSOP) * 2.99 (17 %) were within Teesside (2.99 AMH).* 3.99 (22%) were within North Yorkshire (3.99 AMH) * 4.33 (24%) were within York & Selby (3.99 AMH and 0.33 MHSOP)(*Please note data is displayed in decimal points due to the rolling position being calculated.)All localities are performing better than the target.Based on current trend and performance, it can be expected that we will achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

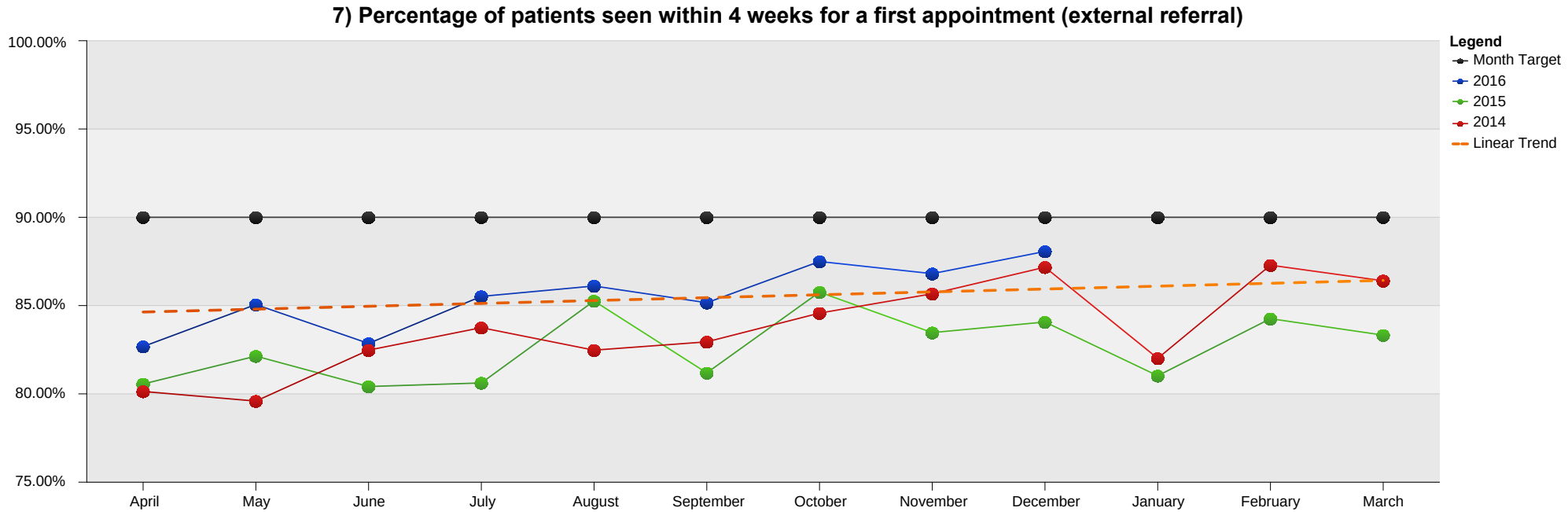
6) Number of instances of patients who have 3 or more admissions in a year (AMH and MHSOP)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	218.66	3.67	76.67	5.67	58.00	7.33	60.67	NA	NA	3.33	23.33

Narrative
The Trust rolling 3 month position ending December 2016 is 20.00, which is 1 under the target of 21 and an improvement on the position reported in November. The Trust position for the financial year to date is 218.66, which is worse than the target of 179. This is the best reported position since January 2015Of the 20 instances* 3.66 (18.30%) were within Durham & Darlington (3.33 AMH and 0.33 MHSOP)* 5.66 (28.30%) were within Teesside (5.33 AMH and 0.33 MHSOP)* 7.33 (36.65%) were within North Yorkshire (6.99 AMH and 0.33 MHSOP)* 3.33 (16.65%) were within York and Selby (2.99 AMH and 0.33 MHSOP)(*Please note data is displayed in decimal points due to the rolling position being calculated.)Comparative data is now included in the dashboard, however York & Selby only started to be collected from April 2016 therefore it is not possible to make a direct comparison with the previous years' data given the indicator measurement is a number. Based on current trend and performance it is unlikely we will achieve the annual target of 237.

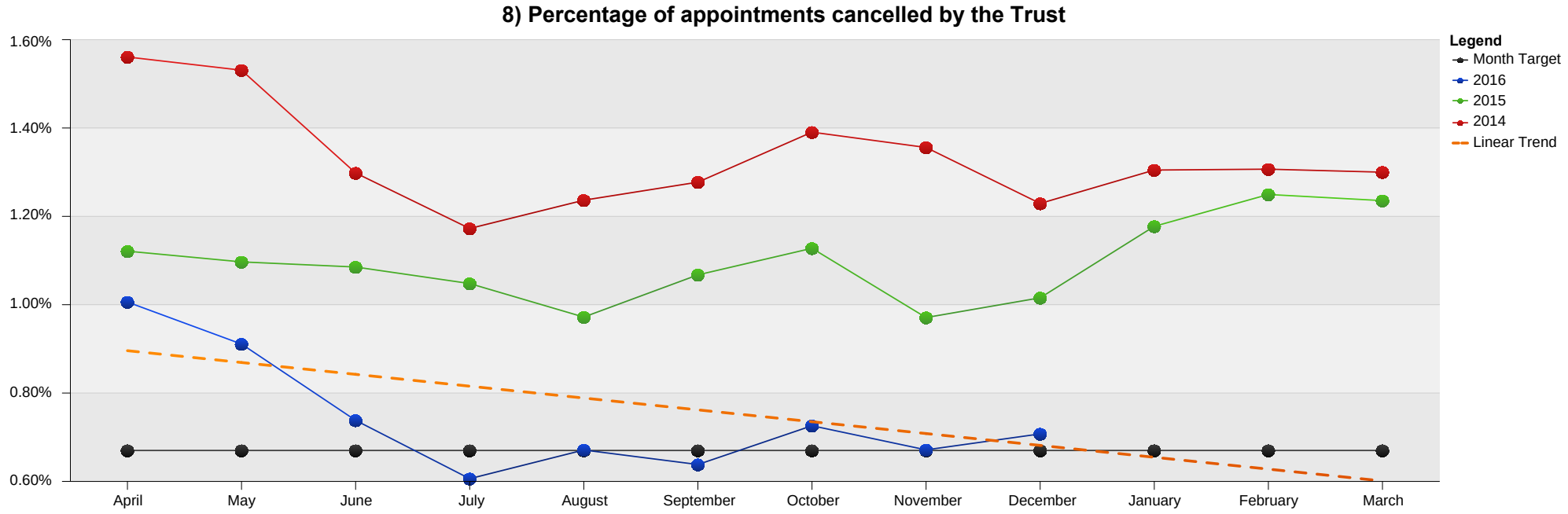
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	88.07%	85.49%	86.58%	81.11%	97.35%	96.65%	75.38%	75.76%	100.00%	99.59%	77.33%	70.36%

Narrative
The position for December 2016 is 88.07%, relating to 485 patients out of 4064 who had waited longer than 4 weeks. This is 1.93% worse than target however an improvement on the position reported in November, and the best position in the past 3 years. The position for financial year to date is 85.49%, which is 4.51% worse than target.Areas of concern are:* North Yorkshire CYP at 59.57% (38 of 94 patients). This is a 0.24% deterioration on the position in November 2016. An action plan is in place with focused work on capacity and demand analysis and actions to address staff vacancies and sickness. * York & Selby CYP at 53.06% (23 out of 49 patients) this is an 11.09% deterioration on November 2016. However a reduction has been seen in the length of time patients are waiting. An action plan continues to progress to timescales with data quality actions being addressed, analysis of current waiting lists being carried out, utilisation of partnership working and a single point of access being established. Based on current trend and performance there is still a risk that we will not achieve the annual target of 90%, however if the current level continues we could report the best annual position in the past 3 years.

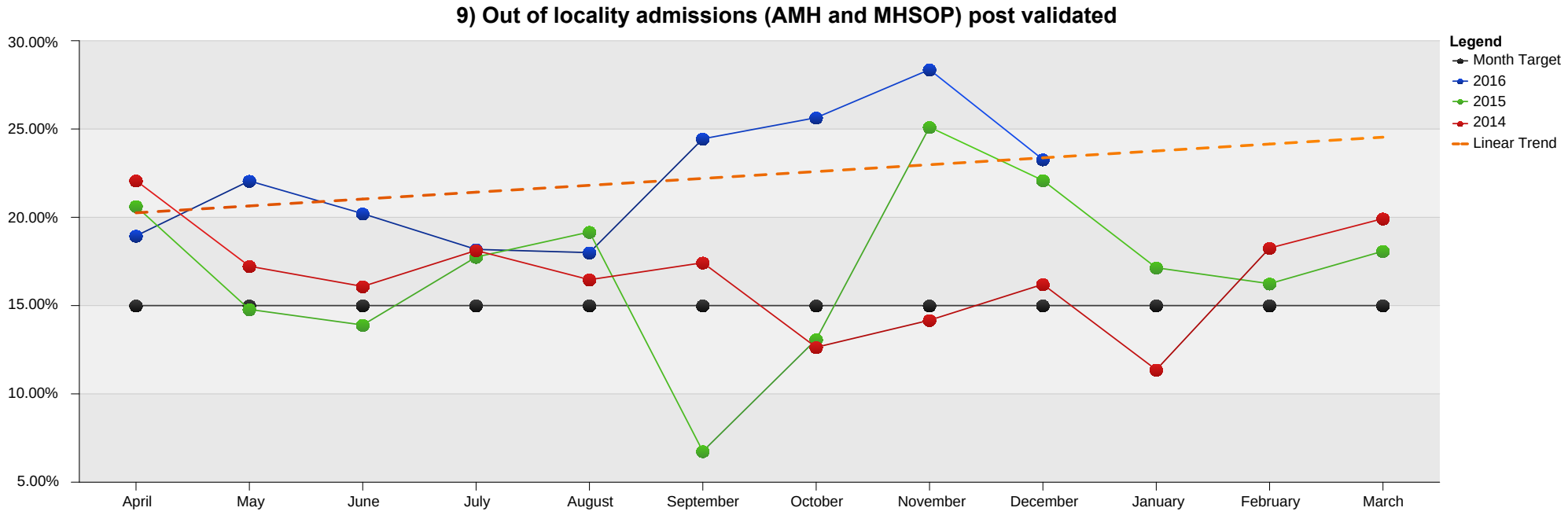
Trust Dashboard Graphs for TRUST



	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
8) Percentage of appointments cancelled by the Trust	0.71%	0.74%	0.68%	0.90%	0.64%	0.58%	1.01%	0.95%	0.00%	0.15%	0.56%	0.49%

Narrative
The Trust position for December 2016 is 0.71%, which relates to 545 appointments out of 77,031 that have been cancelled. This is 0.04% worse than the target and a deterioration on the position reported in November and reverses the increases trend since August. The Trust position for the financial year to date is 0.74%, which is 0.07% worse than the target.Only Durham & Darlington and North Yorkshire are worse than target as a result of vacancies which are going through the recruitment process and sickness which is being managed in line with Trust Policy. Based on current trend and performance it is possible that we could achieve the annual target of 0.67%.

Trust Dashboard Graphs for TRUST

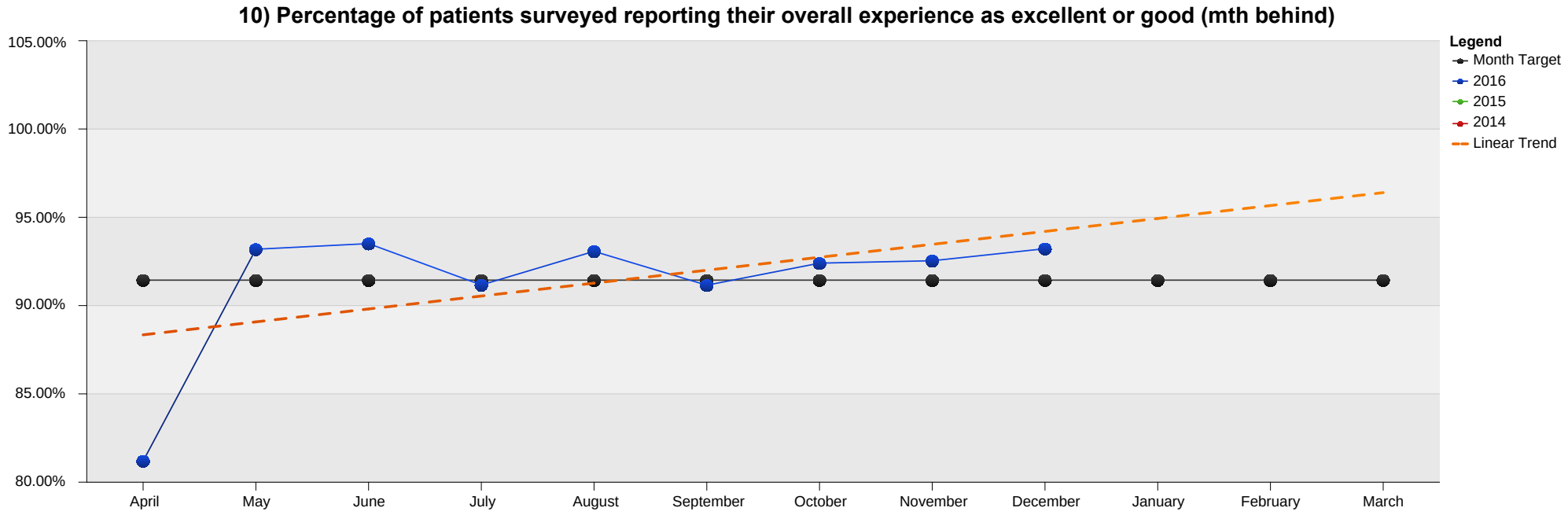


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	23.27%	22.03%	19.80%	20.64%	7.25%	15.59%	29.58%	32.52%	NA	NA	52.94%	23.77%

Narrative

The Trust position for December 2016 is 23.27%, which relates to 64 admissions out of 275 that were admitted to assessment and treatment wards out of locality. This is 8.27% worse than the target of 15%, however an improvement on the position reported in November and reverses the increasing trend since August. The Trust position for the financial year to date is 22.03%, which is 7.03% worse than the target. All localities are worse than target, with the exception of Teesside. The position for Tees is 7.25% which is 7.75% under target.Of the 64 patients (AMH 51, MHSOP 13) admitted to an 'out of locality' bed, all were due to no beds being available at their local hospital with the exception of one admission. This exception was due to a break down in process.Improvements seen in performance relating to bed occupancy is a key contributing factor to the reduction in the number of OOL admissions. Data including the York and Selby locality only started to be collected from April 2016. If comparing the remaining 4 localities, the position is 19.09%. Which is in improvement of 3.29% compared to December 2015. Based on current trend and performance there is a significant risk that we will not achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST



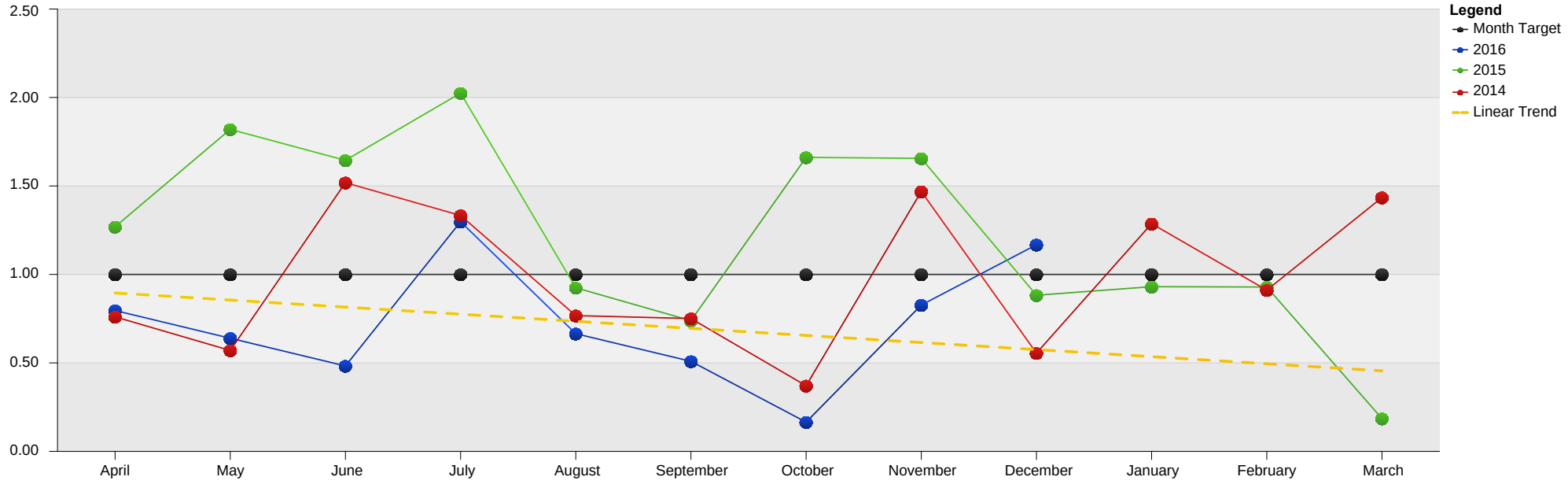
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	93.22%	92.16%	92.64%	94.02%	91.78%	92.69%	97.30%	92.73%	88.41%	80.56%	96.43%	89.97%

Narrative

The Trust position reported in December relates to November performance. The Trust position for November 2016 is 93.22% which is 1.78% better than the target of 91.44% and an improvement on the position reported for October. The Trust position for the financial year to date is 92.16%, which is 0.72% better than the target.As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).Due to an amendment to the indicator for this year, data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available. If performance continues at the overall levels achieved, it can be expected that we will achieve the annual target of 91.44%.

Trust Dashboard Graphs for TRUST

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

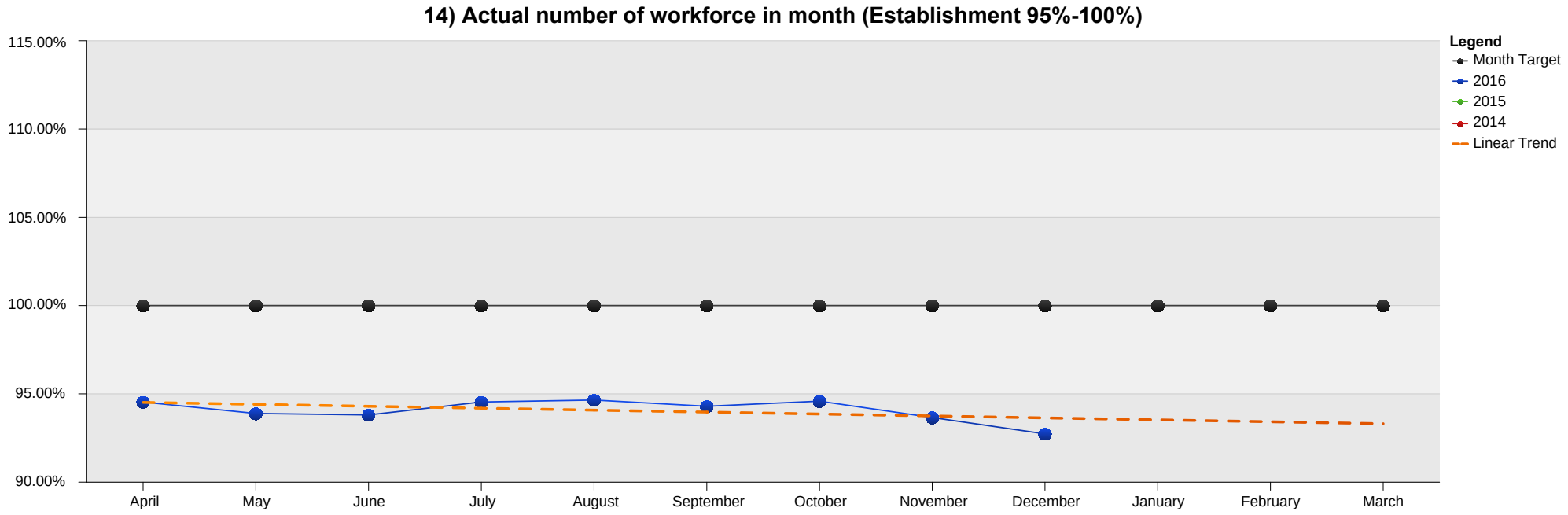


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.17	6.55	0.00	3.40	0.00	4.34	1.76	10.46	34.60	49.65	3.34	10.85

Narrative

The Trust position for December 2016 is 1.17, which is 0.17 worse than the target of 1.00. This rate relates to 7 unexpected deaths which occurred in December. The Trust position for the financial year to date is 6.55 which is 2.45 better than the target.Of the 7 unexpected deaths in December:* 3 were in in York and Selby (AMH)* 2 were in Forensic (Offender Health) * 2 were in North Yorkshire (AMH)Given the 2015/16 data did not include York and Selby data it is not possible to compare the position with previous years totals. However the number of unexpected deaths reported in December 2015 was 4 and therefore the figure of 4 across the Trust area (minus York and Selby) in 2016 is the same. Based on current trend and performance, it can be anticipated that we will achieve the annual target of 12.00.

Trust Dashboard Graphs for TRUST

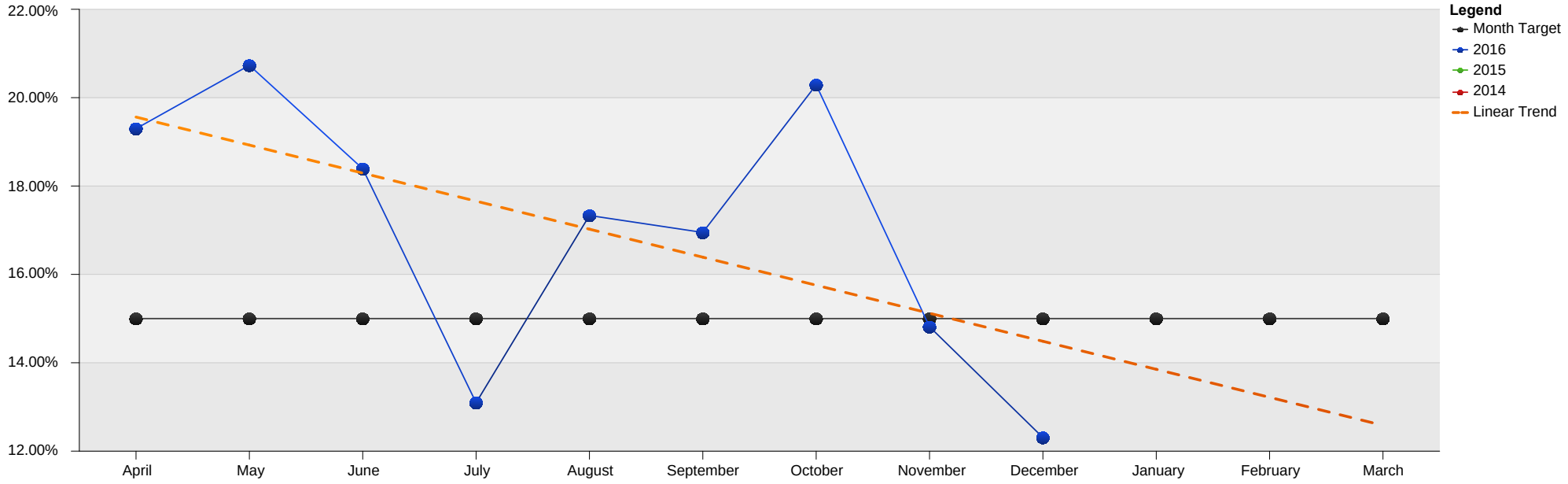


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 95%-100%)	92.74%	92.74%	94.45%	94.45%	96.79%	96.79%	92.71%	92.71%	94.08%	94.08%	89.84%	89.84%

Narrative
The Trust position and the lowest position this year for December 2016 is 92.74% which is below the targeted establishment level of 95-100%. It is anticipated that this figure will improve following a number of recruitment events where the Trust have successfully appointed to a number of nursing vacancies. Data only started to be reported in the dashboard from April 2016; therefore no comparative data for 2015/16 is available currently in this dashboard. Based on current trend and performance so far during 2016/17 it can be expected that we will not achieve the annual target of 100%.

Trust Dashboard Graphs for TRUST

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

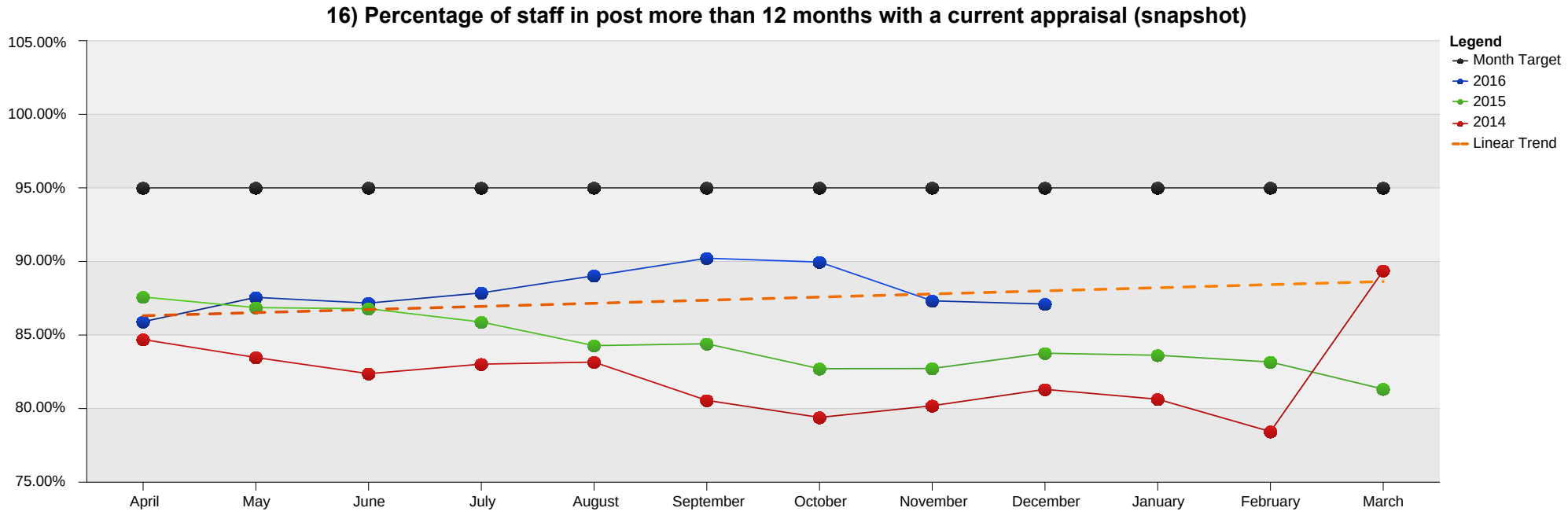


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	12.31%	17.00%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative

The Trust position for December 2016 is 12.31%, which is a significant improvement on the figure of 14.81% previously reported. The figure is within the target of 15.00%. The Trust position for the financial year to date is 17.00%, which is 2.00% worse than the target.There were 7 jobs re-advertised in December for registered healthcare professional jobs and all were permanent positions. Six of the posts were nursing opportunities and 1 was a psychological well-being practitioner.Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available. Based on current trend and performance there is a risk that we will not achieve the annual target of 15.00%.

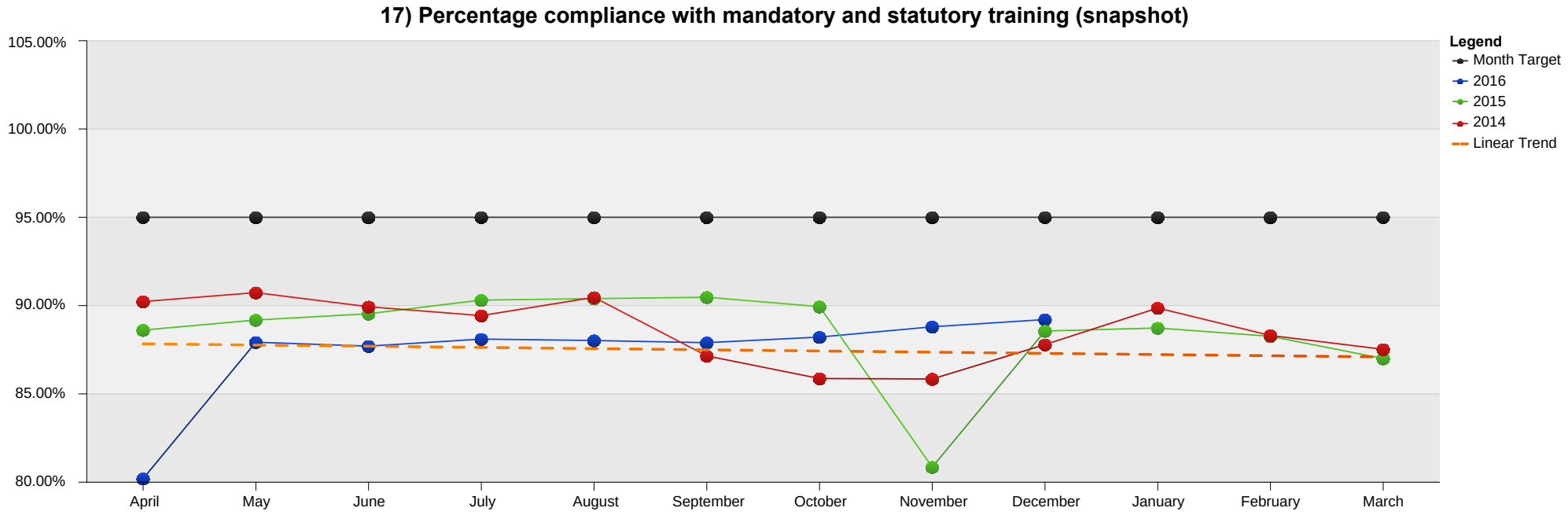
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	87.10%	87.10%	86.37%	86.37%	94.75%	94.75%	82.63%	82.63%	92.49%	92.49%	74.18%	74.18%

Narrative
The Trust position for December 2016 is 87.10% which relates to 736 members of staff out of 5707 that do not have a current appraisal; this is comparable to the figure reported in November. This is 7.90% worse than the target of 95.00%. A number of localities now have regular operational management huddles which include discussions on appraisal compliance levels, this has had a positive impact on performance levels being achieved. These huddles are now being implemented across all localities.A new staff dashboard was launched on the IIC in December which highlights to managers those staff reporting as non-compliant and also those due to be appraised within the following three months. This will support managers in proactive management of appraisals.Based on current performance there is a significant risk that we may not achieve the annual target of 95%.

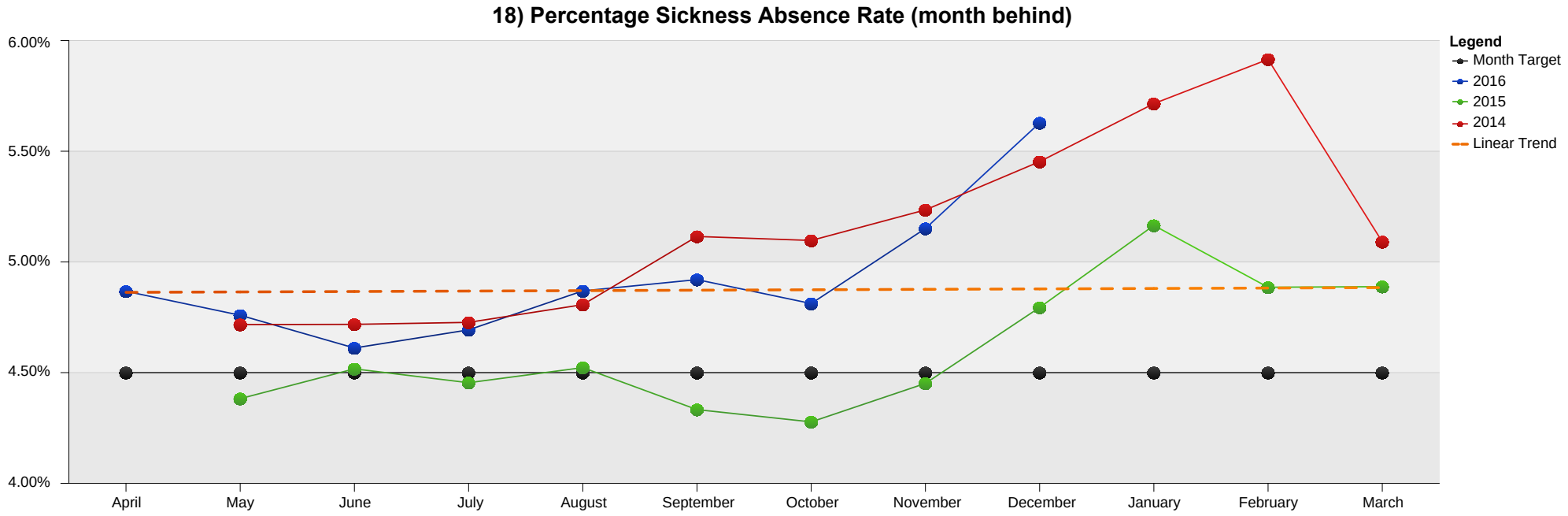
Trust Dashboard Graphs for TRUST



	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
17) Percentage compliance with mandatory and statutory training (snapshot)	89.21%	89.21%	88.97%	88.97%	92.04%	92.04%	87.49%	87.49%	89.95%	89.95%	76.06%	76.06%

Narrative
The position for December 2016 is 89.21%. This is 5.79% worse than the target of 95.00%, however is a slight improvement on the position reported in November. Tees are below target but performing above 90%. Durham and Darlington, North Yorkshire, Forensics and York and Selby are below 90%. York and Selby are achieving the lowest level at 76% but an improvement on previous months has been seen. The work described in KPI16 regarding the additional HR reports also relates to reports associated with mandatory training. Based on current trend and performance, there is a risk that we may not achieve the annual target of 95%.

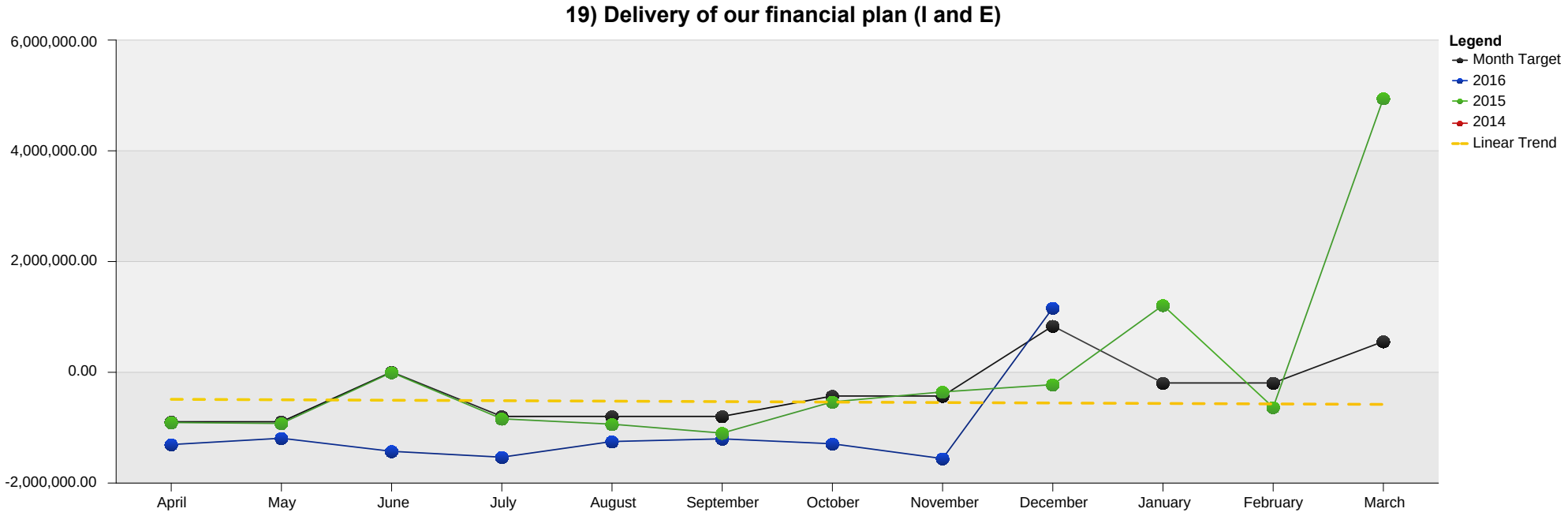
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	5.63%	4.92%	6.44%	5.43%	5.05%	5.19%	4.30%	4.28%	7.03%	5.70%	6.75%	5.35%

Narrative
The Trust position reported in December relates to the November sickness level. The Trust position reported in December 2016 is 5.63%, which is 1.13% worse than the Trust target of 4.50% and a deterioration on the figure reported in November and is highest than that reported in December 2014 and 2015. The Trust position for the financial year to date is 4.92%, which is 0.42% worse than the target. North Yorkshire are the only locality achieving target, however a deterioration on the figure reported in December 2016 compared to November 2016 is seen.The Operational HR team have introduced a more focussed approach to support line managers to manage those staff experiencing 5 or more episodes of short term absence. The long term sickness absence team continues to manage staff on long term sickness, proactively facilitating staff back to work or ultimately to the ending of their employment. As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).Based on past and current performance there is a risk that we will not achieve the annual target of 4.50%.

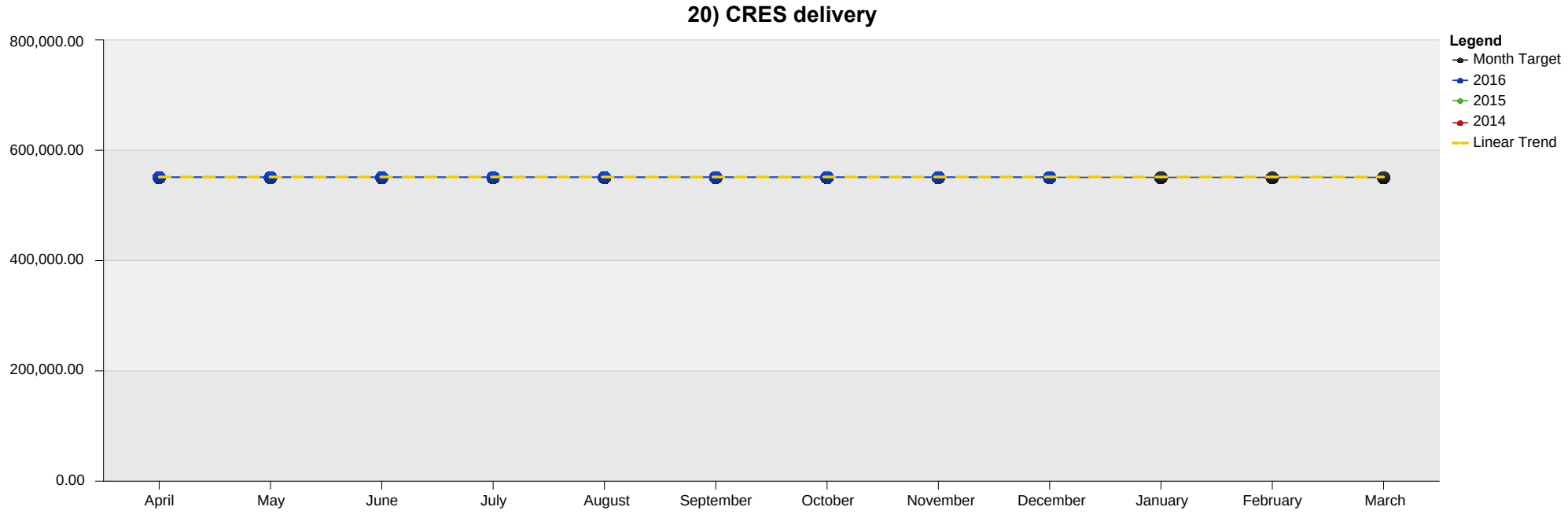
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Delivery of our financial plan (I and E)	1,161,926.00	-9,596,074.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The comprehensive income and expenditure outturn for the period ending 31 December 2016 was a surplus of £9,596,074k, representing 3.9% of the Trust's turnover. The Trust is ahead of plan largely due to non-recurrent credits received against contracts, a refund of historic National Insurance payments linked to trainees, contract variations with commissioners and vacancies. Recruitment to posts is ongoing.

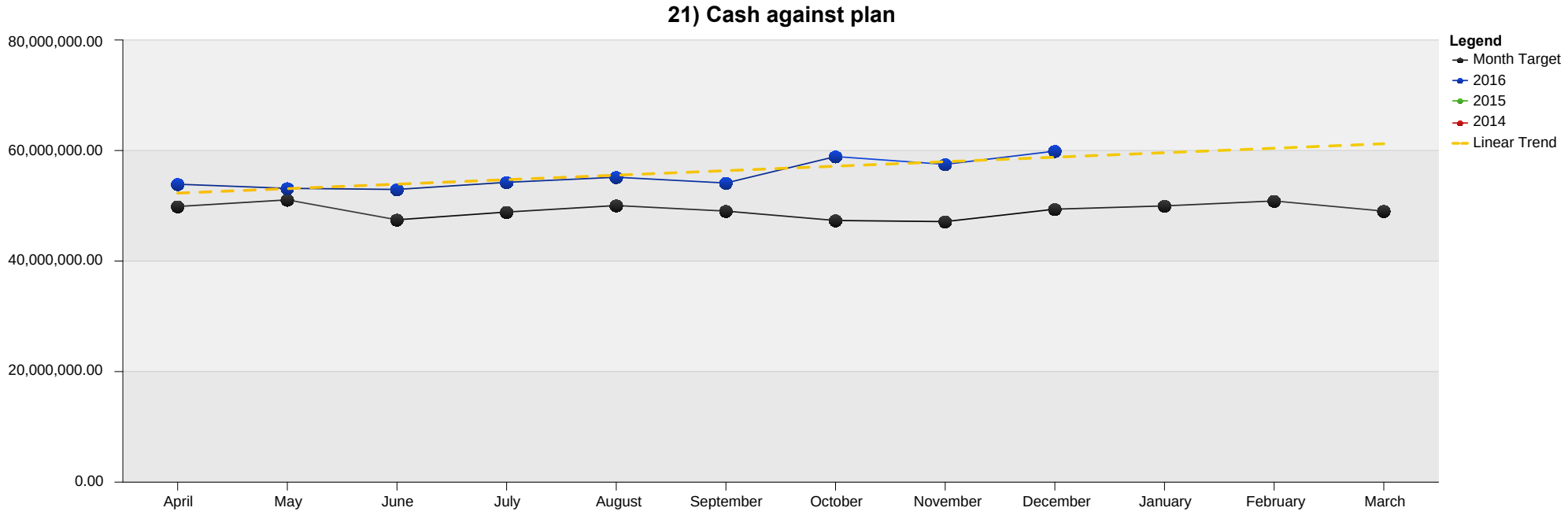
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	551,455.00	4,963,095.00	196,833.00	1,771,497.00	94,000.00	846,000.00	23,583.00	212,247.00	26,833.00	241,497.00		

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

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	59,891,000.00	59,891,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
Total cash at 31 December 2016 is £59,891k and is ahead of plan largely due to the Trusts surplus position and planned delays in the capital programme.

Trust Dashboard - Locality Breakdown for TRUST

Activity

	December 2016												April 2016 To December 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) Total number of External Referrals into Trust Services	15,586.00	15,044.00	3,770.00	3,602.00	3,832.00	3,428.00	3,696.00	3,802.00	1,170.00	1,010.00	3,118.00	3,196.00	138,266.00	147,936.00	33,442.00	35,492.00	33,992.00	34,496.00	32,792.00	36,478.00	10,386.00	10,602.00	27,654.00	30,830.00
2) Caseload Turnover	1.99%	-0.06%	1.99%	-0.72%	1.99%	-0.03%	1.99%	2.49%	NA	NA	1.99%	-1.86%	1.99%	-0.06%	1.99%	-0.72%	1.99%	-0.03%	1.99%	2.49%	NA	NA	1.99%	-1.86%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	89.49%	85.00%	95.45%	85.00%	88.15%	85.00%	91.85%	85.00%	NA	85.00%	76.91%	85.00%	94.58%	85.00%	92.98%	85.00%	96.63%	85.00%	96.10%	85.00%	NA	85.00%	90.74%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	24.00	31.00	8.00	5.00	7.00	5.00	7.00	11.00	NA	NA	3.00	8.00	209.00	264.00	72.00	61.00	57.00	65.00	57.00	70.00	NA	NA	24.00	56.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.86%	15.00%	10.10%	15.00%	4.17%	15.00%	6.45%	NA	NA	15.00%	14.94%	15.00%	7.55%	15.00%	6.94%	15.00%	7.41%	15.00%	7.22%	NA	NA	15.00%	11.23%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	21.00	20.00	6.00	3.67	6.00	5.67	7.00	7.33	NA	NA	2.00	3.33	179.00	218.66	49.00	76.67	49.00	58.00	60.00	60.67	NA	NA	21.00	23.33

Trust Dashboard - Locality Breakdown for TRUST

Money

	December 2016												April 2016 To December 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) Delivery of our financial plan (I and E)	836,386.00	1,161,926.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	-7,335,169.00	-9,596,074.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
20) CRES delivery	550,854.00	551,455.00	183,500.00	196,833.00	168,250.00	94,000.00	117,595.00	23,583.00	92,909.00	26,833.00			4,957,688.00	4,963,095.00	1,651,500.00	1,771,497.00	1,514,250.00	846,000.00	1,058,358.00	212,247.00	836,181.00	241,497.00		
21) Cash against plan	49,385,000.00	59,891,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	440,214,000.00	59,891,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Trust Dashboard - Locality Breakdown for TRUST

Quality

	December 2016												April 2016 To December 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
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	88.07%	90.00%	86.58%	90.00%	97.35%	90.00%	75.38%	90.00%	100.00%	90.00%	77.33%	90.00%	85.49%	340.00%	81.11%	340.00%	96.65%	340.00%	75.76%	340.00%	99.59%	340.00%	70.36%
8) Percentage of appointments cancelled by the Trust	0.67%	0.71%	0.67%	0.68%	0.67%	0.64%	0.67%	1.01%	0.67%	0.00%	0.67%	0.56%	0.67%	0.74%	0.67%	0.90%	0.67%	0.58%	0.67%	0.95%	0.67%	0.15%	0.67%	0.49%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	23.27%	15.00%	19.80%	15.00%	7.25%	15.00%	29.58%	NA	NA	15.00%	52.94%	15.00%	22.03%	15.00%	20.64%	15.00%	15.59%	15.00%	32.52%	NA	NA	15.00%	23.77%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	93.22%	91.44%	92.64%	91.44%	91.78%	91.44%	97.30%	91.44%	88.41%	91.44%	96.43%	91.44%	92.16%	91.44%	94.02%	91.44%	92.69%	91.44%	92.73%	91.44%	80.56%	91.44%	89.97%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.17	1.00	0.00	1.00	0.00	1.00	1.76	1.00	34.60	1.00	3.34	9.00	6.55	9.00	3.40	9.00	4.34	9.00	10.46	9.00	49.65	9.00	10.85

Trust Dashboard - Locality Breakdown for TRUST

Workforce

	December 2016												April 2016 To December 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
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	92.74%	100.00%	94.45%	100.00%	96.79%	100.00%	92.71%	100.00%	94.08%	100.00%	89.84%	100.00%	92.74%	100.00%	94.45%	100.00%	96.79%	100.00%	92.71%	100.00%	94.08%	100.00%	89.84%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	12.31%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	17.00%	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA	15.00%	NA
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	87.10%	95.00%	86.37%	95.00%	94.75%	95.00%	82.63%	95.00%	92.49%	95.00%	74.18%	95.00%	87.10%	95.00%	86.37%	95.00%	94.75%	95.00%	82.63%	95.00%	92.49%	95.00%	74.18%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	89.21%	95.00%	88.97%	95.00%	92.04%	95.00%	87.49%	95.00%	89.95%	95.00%	76.06%	95.00%	89.21%	95.00%	88.97%	95.00%	92.04%	95.00%	87.49%	95.00%	89.95%	95.00%	76.06%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.63%	4.50%	6.44%	4.50%	5.05%	4.50%	4.30%	4.50%	7.03%	4.50%	6.75%	4.50%	4.92%	4.50%	5.43%	4.50%	5.19%	4.50%	4.28%	4.50%	5.70%	4.50%	5.35%

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

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

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

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

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes	1																				**1**
Hanging					1												1				**2**
Suicides	2	1	2		1							1	2					1			**10**
Open			1																		**1**
Drug related death																					**0**
Drowning													1								**1**
Misadventure																					**0**
Awaiting verdict	3	2	4	1	7	1					1	1					1	1	2	1	**25**
Total	**6**	**3**	**7**	**1**	**9**	**1**	**0**	**0**	**0**	**0**	**1**	**2**	**3**	**0**	**0**	**0**	**2**	**2**	**2**	**1**	**40**

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

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
8	7	12	3	10

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

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

ITEM 12

MEETING OF THE BOARD OF DIRECTORS

DATE:	**31st January 2017**
TITLE:	**Trust Dashboard 17/18 Proposed Targets**
REPORT OF:	**Sharon Pickering, Director of Planning & Performance**
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 17/18 Trust Dashboard for discussion and agreement. This report also includes 3 new recommendations in relation to the agreed KPIs.

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 3.2, 3.3 and 3.4 regarding:
  - Changing our internal definition of the Out of Locality indicator
  - They delay in the development of the two outcomes indicators
  - Expanding the definition of the Mandatory and Statutory indicator

MEETING OF:	**Meeting of the Board of Directors**
DATE:	**31st January 2017**
TITLE:	**Trust Dashboard 17/18 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 17/18 Trust Dashboard for discussion and agreement.

1.2 This report also includes 3 new recommendations in relation to the agreed KPIs.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In early October 2016, as part of the Board Business Planning Event, members of the Board, EMT and Senior Clinical Leaders discussed the Trust Dashboard for 17/18 as part of the planning process.

2.2 In late October 2016, the Board of Directors discussed and agreed the final set of Key Performance Indicators for inclusion in the 17/18 Trust Dashboard.

3. KEY ISSUES:

3.1 Target Setting

3.1.1 As part of the 17/18 development process, targets must be set for each of the indicators identified. As there are no changes to the indicators from 16/17 and having already reviewed the 16/17 targets twice this year, minimal changes have been proposed which are for the indicators shown below. A full review is recommended of all targets based on the first 6 months data of 17/18.

- ***Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)*** (Indicator 5)
- ***Percentage of patients surveyed reporting their overall experience as excellent or good*** (Indicator 10)

3.1.2 Executive Management Team (EMT) reviewed the proposals identified by the Corporate Performance Team on the 11th January 2016 and discussed the targets for each of the Key Performance Indicators. The final recommended targets with some options for indicator 5 are detailed in **Appendix A.**

3.2 Out of Locality Admissions and Out of Area Placements

3.2.1 EMT also supported the recommendation from the Corporate Performance Team to amend the agreed definition of the KPI "***Out of Locality admissions***" following the publication of new national requirements. The

current internal KPI "Out of Locality Admissions" has a strict set of rules whereby we define where patients should be admitted to based on their GP Practice and "local" hospital. There is now a national reporting requirement called ***"Out of Area Placements"*** which includes not only "out of locality admissions" but patients placed outside the Trust from our local area.

3.2.2 We are recommending we change the existing Trust Dashboard KPI to align more closely to the new national requirement to be consistent and to reduce confusion with having more than one indicator of a similar nature. The Trust has reviewed the rules for out of locality and aligned these as close as possible to each geographic locality but for North Yorkshire the rules have been based on geography of the patch to make it more appropriate. However, the criteria for this new indicator are **slightly wider** than the Trust's current rules. For example currently patients from North Durham should go to Lanchester Road but for the purpose of the national requirement they can go to Lanchester Road or West Park.

3.2.3 The patients placed outside the Trust will also be included in the new internal KPI but we will exclude admissions to other providers for services that we are not commissioned to provide. This means we will only include admissions to other providers for services that we currently provide but couldn't accommodate the patient at the time of the admission.

3.2.4 OLD PROBLEMS, NEW SOLUTIONS: Improving acute psychiatric care for adults in England FINAL REPORT was published in February 2016 and recommended the practice of sending acutely ill patients long distances for non-specialist treatment is phased out nationally by October 2017. **Current estimates suggest that each month around 500 mentally ill people have to travel over 50km to be admitted into hospitals far from their own homes. These long distance admissions are mainly due to difficulties in finding acute inpatient beds or suitable alternative services in their home area and are a symptom of far more widespread problems in the functioning of the whole mental health system.**

3.2.5 If the Board of Directors supports this recommendation we will need to review the changes to the internal definition and the inclusion of admissions to other providers when setting the new target.

3.3 In addition EMT also supported the recommendation to put on hold the two outcome indicators that are still to be developed from 16/17. It has now been agreed to provide two separate papers to EMT on CROM and PROM in Q4 16/17 in order to agree a way forward. Once EMT has had chance to discuss and agree a way forward, further work will be undertaken to finalise Trust level metrics by the Clinical Lead and an update on this will be provided to the Board of Directors.

3.4 Following discussion at EMT on the 18th January 2017, the Board of Directors are also recommended to agree to change the existing Mandatory Training indicator from only reporting the "core 7" to all mandatory and statutory

training. If the Board of Directors supports this recommendation we would need to review the current baseline when setting the new target.

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 17/18.

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 for each of the Key Performance Indicators in the 17/18 Trust Dashboard.

6.2 A number of recommendations have also been made in relation to 3 agreed KPIs.

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 3.2, 3.3 and 3.4 regarding:

- Changing our internal definition of the Out of Locality indicator
- They delay in the development of the two outcomes indicators
- Expanding the definition of the Mandatory and Statutory indicator

Sarah Theobald
Head of Corporate Performance

Background Papers:

Trust Dashboard 17/18 Proposed Targets — Appendix A

Indicator	Current Target	FYTD TARGET	FYTD ACTUAL	COMMENTS
1) Total number of External Referrals into Trust Services	**91,759** **Between 87,171 and 96,347 (within 5% of target)** **Between 82,584 and 87,170 or 96,348 and 100,934 (between 5 and 10% of target)** **Less than 82,583 or more than 100,935 (10% below or above target)**	61,340	**66,406**	Previous target setting was to maintain out-turn and given pressures on the teams it was not thought appropriate to propose an increase. The target was reviewed by the Board of Directors in November 2016 and increased to take into account the full impact of York & Selby Services. No further change is recommended at this time.
2) Caseload Turnover	**1.99%** **Less than 2%** **Between 2% and 3%** **More than 3%**	1.99%	**-1.09%**	This KPI was only introduced mid 16/17 therefore no change is recommended at this time.
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	**85%** **85-87.5%** **65-84.9% or 87.5-90.0%** **Less than 65% or more than 90%**	85%	**95.27%**	This is the existing bed occupancy target within the Trust for Assessment & Treatment Wards as well as the national recommended occupancy rate, therefore no change is recommended.
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	**277** **On target or less** **Up to 5% above target** **5% or more above target**	185	**233**	Previous target setting included a 13% increase (based on the population increase with the new services) then a 10% reduction (based on general trend of discharged patients from the EMT OOL/OOA report). The target was reviewed by the Board of Directors in November 2016 as the new services accounted for approx. 19%; however the BoD agreed to keep the current target. No further change is recommended at this time.

Indicator	Current Target	FYTD TARGET	FYTD ACTUAL	COMMENTS
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	**15%** **15% or less** **15-20%** **More than 20%**	15%	**7.44%**	The target was reviewed by the Board of Directors in November 2016 as the FYTD position was less than half of the target and all localities were better than target; however the BoD agreed to keep the current target for the current financial year. **Three options are now proposed for the 17/18 target:** **1) Keep the target at 15% (the same as 15/16 and 16/17)** **2) Reduce the target to 10%** 3) **Use the 16/17 outturn as the 17/18 target**
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	**237** **0-237 (on target or less)** **237-249 (up to 5% above target)** **250 or more (5% or more above target)**	158	**199.66**	Previous target setting was the 15/16 target increased by 13% (based on the population increase with the new services on the weighted populations for AMH & MHSOP). The target was reviewed by the Board of Directors in November 2016 as the FYTD for the new services were accounting for approx. 9%. However historic admissions for this locality (prior to 1st April 2016) won't be included unless patients were in other TEWV beds which skew their position. No further change is recommended at this time given original rationale and challenges posed with historic data for York & Selby.

Indicator	Current Target	FYTD TARGET	FYTD ACTUAL	COMMENTS
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	**90%** **90% or more** **85-89.9%** **Less than 85%**	90%	**85.22%**	Previous target setting included a reduction to accommodate expansion into York & Selby where overall performance was not known and pressures within existing services. FYTD is amber i.e. within 5% of the target and latest 3 month trend shows one of improvement therefore no further change is recommended at this time.
8) Percentage of appointments cancelled by the Trust	**0.67%** **0.67% or less** **0.67-0.70% (within 5% or target)** **More than 0.70% (more than 5% above target)**	0.67%	**0.74%**	Same as 15/16 and 16/17 target until indicator expanded to all appointments (i.e. not just those that are appointment that were "clinic based").
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	**15%** **15% or less** **15-20%** **More than 20%**	15%	**21.88%**	**See Key Issue 3.2**
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	**91.44%** **On target or higher** **Up to 5% below target** **5% or more below target**	91.44%	**92.02%**	Previous target setting was to maintain the out-turn with the knowledge that the data will start to include York & Selby over the year **Would recommend same approach is taken for 17/18 target (i.e. maintain outturn)**
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases – Post Validated	**12.00** **12.00 or less** **12.01-13.20 (within 10% of target)** **13.20 or more (10% or more above target)**	8.00	**5.39**	Same as 15/16 and 16/17 target given nature of indicator.

Indicator	Current Target	FYTD TARGET	FYTD ACTUAL	COMMENTS
14) Actual number of workforce in month (Establishment 90%-95%)	**100%** **95-100%** **90-95% or 100-102%** **Less than 90% or more than 102%**	100%	**93.66%**	The target for this KPI was revised following the Q1 review of 16/17 KPIs. No further change recommended at this time.
15) Percentage of registered healthcare professional jobs that are advertised two or more times	**15%** **15% or less** **15-17.5%** **17.5% or more**	15%	**17.51%**	The target for this KPI was revised following the Q1 review of 16/17 KPIs. No further change recommended at this time.
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	**95%** **95% or more** **88.00% -94.99%** **Less than 88%**	95%	**87.30%**	Same as 15/16 and 16/17 target given "Trust standard".
17) Percentage compliance with mandatory and statutory training (snapshot)	**95%** **95% or more** **88.00% -94.99%** **Less than 88%**	95%	**89.17%**	**See Key Issue 3.4**
18) Percentage Sickness Absence Rate (month behind)	**4.5%** **4.5% or less** **4.51-4.99%** **More than 4.99%**	4.5%	**4.83%**	Same as 15/16 and 16/17 target as recognised impact of sickness on both quality and finances
19) Delivery of our financial plan (I and E)	**8,057,087.00** **Within target** **N/A** **Outside target**	-8,171,555	**-10,758,000**	As per Financial Plan
20) CRES delivery	**6,610,251.00** **Within target** **N/A** **Outside target**	4,406,834	**4,411,640**	As per Financial Plan
21) Cash against plan	**49,036,000.00** **Within target** **N/A** **Outside target**	47,138,000	**57,498,000**	As per Financial Plan

ITEM 13.

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31st JANUARY 2017**
TITLE:	**Quarterly Workforce Report**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information**

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

Executive Summary:

The report provides information about key workforce performance mainly for the period October to December 2016.

Steady progress is being made with increasing registered nursing vacancy fill rates recorded though this issue will require on-going attention. Allied Health Professional recruitment, though much smaller in scale than nurse recruitment, is proving to be increasingly difficult.

The health and wellbeing of the workforce continues to be a key issue for TEWV and there is evidence of greater numbers of staff being unwell than before.

Mandatory training compliance is improving overall and recently introduced revised reporting arrangements are expected to assist with making further improvement.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**31st January 2017**
TITLE:	**Quarterly Workforce Report**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with information about key workforce performance mainly in respect of the period October to December 2016. Non-medical workforce information is provided in Appendix 1 and medical workforce information is provided in Appendix 2.

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3.1 Steady progress with improving our ability to recruit staff, particularly registered nursing staff, was made during the last quarter. A 2% increase in the registered nurse fill rate was recorded compared to the previous quarter. The Recruitment and Retention Action Plan that was agreed by the Executive Management Team in October 2016 continues to be implemented. There is to be an increased focus upon allied health professional staff recruitment given the recruitment difficulties reported in respect of this staff group.

3.2 Sickness absence rose during the quarter and a comparison with the same period in 2015 confirms that most localities reported a higher sickness absence rate than at the equivalent time a year ago. The Executive Management Team has recently endorsed a proposal to review short term sickness absence within TEWV and a report of the review findings will be presented to the Executive Management Team in May 2017. The latest information that is available highlights a significant increase in the number of staff that are absent from work due to sickness. There was an increase of 15% in the number of staff unable to work due to sickness during the period December 2015 to November 2016 compared to the previous twelve months period. Increases were recorded within all localities. This is a worrying development and further proof of the need to redouble efforts to improve staff health and wellbeing. Efforts to better understand the reasons for this increase will be made and findings reported to the Executive Management team and to the Board of Directors. The Executive Management Team recently approved a revised TEWV Health and Wellbeing Plan and addressing the health and wellbeing of the workforce continues to be of great importance.

3.3 Trust-wide appraisal compliance was 87% for the quarter compared to a target rate of 95%. The Teesside and Forensic Services localities reported compliance rates in excess of 90% on a regular basis. Roll out of the recently revised appraisal system continues and is expected to be completed by the spring of 2017. The revised appraisal system has received positive feedback to date and ought to assist with efforts to improve the quality of appraisal as well as the volume of appraisal activity.

3.4 Core mandatory training compliance was 89% compared to a target of 95%. Forensic Services, Estates and Facilities Management and Corporate directorates recorded compliance rates of 90% or more. When core and non-core mandatory training compliance is considered as a whole the TEWV mandatory training compliance rate is currently 83%. In December 2016 new mandatory training reporting arrangements were implemented including weekly reports to Directors and Heads of Service. These Integrated Information Centre reports identify those teams whose compliance rates are less than 75% and those teams whose compliance rates will fall to less than 75% within the next three months should mandatory training that is due to be undertaken during that time not take place. In addition managers can now view their own team's mandatory training compliance details using the Integrated Information Centre. Work is underway at present to review whether existing face to face mandatory training capacity is sufficient to meet future demand, including accommodation and travel issues. The scope for further use of e-learning is believed to be limited. TEWV is now the eighth highest user of e-learning within the NHS.

3.5 In response to a query about the issue previously raised of staff choosing to take up lower banded positions it should be noted that a total of 23 staff took up lower banded positions during the last year. Approximately half were nurses. It is understood that the reasons for these changes include individuals choosing to seek positions with less responsibility and job role changes being made in response to factors outside of work. Further efforts will be made to track this information in the future and to better understand the reasons for the changes made.

3.6 Appendix 2 provides comprehensive information about medical staffing and medical development issues. Previously reported recruitment pressures continue for some specialties and localities. The number of Trust Doctors has increased during the last three years and as a consequence for the second successive quarter TEWV is not using agency doctors to fill junior doctor vacancies. The Medical Education Report includes the excellent feedback that TEWV has received from the GMC Trainee survey during each of the last four years.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

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

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: The risk to future workforce supply continues to be a concern.

6. CONCLUSIONS:

6.1 Steady progress is being made to improve the ability of TEWV to recruit registered nurses though much more remains to be done and a greater focus upon allied health professional staff recruitment is needed.

6.2 Though sickness absence rates are not high by historical standards work is planned to review the approach being taken toward short term sickness absence and to better understand the reported increase in the total number of staff that have been absent due to sickness during the last year compared to the previous year.

6.3 Core mandatory training compliance is consistently above 90% within some localities which is welcome however, the overall compliance rate is below target. Recently strengthened reporting arrangements are expected to help improve mandatory training compliance, particularly in respect of non-core mandatory training.

7. RECOMMENDATIONS:

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

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1

HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT DIRECTORATE

QUARTERLY WORKFORCE REPORT INCLUDING PROGRESS AGAINST KEY PERFORMANCE INDICATORS OCTOBER TO DECEMBER 2016

1.0 INTRODUCTION

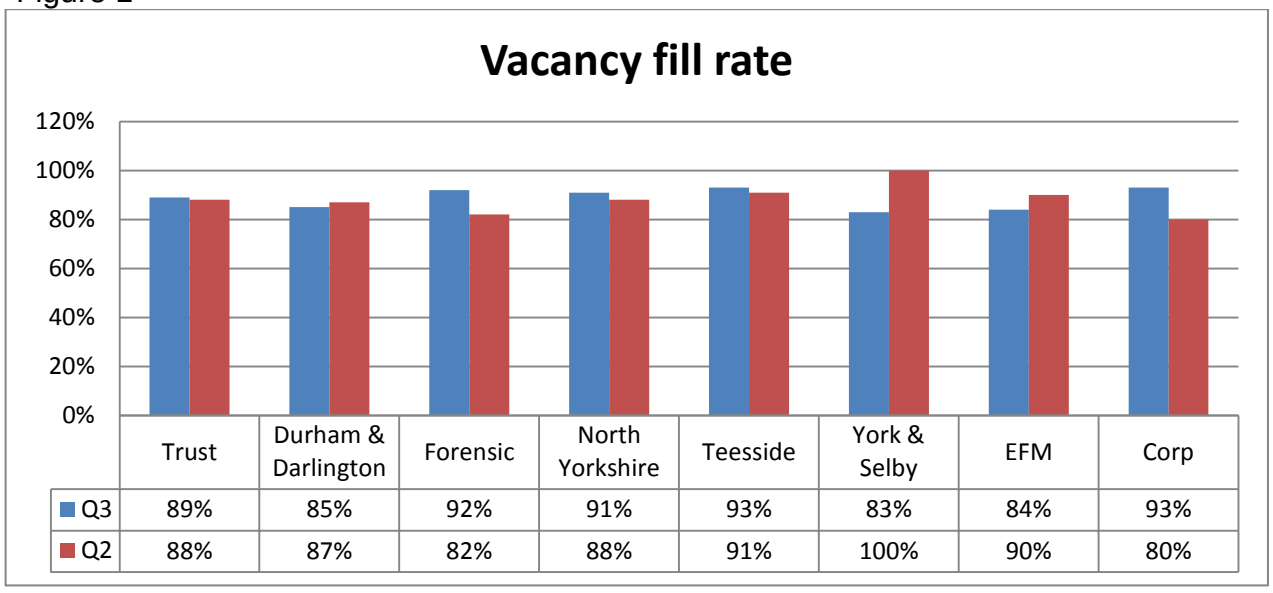
1.1 This report provides detailed analysis on a range of workforce related activities along with an update on progress towards the key HR related workforce performance indicators as at December 2016. The report will provide detailed analysis on:-

- Recruitment and retention
- Sickness absence
- Appraisals
- Mandatory training

2.0 Recruitment Analysis

2.1 The total number of vacancies during the reporting period was 392, with a total of 347 successful appointments made. The increase in the number of vacancies and successful appointments in quarter three equates to **22%**. Figure 1 highlights a vacancy fill rate of **89%** which represents a slight improvement on the figure of 88% at quarter two. The figures are based on people commencing in post during the quarter and unfilled vacancies. The lowest vacancy fill rates were reported in York and Selby at 83% fill and Estates and Facilities Management at 84%. Analysis of the vacancies not filled within York and Selby included a requirement for 6 x IAPT Well-being practitioners of which 5 were successfully recruited to. Other unfilled posts generally related to band 5 and 6 registered nursing posts.

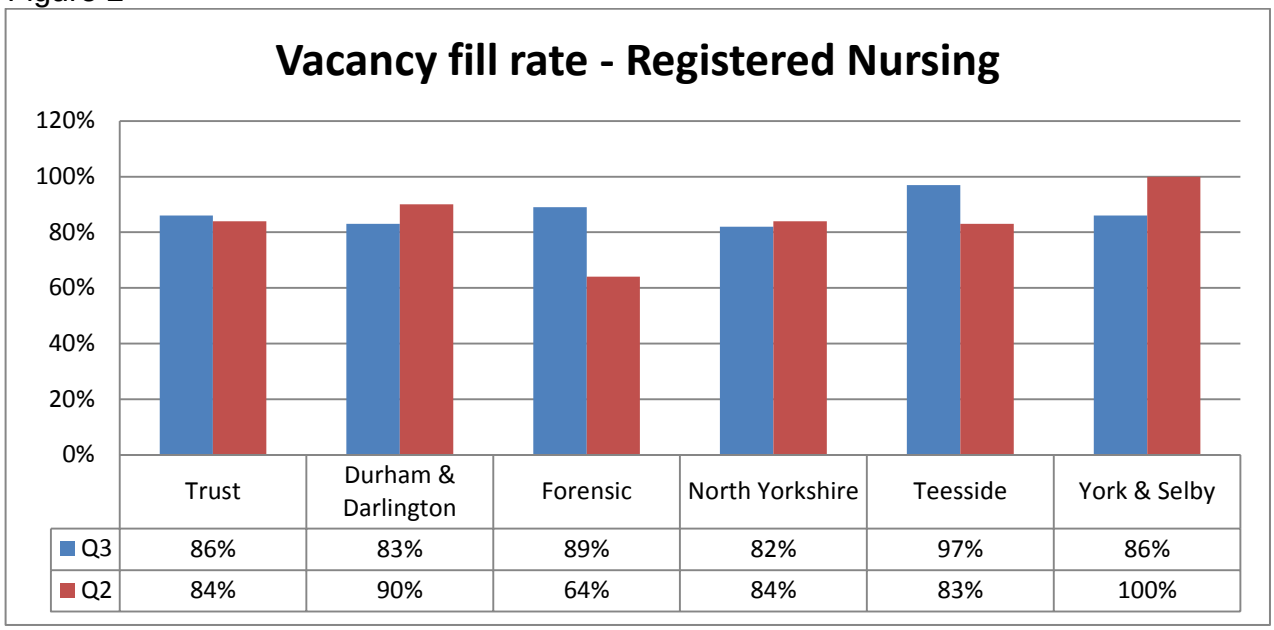
Figure 1



	Trust	Durham & Darlington	Forensic	North Yorkshire	Teesside	York & Selby	EFM	Corp
Q3	89%	85%	92%	91%	93%	83%	84%	93%
Q2	88%	87%	82%	88%	91%	100%	90%	80%

2.2 Figure 2 provides the vacancy fill rate for registered nursing vacancies within the reporting period. The Trust reported a figure of 86% which is an improvement on the figure 84% reported in quarter 2. Durham and Darlington reported the lowest fill rate at 83%. It is worth noting that during the reporting period Durham and Darlington CAMHS service received an investment to establish a Crisis and Liaison services. The service required a significant number of registered nurses in a short period of time. It was not possible to fill all of those vacancies which will have impacted on the fill rate this quarter.

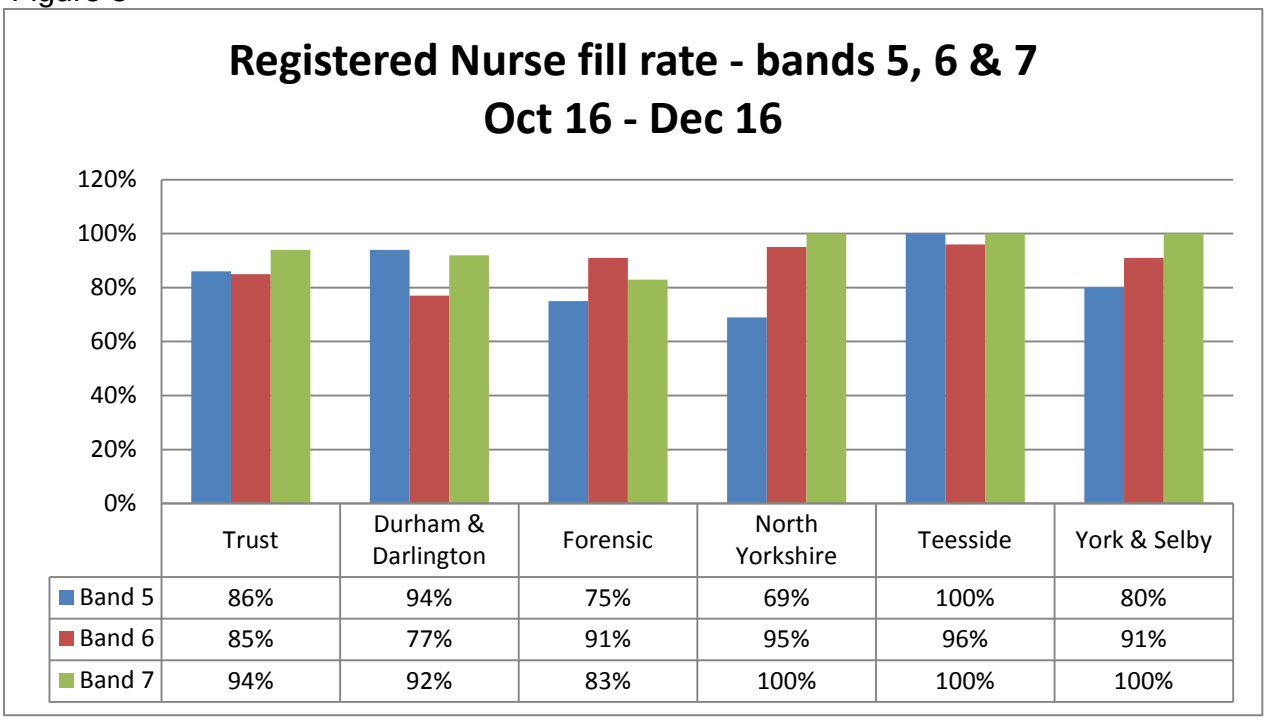
Figure 2



	Trust	Durham & Darlington	Forensic	North Yorkshire	Teesside	York & Selby
Q3	86%	83%	89%	82%	97%	86%
Q2	84%	90%	64%	84%	83%	100%

2.3 Figure 3 provides a breakdown of the vacancy fill rate for registered nurse recruitment to bands 5, 6 and 7 during the reporting period. The fill rate for band 5 in Forensic is reporting as low but contextually is related to a requirement for 4 staff nurses of which 3 were successfully recruited. North Yorkshire continue to experience difficulties in recruiting Staff Nurses particularly in Scarborough, Harrogate and Malton. Representatives from North Yorkshire were involved in the recruitment fair held in York in November and also the York University recruitment fair in December. A bespoke recruitment fair for Harrogate is being held in March 2016 and an event in Scarborough is currently being planned. The Trust is also involved in an RCN recruitment fair in Manchester in February and are focussing on promoting North Yorkshire as a place to work and live. The Head of Nursing for the locality is participating in the event.

Figure 3



	Trust	Durham & Darlington	Forensic	North Yorkshire	Teesside	York & Selby
Band 5	86%	94%	75%	69%	100%	80%
Band 6	85%	77%	91%	95%	96%	91%
Band 7	94%	92%	83%	100%	100%	100%

2.4 A task and finish group was established in late 2015 to focus initially on the recruitment difficulties being experienced in attracting registered nurses and students within York and Selby locality. A range of initiatives were identified and implemented which have proven successful. One key initiative was proactively promoting the Trust as an excellent employer and the belief that the reputation of the Trust would result in attracting nurses to want to come to work for us. There are a number of private healthcare providers within the locality competing for registered nurses and students qualifying. Analysis of band 5 registered nurses recruited over the last 12 months within York and Selby highlights that 65% have been recruited from a private provider and 24% have been recruited from Leeds and York Partnership Foundation Trust. The table at figure 4 highlights the success the Trust has had in attracting student nurses to come to work for us. Band 6 analysis highlights 40% came from a private provider and 60% from neighbouring NHS Trusts.

2.5 Figure 4 provides a summary of the progress to date using the recruitment fair approach in attracting registered nurses to come and work for the Trust. The Trust has participated in a range of internal bespoke organised events and externally organised events or recruitment campaigns. The attrition rate from events is variable due to the number of students offered employment and yet to take up employment. The Trust is committed to participating in two further external events in Manchester and Dublin. An evaluation on the value of participating in such events will be undertaken and included in the quarter 1 2017-18 quarterly workforce report.

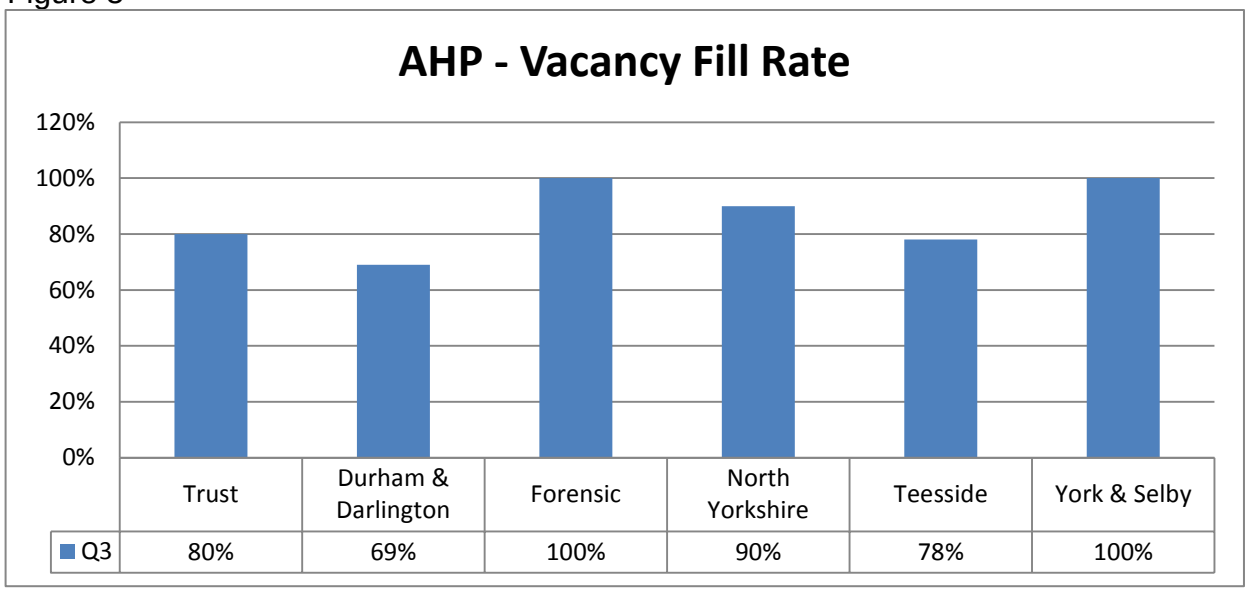
Figure 4

Event	Offers made	Started	Withdrawn	Attrition rate
Durham & Darlington event	52	29 (2 yet to qualify)	21	40%
York event	36	9 (18 yet to qualify and 4 ready to start waiting post)	5	14%
Glasgow RCN event	14	2 (2 yet to qualify)	10	71%
Liverpool RCN event	11	0 (9 yet to qualify)	2	18%
Teesside – generic advertisement campaign	17	16 (1 yet to qualify)	0	0%

2.6 Figure 5 highlights the vacancy fill rate for allied health professionals. Durham and Darlington reported the lowest fill rate at 69%. A review of the vacancies unable to be recruited to within Durham and Darlington highlighted significant difficulties being experienced in both Dietetics and Speech and Language therapy. The Head of Dietetics reports that vacancies are being covered by agency staff primarily from Australia. The Trust has recently offered a post to a Dietitian from Australia following a recruitment episode. There are a number of requirements to meet prior to embarking upon recruiting internationally. The first being identifying whether the post falls within the national shortage occupation list. Dietitions are not included on this list, in these circumstances there is a requirement to satisfy the resident labour market test which states the advertisement must be advertised locally for a period of 28 days. The post on offer must also meet the minimum salary threshold which is

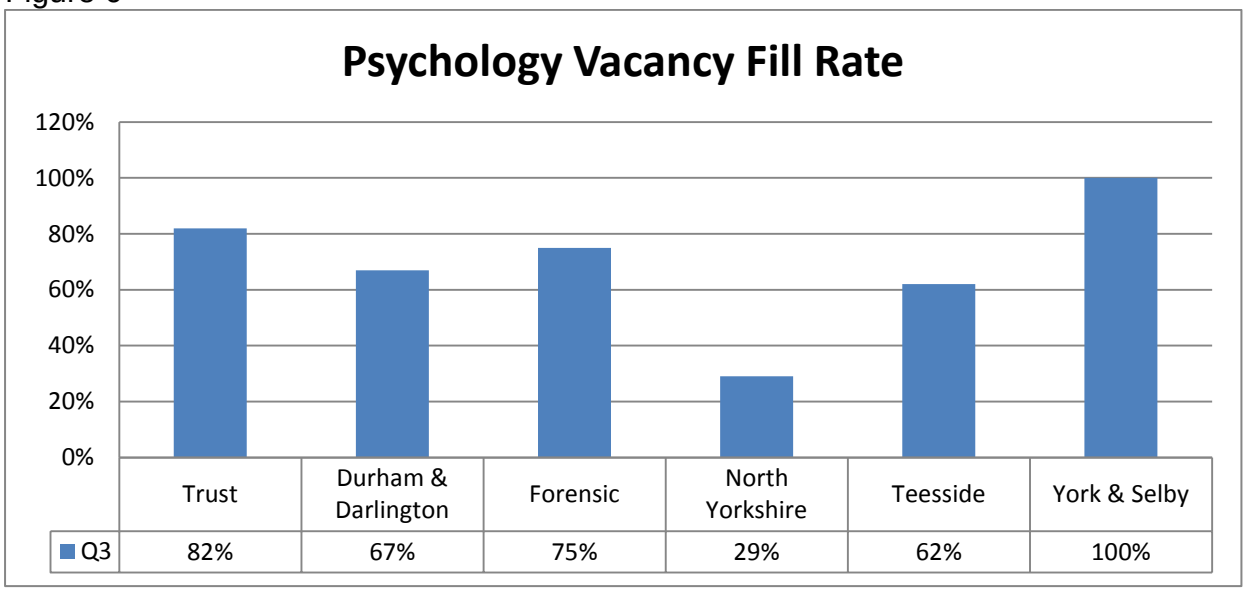
currently £25,000 per annum, this figure is increasing to £30,000 from 1st April 2017. The post on offer was a band 5 so fell within the minimum salary threshold, but won't meet the threshold following the increase.

Figure 5



2.6 Figure 6 provides vacancy fill rate information about psychologists. North Yorkshire continue to experience difficulties in recruiting to psychology vacancies. Analysis of the vacancies highlights that 70% were fixed term which may have an impact on the ability to recruit to the vacancy.

Figure 6



2.7 Figure 7 provides a summary of turnover rate for each professional group in quarter two and three.

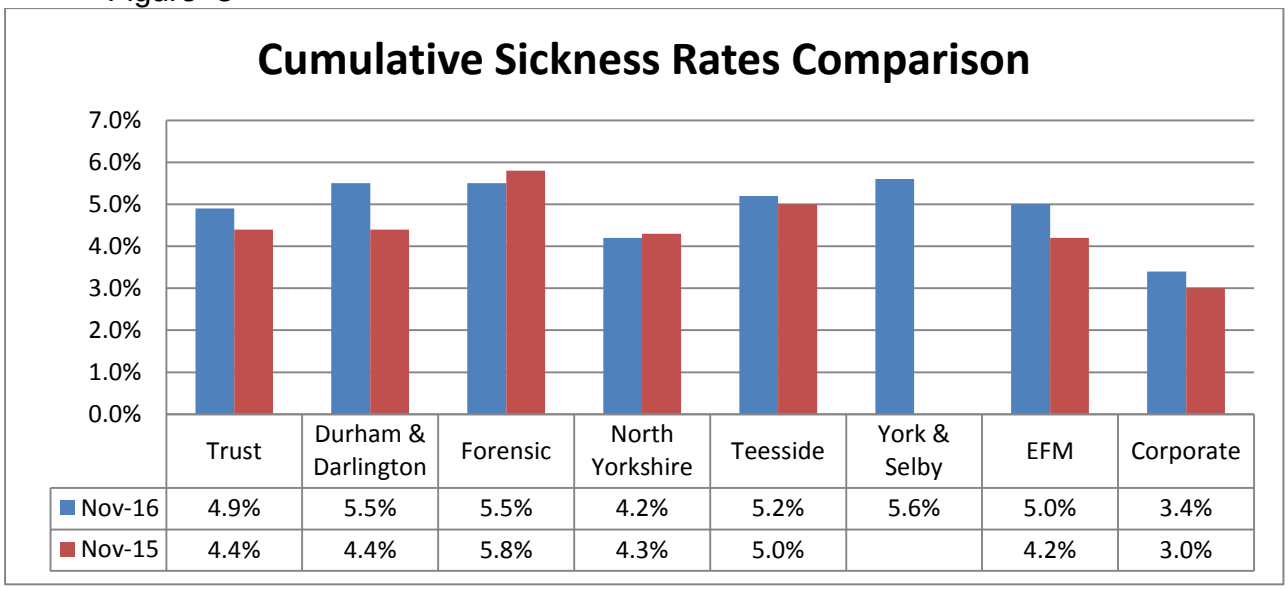
Figure 7

Turnover rate	Professional & Scientific	Add Clinical Services	Admin & Clerical	AHP	EFM	Medical & Dental	Nursing & Midwifery
Q3	10%	11%	13%	13%	15%	11%	8%
Q2	8%	11%	12%	13%	15%	9%	9%

3.0 Sickness Absence Analysis

3.1 A snapshot comparison analysis has been undertaken reviewing absence reported as at April - November 2015 and April - November 2016. Figure 8 highlights the sickness absence rates. The majority of localities are reporting an increase in absence rates.

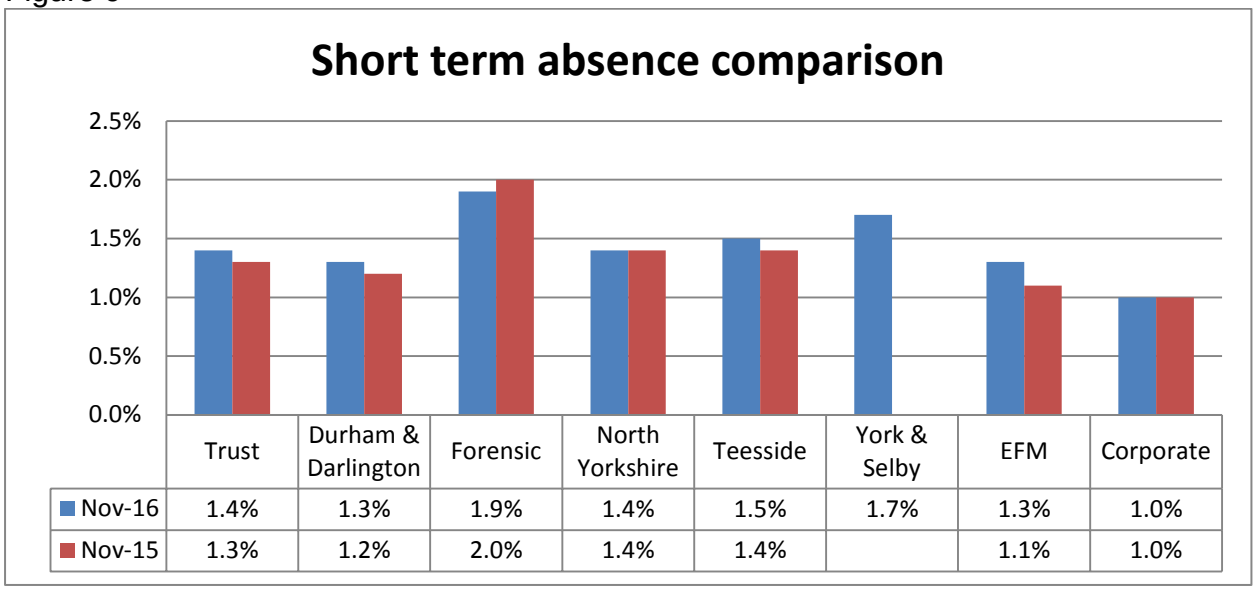
Figure 8



	Trust	Durham & Darlington	Forensic	North Yorkshire	Teesside	York & Selby	EFM	Corporate
Nov-16	4.9%	5.5%	5.5%	4.2%	5.2%	5.6%	5.0%	3.4%
Nov-15	4.4%	4.4%	5.8%	4.3%	5.0%		4.2%	3.0%

3.2 Figure 9 highlights a comparison of short term absence rates. As can be seen a number of localities are reporting an increase in reported short term absence. Although the percentage increase is small it is important to recognise that the difference in lost days compared with the same period in November 2015 equates to 1,058 days additional days lost, an increase of 6%. (York and Selby figures have been excluded for the purposes of this calculation). Analysis recently undertaken highlights that 187 staff have experienced 5 or more episodes of absence in the last 12 months.

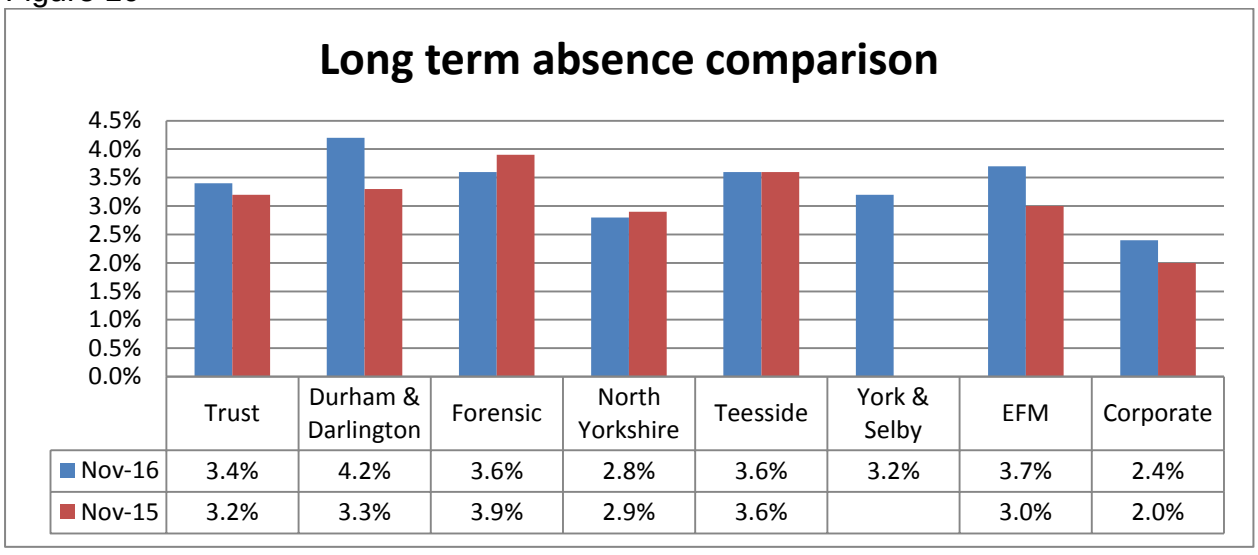
Figure 9



	Trust	Durham & Darlington	Forensic	North Yorkshire	Teesside	York & Selby	EFM	Corporate
Nov-16	1.4%	1.3%	1.9%	1.4%	1.5%	1.7%	1.3%	1.0%
Nov-15	1.3%	1.2%	2.0%	1.4%	1.4%		1.1%	1.0%

3.3 Figure 10 provides a comparison of long term absence rates. There has been a significant increase in long term absence being reported in both Durham and Darlington and Estates and Facilities Management. The difference in lost days equates to an additional 3,120 days lost, an increase of 7% on the previous year.

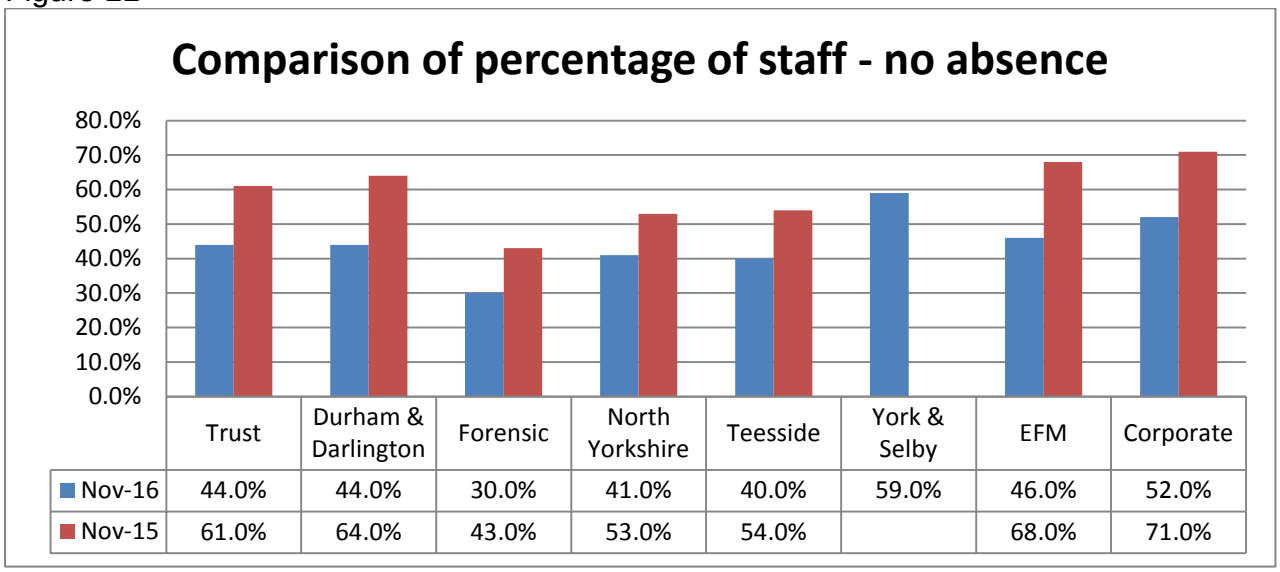
Figure 10



	Trust	Durham & Darlington	Forensic	North Yorkshire	Teesside	York & Selby	EFM	Corporate
Nov-16	3.4%	4.2%	3.6%	2.8%	3.6%	3.2%	3.7%	2.4%
Nov-15	3.2%	3.3%	3.9%	2.9%	3.6%		3.0%	2.0%

3.4 Figure 11 shows the percentage of staff reporting no absence during the reporting period. It is concerning to note the significant decrease in the rates reported between the two years.

Figure 11

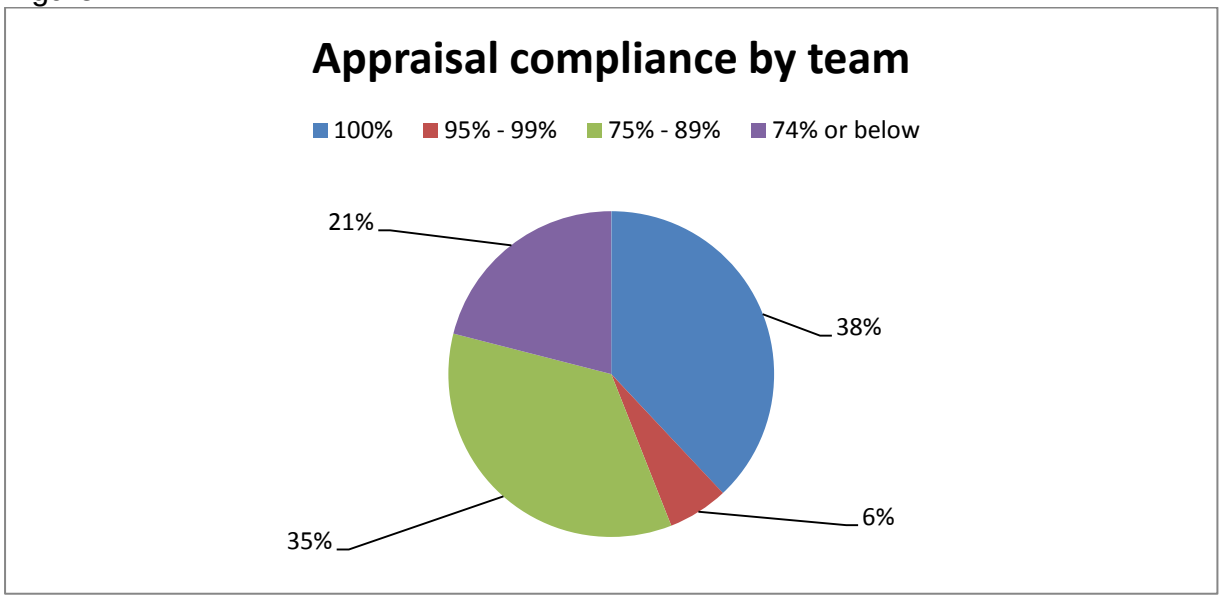


	Trust	Durham & Darlington	Forensic	North Yorkshire	Teesside	York & Selby	EFM	Corporate
Nov-16	44.0%	44.0%	30.0%	41.0%	40.0%	59.0%	46.0%	52.0%
Nov-15	61.0%	64.0%	43.0%	53.0%	54.0%		68.0%	71.0%

4.0 Appraisal analysis

4.1 Figure 12 provides an overview of the percentage of teams (based on cost centre) reporting compliance rates in relation to appraisal. 38% of teams are reporting 100% and 44% reporting over the Trust target of 95%. Teesside are the first locality to consistently report 95% compliance and are reporting 56% of teams as 95% or more compliance.

Figure 12



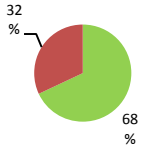
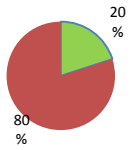
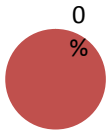
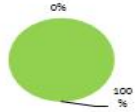
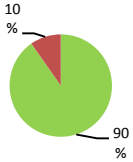
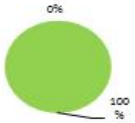
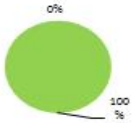
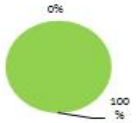
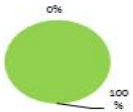
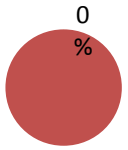
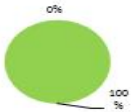
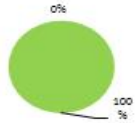
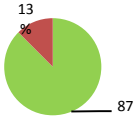
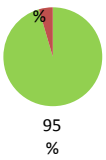
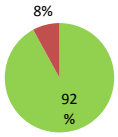
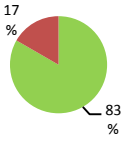
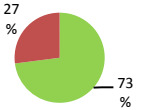
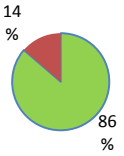
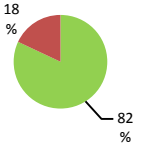
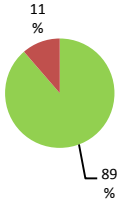
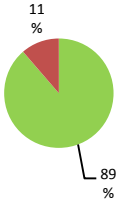
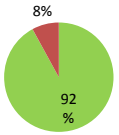
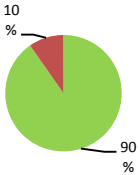
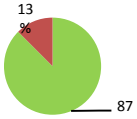
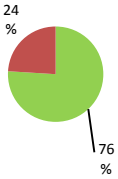
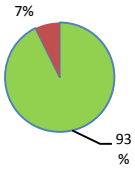
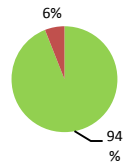
5.0 Mandatory Training

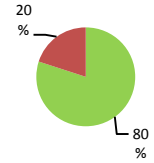
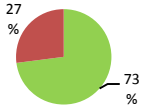
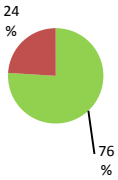
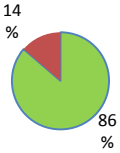
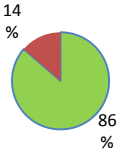
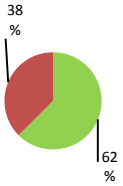
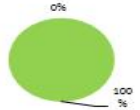
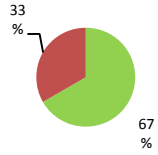
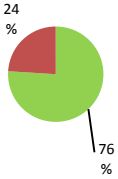
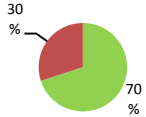
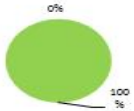
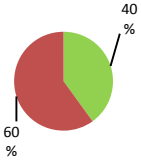
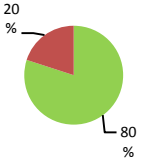
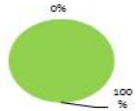
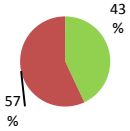
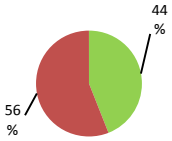
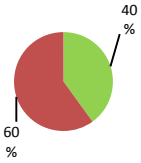
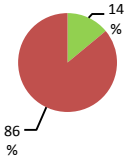
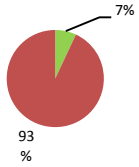
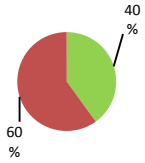
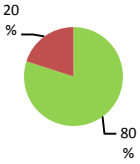
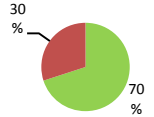
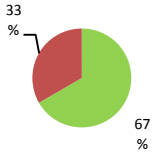
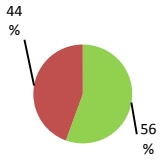
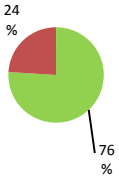
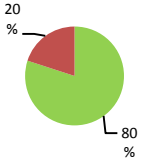
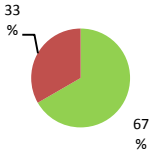
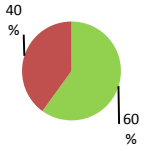
5.1 Figure 13 provides information about mandatory training compliance rates for core and non-core mandatory training as at December 2016.

Competency Name	Compliance	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov	Dec-16
Equality and Diversity	Meets requirement	5421	5401	5354	5810	5879	5920	5931	5457	5910	5345	5776	5723
	Does not meet requirement	397	434	454	626	493	453	447	344	503	491	500	485
	Total	5818	5835	5808	6436	6372	6373	6378	5801	6413	5836	6276	6208
		93.2%	92.6%	92.2%	90.3%	92.3%	92.9%	93.0%	94.1%	92.2%	91.6%	92.0%	92.2%
Fire	Meets requirement	4933	4936	4912	5327	5302	5239	5340	4953	5195	4890	5235	5196
	Does not meet requirement	885	899	896	1109	1070	1134	1038	848	1218	946	1041	1012
	Total	5818	5835	5808	6436	6372	6373	6378	5801	6413	5836	6276	6208
		84.8%	84.6%	84.6%	82.8%	83.2%	82.2%	83.7%	85.4%	81.0%	83.8%	83.4%	83.7%
Infection Control	Meets requirement	4942	4897	4971	5239	5250	5223	5208	4943	5165	3149	5152	5079
	Does not meet requirement	876	938	837	1197	1122	1150	1170	858	1248	689	1124	1129
	Total	5818	5835	5808	6436	6372	6373	6378	5801	6413	3838	6276	6208
		84.9%	83.9%	85.6%	81.4%	82.4%	82.0%	81.7%	85.2%	80.5%	82.0%	82.1%	81.8%
Safeguarding Children Level 1	Meets requirement	5664	5652	5647	6117	6104	6112	6100	5622	6083	3668	5989	5945
	Does not meet requirement	154	183	161	319	268	261	278	179	330	173	287	263
	Total	5818	5835	5808	6436	6372	6373	6378	5801	6413	3841	6276	6208
		97.4%	96.9%	97.2%	95.0%	95.8%	95.9%	95.6%	96.9%	94.9%	95.5%	95.4%	95.8%
Safeguarding Adults	Meets requirement	5573	5569	5555	6049	6020	6023	6024	5540	6050	3591	5915	5815
	Does not meet requirement	245	266	253	387	352	350	354	261	363	247	361	393
	Total	5818	5835	5808	6436	6372	6373	6378	5801	6413	3838	6276	6208
		95.8%	95.4%	95.6%	94.0%	94.5%	94.5%	94.4%	95.5%	94.3%	93.6%	94.2%	93.7%
Health & Safety	Meets requirement	5424	5416	5427	5930	5927	5935	5958	5476	5883	5360	5742	5689
	Does not meet requirement	394	419	381	506	445	438	420	325	530	476	534	519
	Total	5818	5835	5808	6436	6372	6373	6378	5801	6413	5836	6276	6208
		93.2%	92.8%	93.4%	92.1%	93.0%	93.1%	93.4%	94.4%	91.7%	91.8%	91.5%	91.6%
Information Governance	Meets requirement	5435	5479	5475	4829	4981	5158	5257	5109	5408	5467	5785	5748
	Does not meet requirement	383	356	333	1608	1391	1215	1121	692	1005	369	491	460
	Total	5818	5835	5808	6437	6372	6373	6378	5801	6413	5836	6276	6208
		93.4%	93.9%	94.3%	75.0%	78.2%	80.9%	82.4%	88.1%	84.3%	93.7%	92.2%	92.6%
Core 7 Compliance	Meets requirement	37392	37350	37341	39301	39463	39610	39818	37100	39694	31470	39594	39195
	Does not meet requirement	3334	3495	3315	5752	5141	5001	4828	3507	5197	3391	4338	4261
	Total	40726	40845	40656	45053	44604	44611	44646	40607	44891	34861	43932	43456
		91.8%	91.4%	91.8%	87.2%	88.5%	88.8%	89.2%	91.4%	88.4%	90.3%	90.1%	90.2%
Dual Diagnosis	Meets requirement	2160	2159	2158	2172	2195	2220	2221	2102	2112	1550	N/A	N/A
	Does not meet requirement	134	136	145	379	349	324	316	168	428	296	N/A	N/A
	Total	2294	2295	2303	2551	2544	2544	2537	2270	2540	1846	N/A	N/A
		94.2%	94.1%	93.7%	85.1%	86.3%	87.3%	87.5%	92.6%	83.1%	84.0%	N/A	N/A
Clinical Supervision	Meets requirement	2203	2200	2210	2236	2262	2282	2289	2201	2302	1687	2296	2295
	Does not meet requirement	142	149	146	365	332	311	298	120	289	159	308	280
	Total	2345	2349	2356	2601	2594	2593	2587	2321	2591	1846	2604	2575
		93.9%	93.7%	93.8%	86.0%	87.2%	88.0%	88.5%	94.8%	88.8%	91.4%	88.2%	89.1%
CPA & Care Coordination	Meets requirement	2184	2180	2188	2219	2241	2261	2263	2179	2276	1697	2273	2275
	Does not meet requirement	110	115	115	332	303	283	274	91	264	149	373	343
	Total	2294	2295	2303	2551	2544	2544	2537	2270	2540	1846	2646	2618
		95.2%	95.0%	95.0%	87.0%	88.1%	88.9%	89.2%	96.0%	89.6%	91.9%	85.9%	86.9%
CRAM	Meets requirement	3527	3532	3524	3894	3932	3961	3956	3603	4002	2804	3950	3936
	Does not meet requirement	517	529	506	652	558	529	532	404	522	320	509	474
	Total	4044	4061	4030	4546	4490	4490	4488	4007	4524	3124	4459	4410
		87.2%	87.0%	87.4%	85.7%	87.6%	88.2%	88.1%	89.9%	88.5%	89.8%	88.6%	89.3%
Manual Handling - Objects	Meets requirement	381	377	371	373	370	367	371	374	370	355	N/A	N/A
	Does not meet requirement	10	12	19	49	44	43	46	41	47	61	N/A	N/A
	Total	391	389	390	422	414	410	417	415	417	416	N/A	N/A
		97.4%	96.9%	95.1%	88.4%	89.4%	89.5%	89.0%	90.1%	88.7%	85.3%	N/A	N/A
Manual Handling - Patients	Meets requirement	325	310	293	211	264	239	187	238	273	280	N/A	N/A
	Does not meet requirement	295	309	316	439	512	531	564	364	551	391	N/A	N/A
	Total	620	619	609	650	776	770	751	602	824	671	N/A	N/A
		52.4%	50.1%	48.1%	32.5%	34.0%	31.0%	24.9%	39.5%	33.1%	41.7%	N/A	N/A
Manual Handling - Patients PT 1 Core	Meets requirement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	389	392
	Does not meet requirement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	272	260
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	661	652
		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	58.9%	60.1%
Manual Handling - Patients Pt 1 Update	Meets requirement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	220	240
	Does not meet requirement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	441	412
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	661	652

Manual Handling - Patients PT 2 Update	Meets requirement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	187	206
	Does not meet requirement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	306	279
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**493**	**485**
		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**37.9%**	**42.5%**
Medicines Management	Meets requirement	1580	1556	1559	1561	1566	1578	1576	1566	1622	1387	1624	1632
	Does not meet requirement	234	261	266	438	429	413	407	224	355	250	363	339
	Total	**1814**	**1817**	**1825**	**1999**	**1995**	**1991**	**1983**	**1790**	**1977**	**1637**	**1987**	**1971**
		87.1%	**85.6%**	**85.4%**	**78.1%**	**78.5%**	**79.3%**	**79.5%**	**87.5%**	**82.0%**	**84.7%**	**81.7%**	**82.8%**
MOVA	Meets requirement	3665	3650	3632	3923	3898	3883	3878	3652	3850	2525	3545	3545
	Does not meet requirement	733	768	758	1010	972	983	993	738	1060	599	1358	1358
	Total	**4398**	**4418**	**4390**	**4933**	**4870**	**4866**	**4871**	**4390**	**4910**	**3124**	**4903**	**4903**
		83.3%	**82.6%**	**82.7%**	**79.5%**	**80.0%**	**79.8%**	**79.6%**	**83.2%**	**78.4%**	**80.8%**	**72.3%**	**72.3%**
RESUS	Meets requirement	2251	2228	2246	2396	2301	2198	2115	2072	2214	1195	1244	1333
	Does not meet requirement	1793	1833	1784	2150	2189	2292	2373	1935	2310	1929	1117	1008
	Total	**4044**	**4061**	**4030**	**4546**	**4490**	**4490**	**4488**	**4007**	**4524**	**3124**	**2361**	**2341**
		55.7%	**54.9%**	**55.7%**	**52.7%**	**51.2%**	**49.0%**	**47.1%**	**51.7%**	**48.9%**	**38.3%**	**52.7%**	**56.9%**
Safeguarding Children Level 2	Meets requirement	3796	3800	3779	3982	3972	4003	3985	3756	3978	3791	1686	1689
	Does not meet requirement	301	317	306	616	570	538	555	305	600	284	331	302
	Total	**4097**	**4117**	**4085**	**4598**	**4542**	**4541**	**4540**	**4061**	**4578**	**4075**	**2017**	**1991**
		92.7%	**92.3%**	**92.5%**	**86.6%**	**87.5%**	**88.2%**	**87.8%**	**92.5%**	**86.9%**	**93.0%**	**83.6%**	**84.8%**
Safeguarding Children Level 3 Core	Meets requirement	1076	1081	1015	989	1077	1046	1041	1025	1088	1070	1371	1346
	Does not meet requirement	384	444	441	753	576	611	628	549	719	533	1202	1203
	Total	**1460**	**1525**	**1456**	**1742**	**1653**	**1657**	**1669**	**1574**	**1807**	**1603**	**2573**	**2549**
		73.7%	**70.9%**	**69.7%**	**56.8%**	**65.2%**	**63.1%**	**62.4%**	**65.1%**	**60.2%**	**66.7%**	**53.3%**	**52.8%**
Safeguarding Children Level 3 Update	Meets requirement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1319	1336
	Does not meet requirement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1254	1213
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**2573**	**2549**
		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**51.3%**	**52.4%**
Safeguarding Adults Level 2	Meets requirement	2243	2256	2267	2313	2332	2380	2416	2352	2500	1648	2515	2515
	Does not meet requirement	361	375	339	632	562	516	586	227	414	198	374	343
	Total	**2604**	**2631**	**2606**	**2945**	**2894**	**2896**	**3002**	**2579**	**2914**	**1846**	**2889**	**2858**
		86.1%	**85.7%**	**87.0%**	**78.5%**	**80.6%**	**82.2%**	**80.5%**	**91.2%**	**85.8%**	**89.3%**	**87.1%**	**88.0%**
Rapid Tranq 1	Meets requirement	153	153	147	177	171	161	168	142	174	142	164	160
	Does not meet requirement	47	70	43	83	43	51	47	47	56	46	59	63
	Total	**200**	**223**	**190**	**260**	**214**	**212**	**215**	**189**	**230**	**188**	**223**	**223**
		76.5%	**68.6%**	**77.4%**	**68.1%**	**79.9%**	**75.9%**	**78.1%**	**75.1%**	**75.7%**	**75.5%**	**73.5%**	**71.7%**
Rapid Tranq 2	Meets requirement	319	308	294	284	271	266	267	238	241	233	220	238
	Does not meet requirement	294	312	320	390	391	440	625	307	401	344	435	405
	Total	**613**	**620**	**614**	**674**	**662**	**706**	**892**	**545**	**642**	**577**	**655**	**643**
		52.0%	**49.7%**	**47.9%**	**42.1%**	**40.9%**	**37.7%**	**29.9%**	**43.7%**	**37.5%**	**40.4%**	**33.6%**	**37.0%**
Rapid Tranq 3	Meets requirement	549	495	457	426	406	411	424	376	385	365	377	380
	Does not meet requirement	385	430	460	605	611	658	960	490	670	578	643	627
	Total	**934**	**925**	**917**	**1031**	**1017**	**1069**	**1384**	**866**	**1055**	**943**	**1020**	**1007**
		58.8%	**53.5%**	**49.8%**	**41.3%**	**39.9%**	**38.4%**	**30.6%**	**43.4%**	**36.5%**	**38.7%**	**37.0%**	**37.7%**
Safe Perscribing	Meets requirement	189	186	180	184	184	182	184	169	182	173	185	173
	Does not meet requirement	11	37	10	76	30	30	31	20	48	15	46	16
	Total	**200**	**223**	**190**	**260**	**214**	**212**	**215**	**189**	**230**	**188**	**231**	**189**
		94.5%	**83.4%**	**94.7%**	**70.8%**	**86.0%**	**85.8%**	**85.6%**	**89.4%**	**79.1%**	**92.0%**	**80.1%**	**91.5%**
Dual Diagnosis - Medics	Meets requirement	159	159	154	164	170	174	176	155	176	152	N/A	N/A
	Does not meet requirement	41	64	36	96	44	38	39	34	54	36	N/A	N/A
	Total	**200**	**223**	**190**	**260**	**214**	**212**	**215**	**189**	**230**	**188**	**N/A**	**N/A**
		79.5%	**71.3%**	**81.1%**	**63.1%**	**79.4%**	**82.1%**	**81.9%**	**82.0%**	**76.5%**	**80.9%**	**N/A**	**N/A**
Investigation of Incidents & Complaints		**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

KEY PERFORMANCE INDICATOR SUMMARY

	Key Performance indicators	Target	Trust	Durham & Darlington	Teesside	Forensic	North Yorks	York and Selby	EFM	Corp
1	Labour Turnover rate	8% - 12%	10.8%	8.2%	9.5%	7.8%	9.4%	17.0%	14.6%	14.0%
2	Sickness Absence FYTD	4.5 %	4.9%	5.5%	5.1	5.7%	4.3%	6.8%	6.3%	3.5%
3	% of investigations concluded within 8 weeks	95%								
4	% of grievances concluded with 3 months	95%								
5	% of staff receiving an annual appraisal	95%								
6	% of staff compliant with mandatory and statutory training	95%								

	Key Performance indicators	Target	Trust	Durham & Darlington	Teesside	Forensic	North York	York and Selby	EFM	Corp
7	% of new starters attending corporate induction within 3 months of commencing employment	100%								
8	% of new starters confirmation of local induction checklist completed within 2 weeks of commencing employment	100%								
9	% of band 1 -5 recruited within 13 weeks	75%								
10	% of band 6 – 9 recruited within 15 weeks	75%								

Medical Workforce Report (2016 Quarter 3)

MEDICAL DIRECTORATE

This report provides information about the medical workforce during the third quarter (October, November and December 2016).

The report will be divided into the following sections:

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

Section 1: Medical Staffing Profile

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

Table 1	D&D	Tees	N Yorks	Forensic	York and Selby	Overall Total
Permanent	93	86	58	26	47	310
Trust Locums	4	4	8		2	18
Agency Locums	5	2	5	2	5	19
Flex Retirement	3	3	3			9
Career Break				1		1
Honorary	2	1		1	1	5
Total	107	96	74	30	55	**371**

Table 1 shows another slight increase in workforce since quarter 2 (364). The table shows that 30% of our permanent workforce is in the Durham & Darlington locality. The number of agency doctors remains the same. Currently there are 7 agency doctors over capped rates.

The table identifies that the permanent workforce make up 84% of the total medical workforce. This is comparable with the percentage in 2013.

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

Consultant Psychiatrists

Table 2	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Permanent	62	31	29	12	10	7	151
Trust Locums	1		3				4
Agency Locums	6	2	2		1		11
Flex Retirement	3	4	1	1			9
Vacant not cov'd	5	7	2	1			15
Career Break					1		1
Honorary	3	1			1		5
Total	80	45	37	14	13	7	**196**

Table 2 shows the number of consultants currently working within the Trust defined by specialty. Please note that out of the 11 agency doctors, 9 are covering vacant posts, 1 is covering maternity leave and 1 is covering sickness.

The consultant workforce in CYPS is of concern given that 31% of its workforce is not permanent and may pose a risk in the future. This remains equal to last quarter and is slightly higher than figures in 2014.

SAS Doctors

Table 3	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Permanent	13	6	12	1	3	3	38
Trust Locums	1	1	3				5
Agency Locums	2	1	4		1		8
Flex Retirement							
Vacant not cov'd	2	2			1		5
Career Break							
Honorary							
Total	18	10	19	1	5	3	**56**

Table 3 shows the number of SAS grade doctors currently working within the Trust defined by specialty. Out of the 8 agency locums, 1 is covering sickness, 4 are covering vacancies and 3 are helping out with the workload. Of concern, is that over half (58%) of the MHSOP workforce is not permanent. This remains equal to last quarter.

Junior Doctors

Table 4	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Current	69	11	26	7	4		117
Vacancies not covered	8	5	4	2	4		23
Trust Locums	4	1	3		1		9
Agency Locums							
Total number of posts	81	17	33	9	9		**149**

Table 4 shows all Trust junior doctor training posts. The number of vacancies are those posts that remain unfilled after trust doctor and agency locums have been appointed. For information, Trust Doctors are used to fill vacant training posts and are not on a formal training programme, however, there is 1 trust doctor in post that is filling a service need in AMH within Teesside. There are currently 32 vacancies that are either filled by locums or that remain empty. For the second quarter in a row, the trust is not using agency doctors to fill the vacancies. The number of trust doctors remain the same.

You will note that the Trust has 9 Trust doctor posts compared to 3 in 2013. This is quite unique and the Trust Doctor Programme was developed to make the doctor better equipped to be succesful on their application for core training. The Trust is planning a further trip to Europe early next year to recruit more Trust Doctors.

Table 5	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Foundation Yr 1	9		5				14
Foundation Yr 2	9		3				12
CT 1-3	28	6	8	6	3		51
ST 4-6	11	5	5	1	1		23
GP Registrars	12		5				17
Total	69	11	26	7	4		**117**

Table 5 shows the breakdown of junior doctors that are currently in post in the Trust. We continue to do all we can to support core trainees in passing their written and clinical papers. We have introduced the independent assessment of clincial skills (IACS), and this is now held twice yearly. A structured day long CASC programme was lauched last year and we continue to encourage opportunitist clincial skills training with trained supervisors. Of concern though, is that a third of

senior registrar posts are unfilled, which will have implications in the future with consultant recruitment.

Section 2: Medical Staffing Monitoring Profile

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

Consultants by Age & Gender

	D&D		Tees		NY		Forensic		York & Selby		Total	
Table 1	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
30 – 34		1		3		1			1		**1**	**5**
35 – 39	3	7	7	3	2	1	3	2	3	1	**18**	**14**
40 – 44	6	3	9	4	4	2	4	2	1	5	**24**	**16**
45 – 49	6	5	3	5	9	4	5	1	3	3	**26**	**18**
50 – 54	5	6	3	2	2	3	1	1	3	1	**14**	**13**
55 – 59	3	2	1	2	1				2		**7**	**4**
60 – 64	3		1		2				1		**7**	
65 – 69			1		1						**2**	
70+									1		**1**	
Total	**26**	**24**	**25**	**19**	**21**	**11**	**13**	**6**	**15**	**10**	**100**	**70**

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

The majority of our consultant workforce is aged between 40 and 49 (49%), with the modal average being the 45-49 age group. This remains unchanged from last quarter. In contrast, Forensic Services remain relatively young with no-one over the age of 55. The male and female split in Durham and Darlington and York and Selby are fairly equal which is not replicated in the other localities (there are twice as many males than females in Forensics and North Yorkshire). Overall, there is a 59/41% male/female split respectively (1% increase/decrease from last quarter).

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

Consultants by Age & Gender in Specialties

Table 2	AMH		CYPS		MHSOP		LD		Forensic MH		Forensic LD		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
30 – 34	1	1		2		2							**1**	**5**
35 – 39	6	5	2	5	4	2	3		3	2		2	**18**	**14**
40 – 44	9	8	4	1	6	2	1	3	2		2	2	**24**	**16**
45 – 49	11	4	4	7	5	5	1	1	4		1	1	**26**	**18**
50 – 54	9	2	1	6	2	3	1	1	1	1			**14**	**13**
55 – 59	4	2	1	1		1	2						**7**	**4**
60 – 64	4		2		1								**7**	
65 – 69	2												**2**	
70+	1												**1**	
Total	47	22	14	22	18	15	8	5	10	2	3	3	**100**	**70**

Table 2 shows the number of male and female consultants in various age brackets defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Interestingly, Forensic Services remains with a relatively young workforce with only 2 out of 19 doctors over the age of 50, while the other specialties together make up 30% of the consultant workforce over the age of 50 (a 1% increase since last quarter). In addition, the lack of a female workforce in Adult Mental Health and Forensic Mental Health remains evident from the data.

SAS Doctors by Age & Gender

Table 3	D&D		Tees		NY		Forensic		York & Selby		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
30 – 34												
35 – 39	1		1	2		1					**2**	**3**
40 – 44	3	2	1				1	1			**5**	**3**
45 – 49	2	3		2		1	1	1			**3**	**7**
50 – 54		2	2	3		1					**2**	**6**
55 – 59		2		1	1	1	1				**2**	**4**
60 – 64			2	2				1			**2**	**3**
65 – 69												
70+	1										**1**	
Total	**7**	**9**	**6**	**10**	**1**	**4**	**3**	**3**			**17**	**26**

Table 3 shows the number of male and female SAS doctors in various age brackets defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Please note there are no specialty doctors in York and Selby. In comparison to the consultant workforce, there is a 40/60% split in favour of females (3% increase/decrease in males/females since last quarter), with noticably few males (1) in the North Yorkshire locality. In addition, the average workforce age is the same as consultants, with no-one under the age of 34 and almost a half (47%) being over the age of 50. It is also worth noting that our Teesside and North Yorkshire localities has a high proportion of its workforce in the over 50 category (63/60% respectively).

SAS Doctors by Age & Gender in Specialties

Table 4	AMH		CYPS		MHSOP		LD		Forensic MH		Forensic LD		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
30 – 34														
35 – 39	1	1		1	1	1							**2**	**3**
40 – 44	1	1	1	1	2				1			1	**5**	**3**
45 – 49	1	3		1	1	2				1	1		**3**	**7**
50 – 54		2		1	2	3							**2**	**6**
55 – 59	1	1		2		1					1		**2**	**4**
60 – 64	1	1			1			1		1			**2**	**3**
65 – 69														
70+					1								**1**	
Total	**5**	**9**	**1**	**6**	**8**	**7**		**1**	**1**	**2**	**2**	**1**	**17**	**26**

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

Ethnic Origin

Consultants Table 5	D&D		Tees		NY		Forensic		York & Selby		Total	
	M	F	M	F	M	F	M	F	M	F	**M**	**F**
White British	7	19	8	13	10	7	7	2	10	7	**42**	**48**
White Irish	1								1		**2**	
White European	2		3	1	3	1	1				**9**	**2**
White Other		1				1				1		**3**
Asian British – Indian	10	3	11	1	2	1	2	4	3		**28**	**9**
Asian British–Pakistani	1				1		1				**3**	
Asian British–Bangladesh					1						**1**	
Asian British–Other	1		1	1	1				1		**4**	**1**
Black British–African		1	1	2	2					1	**3**	**4**
Black British - Nigerian	1										**1**	
Black British–Other	1						1				**2**	
Mix White/Black–African	1										**1**	
Mixed – Other			1				1				**2**	
Chinese										1		**1**
Other	1			1	1						**2**	**1**
Not Stated						1						**1**

Table 5 shows the number of male and female consultants in ethnic origin categories defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. The table shows that just over half of the consultant workforce are 'White British' (90 White British and 80 non-White British).

When considering BAME consultants, 106 are from Europe while 64 are from Asia, Africa or elsewhere (62/38% respectively) which is a 2% increase/decrease to last quarter. Interestingly, the male/female split between Europe and BAME areas is quite distinct – 50% of the European workforce are male and 50% are female; in BAME areas, 73% of the workforce are male compared to 27% female. Also of note, is that the Durham & Darlington, Teesside and Forensic localities have fairly even numbers of European/other doctors (60%, 57% in favour of Europe and 53% in favour of other ethnicities in forensics), however, it's quite evident that North Yorkshire and York and Selby highly favour European doctors (69% and 76% respectively).

SAS Doctors

Table 6

	D&D		Tees		NY		Forensic		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
White British	1	4		4		3	1		**2**	**11**
White European		1								**1**
White Other	1			1	1			1	**2**	**2**
Asian British–Indian	1	2	4	3				1	**5**	**6**
Asian British–Pakistani	1		1	1			1		**3**	**1**
Asian British- Banglaesh	1								**1**	
Asian British–Other						1		1		**2**
Black British–African		1					1		**1**	**1**
Black British			1						**1**	
Vietnamese				1						**1**
Other	2	1							**2**	**1**

Table 6 shows the number of male and female SAS doctors in various ethnic origin categories defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. This table shows the opposite trend to consultants in that 30% of the SAS workforce are 'White British' (13 are White British and 30 (70%) are non-White British). When considering BAME SAS doctors, 18 are from Europe and 25 are from Asia and Africa or elsewhere (42/58% respectively). In contrast to consultants, the male/female split in BAME areas is (52/48% respectively) whereas the European workforce is highly biased towards females (22% males/78% females). In addition, Teesside and Forensics have twice as many BAME doctors than European ones.

Full Time / Part Time

Table 7

Consultant												
	D&D		**Tees**		**NY**		**Forensic**		**York & Selby**		**Total**	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	M	F
Full Time	23	12	23	12	13	6	11	5	8	6	**78**	**41**
Part Time	3	12	2	7	8	5	2	1	7	4	**22**	**29**
Specialty Doctors												
Full Time	6	5	6	4	1		2	2			**15**	**11**
Part Time	1	4		6		4	1	1			**2**	**15**

Table 7 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. This shows that almost half (44%) of the career grade workforce are full time males with less than a quarter (24%) of females in full time positions (a 2% increase from last quarter). In addition, 11% of males and 21% of females are working part time. Seventy

percent of the consultant workforce are full time, whereas the gap is less distinct within the SAS group (61% full time). Overall, 68% of the career grade workforce are full time. The number of part time workers has increased by 1% since last quarter and could continue to increase over the next few years due to the introduction of flexible working options open to all doctors.

Table 8

Consultant														
	AMH		**CYPS**		**MHSOP**		**LD**		**Forensic MH**		**Forensic LD**		**Total**	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
Full Time	40	13	9	10	15	10	4	2	8	2	3	3	**79**	**40**
Part Time	7	9	5	12	3	5	4	3	2			1	**21**	**30**
Specialty Doctors														
Full Time	5	4		3	8	2			1	2	1		**15**	**11**
Part Time		5	1	3		5		1			1	1	**2**	**15**

Table 8 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Interestingly, the gap between full time males and females is quite evident in AMH, MHSOP and Forensic MH (54/20%, 48/25% and 60/27% male/female respectively).

Section 3: Vacancies

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

Table 1	**D&D**	**Tees**	**NY**	**Forensic**	**York & Selby**	**Total**
Consultant	9	10	6	1	2	28
SAS	2	2	1	1	2	8

Table 1 above shows the current vacancies in each directorate. The number of consultant vacancies has decreased by 1 since last quarter while the SAS vacancies have remained the same.

Table 2	**AMH**	**CYPS**	**MHSOP**	**LD**	**FMH**	**FLD**	**Total**
Consultant	11	8	8		1		28
SAS	4	1	2		1		8

Table 2 above shows the current vacancies in each specialty. The number of CYPS vacancies has reduced since last quarter.

Vacancy Breakdown

Table 3

Vacancies	**Locum in place**	**Times Advertised**	**Date of Advert**	**Date of Interview**	**Appt made**	**Start date**
Consultant in AMH (PICU) RPH	No	1	21/05/16	11/07/16	No	
Consultant in AMH (S'ton Inpatient / Crisis) RPH	Acting Cons					
Consultant in AMH (S'ton Inpatient) RPH	Agency Cons					
Consultant in AMH (ADHD), Lancaster House	No					
Specialty Doctor in AMH (Rehabilitation) Lustrum Vale/RPH	No	1	23/07/16	13/09/16	No	
Consultant in Liaison North Tees	No	2	~~14/05/16~~ 17/12/16	~~04/07/16~~ 15/02/17	No	
Consultant in CYPS The Ridings, Redcar	No	1	07/05/16	29/06/16	No	

Vacancies	Locum in place	Times Advertised	Date of Advert	Date of Interview	Appt made	Start date
Consultant in CYPS (6 PA) Dover House, Hartlepool	No	1	07/05/16	29/06/16	No	
Consultant in CYPS (8PA) (Tier 4) West Lane Hospital	No	1	15/10/16	05/12/16	Yes	May 2017
Senior Specialty Doctor in CYPS (ADHD), West Lane Hospital	No	0	07/01/17	27/02/17		
Consultant in MHSOP (8PA) (Liaison) North Tees/Hartlepool	Trust Locum					
Consultant in MHSOP Lustrum Vale	Acting Cons					
Consultant in MHSOP (R&C), Guisborough	No					
Consultant in AMH (Community Eating Disorders) Imperial House	Agency Cons	1	04/06/16	01/08/16	No	
Consultant in AMH (PICU) West Park Hospital	No					
Consultant in AMH (Affective Disorders) North End House	No	2	~~04/06/16~~	~~12/09/16~~ 03/01/17	No	
Consultant in AMH (EIP) Bishop Auckland	Agency Cons	2	~~04/06/16~~	~~01/08/16~~ 03/01/17	No	
Consultant in AMH (In-patient) WPH	Agency Cons					
Specialty Doctor in AMH (5 PA) (Affective Disorders) Enterprise House	No	2	~~04/06/16~~ 17/09/16	~~01/08/16~~ Jan 2017	~~No~~	
Specialty Doctor in AMH (5PA) (Affective Disorders) North End House	No	2	17/09/16	Jan 2017	~~No~~	
Consultant in CYPS (6PA) Chester le Street	No					
Consultant in CYPS (5PA) Winchester House, Peterlee	No					
Consultant in CYPS LD Mulberry Centre/Acley Centre	No	1	10/09/16	02/11/16	Yes	Feb 2017
Consultant in MHSOP Easington	Trust Cons	3		18/03/15	No	
Consultant in MHSOP (6PA) (Liaison) LRH	No	4	28/05/16	18/07/16	No	
Consultant in AMH (Working Age Psychiatry) Ellis Ct, Sbr	Trust Cons	2		27/04/15	No	
Consultant in MHSOP Cross Lane Hospital / Malton	Trust Cons	2	05/12/15	~~30/07/15~~ 19/01/16	No	
Consultant in MHSOP (6PA) Whitby / Cross Lane Hospital	Acting Cons					
Specialty Doctor in AMH Friarage Northallerton	Agency Doctor	2	30/07/16	~~12/09/16~~ 18/11/16	No	
Consultant in CYPS Scarborough	No					
Consultant in CYPS (6PA) Scarborough	Trust Cons					
Consultant in CYPS (6PA) Northallerton	Agency Cons	2	13/08/16	~~27/05/16~~ ~~tba~~	~~No~~	
Consultant in Forensic (Forensic Mental Health), RPH	Subs Cons	1	26/11/16	13/01/17		
Specialty Doctor in Forensic (Forensic Mental Health), RPH	No	2	23/07/16	~~13/09/16~~ 27/11/16	No	
Specialty Doctor in MHSOP York	Agency Doctor	1	30/07/16	06/09/16	tba	
Specialty Doctor in MHSOP York	Agency Doctor	1	30/07/16	06/09/16	No	

Vacancies	Locum in place	Times Advertised	Date of Advert	Date of Interview	Appt made	Start date
Consultant in CYPS (6PA) York	Agency Cons	2	~~12/02/16~~ 23/07/16	~~20/04/16~~ 05/09/16	No	
Consultant in MHSOP (8PA) York	Agency Cons	1	11/06/16	29/07/16	No	

Table 3 shows the breakdown of each vacancy in the Trust and the number of times the post has been advertised (including any current adverts).

The table below shows the recruitment activity in this period (October to December 2016). Within this period 6 posts were advertised with 2 (33%) successfully recruited to (compared to 6 of 19 posts in the last quarter).

Table 4

Vacancies advertised	Times advertised	No of candidates applied	No of candidates shortlisted	Appointment made
Specialty Doctor in AMH (Rehab) Roseberry Park/Lustrum Vale	2	1	0	No
Consultant in CYPS (8PA) (Tier 4) West Lane Hospital	1	1	1	Yes
Consultant in CYPS LD Mulberry Centre/Acley Centre	1	1	1	Yes
Specialty Doctor in AMH Friarage Northallerton	2	0	0	No
Consultant in CYPS (6PA) Northallerton	2	0	0	No
Specialty Doctor in Forensic (FMH) Roseberry Park	2	1	0	No

Section 4: Sickness

Doctors on Long Term Sick Leave by Locality

Figure 1

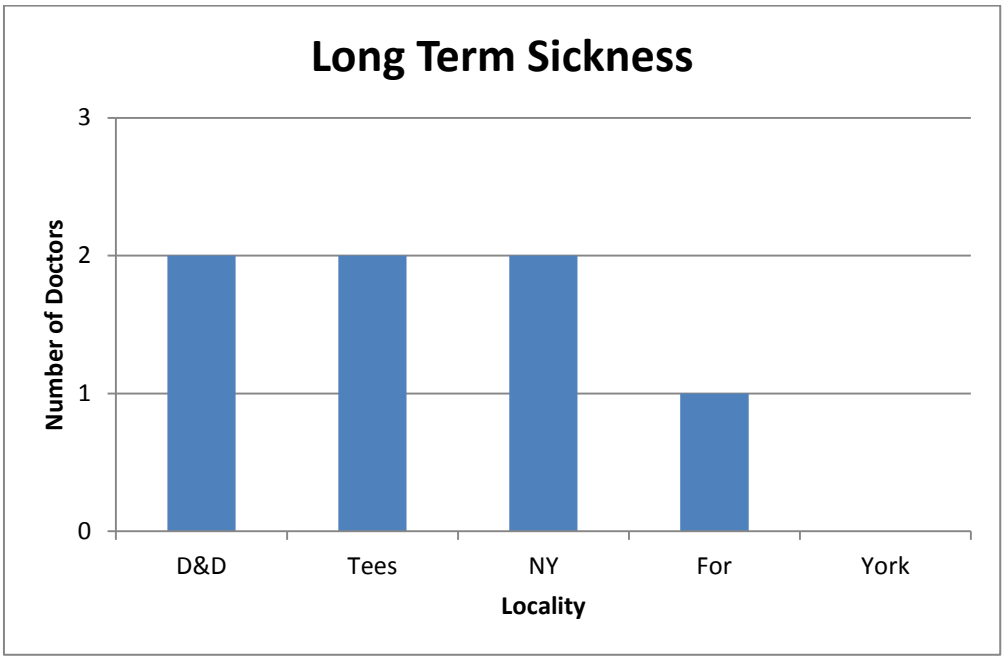


Figure 1 shows the number of doctors on long term sick on 31st December 2016. This has increased from 3 last quarter to 7. Only one who was on sick leave last quarter remains on sick leave this quarter. Two of the long term sickness is due to cancer, three to musculoskeletal issues and two due to stress.

Reasons for Sickness Absence

Figure 2

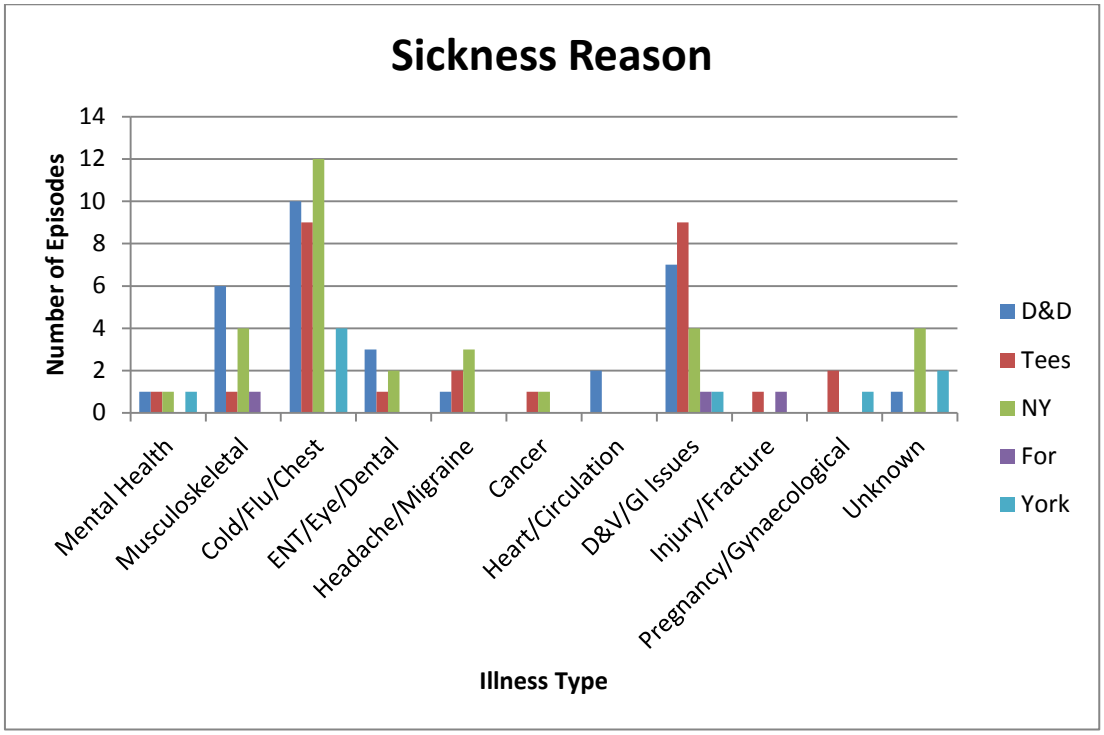


Figure 2 shows the reasons for sickness absence (including long term sickness) during the period October to December 2016. This includes all grades of doctor except agency locums. The number

of cold, flu and chest problems has increased overall from 16 to 35. The number of mental health issues has doubled from 2 to 4 overall. Similarly, the number of GI issues has increased from 16 to 22 overall, with a dramatic increase in Teesside (3 last quarter to 9 this quarter).

Overall, 610 work days were lost due to sickness (327 days more than last quarter) out of which 357 days were for short term illnesses (an increase of 180 from last quarter) and 253 were for long term illnesses (an increase of 147).

Section 5: Appraisals and Revalidation

Consultants

Table 1	D&D	Tees	NY	For	Y&S	Total
Appraisals Due	15	13	10	5	5	48
Appraisals Actual	14	12	9	5	5	45

Table 1 shows the number of consultant appraisals that were due between 1st October and 31st December 2016 and how many were actually completed. The total number is broken down into locality.

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

Table 2 shows the number of consultants who were due revalidation between 1st October and 31st December 2016 and those who were successfully revalidated. The numbers are broken down into locality.

SAS

Table 3	D&D	Tees	NY	For	Y&S	Total
Appraisals Due	7	5	0	2	0	14
Appraisals Actual	7	5	0	2	0	14

Table 3 shows the number of SAS doctor appraisals that were due between 1st October and 31st December 2016 and how many were actually completed. The total number is broken down into locality.

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

Table 4 shows the number of SAS doctors who were due revalidation between 1st October and 31st December 2016 and those who were successfully revalidated. The numbers are broken down into locality.

Trust Doctor

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

Table 3 shows the number of Trust doctor appraisals that were due between 1st October and 31st December 2016 and how many were actually completed. The total number is broken down into locality.

Table 6	D&D	Tees	NY	For	Y&S	Total
Revalidation Due	0	0	2	0	0	2
Revalidation Actual	0	0	1	0	0	1

Table 4 shows the number of Trust doctors who were due revalidation between 1st October and 31st December 2016 those who were successfully revalidated. The numbers are broken down into locality.

Section 6: Turnover

This section considers the number of doctors who have commenced in the Trust between 1st April and 30th June 2016. It also highlights the number of doctors leaving the Trust and their leaver destination.

New Starters vs Leavers by Locality

Table 1	D&D	Tees	NY	Forensic	York & Selby	Total
New Starters	3					3
Leavers	3	1	1	1	1	7

Table 1 highlights the number of new starters against the number of leavers. Again, this includes all types of staff except agency locums. The number of leavers has reduced since last quarter; however, the number of new starters has also reduced from 12 to 3. This could perhaps be explained by the recruitment of those in the last quarter who had qualified in August as consultants.

New Starters vs Leavers by Specialty

Table 2	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
New Starters	2	1					3
Leavers	4	1	1		1		7

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

New Starters vs Leavers Grade Breakdown

Table 3	Consultants	SAS	Trust Doctors
New Starters		2	1
Leavers	5	2	

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

Leaver Destination by Locality

Table 4	D&D	Tees	NY	Forensic	York & Selby	Total
Flexible Retirement						
Retired (ill health)						
Fully Retired		1	1	1	1	4
Moved Abroad	3					3
Needed to Relocate						
Left (alternative work)						
Other Local Trust						
Training Scheme						
End of Contract						

Table 4 shows the destination of doctors after leaving the Trust, defined by locality. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums. Out of the 3 who moved abroad, 1 was already on a career break working abroad.

Leaver Destination by Specialty

Table 5	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Flexible Retirement							
Fully Retired (ill health)							
Fully Retired	1	1	1		1		4
Moved Abroad	3						3
Needed to Relocate							
Left (alternative work)							
Joined Local Trust							
Joined Training Scheme							
End of Contract							

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

Leaver Destination by Grade

Table 6	Consultants	SAS	Trust Doctors
Flexible Retirement			
Fully Retired (ill health)			
Fully Retired	2	2	
Moved Abroad	3		
Needed to Relocate			
Left (alternative work)			
Joined Local Trust			
Joined Training Scheme			
End of Contract			

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

Leavers over the last 2 years

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

Table 7	D&D	Tees	NY	Forensic	York	Total
Flexible Retirement		3		1		4
Retired (ill health)	1		1			2
Retired Fully	2	4	2		1	9
Moved Abroad	6			2		8
Needed to Relocate		2		1		3
Joined Another Trust	2	1			1	4
Joint Private Organisation	1	1				2
Joined Training Scheme	3	4	4	1		12
End of Contract	1	1	6			8
Left (alternative work)	4	3	2			9

Table 7 shows that the majority of leavers came from the Durham & Darlington and Teesside localities. Interestingly, 20% of doctors left the Trust to join a training scheme, while those who either moved abroad, joined another Trust or left to find alternative work (eg with an agency or outside of medicine) make 38% of leavers. In addition, those who retired make up a quarter (25%) of the total leavers.

Table 8	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Flexible Retirement		2	1			1	4
Fully Retired (ill health)	1	1					2
Fully Retired	3	4	1	1			9
Moved Abroad	5			1	1	1	8
Needed to Relocate	2					1	3
Joined Another Trust	1	2	1				4
Joined Private Org	1	1					2
Joined Training Scheme	10	1			1		12
End of Contract	4		4				8
Left (alternative work)	2	2	5				9

Table 8 shows that 48% of leavers were from Adult Mental Health (possibly due to the fact that the majority of Trust doctors are placed within AMH services) while 21% were from Child and Young Person's Services.

Table 9	Consultants	SAS	Trust Doctors
Flexible Retirement	4		
Fully Retired (ill health)	1	1	
Fully Retired	6	3	
Moved Abroad	7	1	
Needed to Relocate	2	1	
Joined Another Trust	4		
Joined Private Org	2		
Joined Training Scheme		6	6

Table 9	Consultants	SAS	Trust Doctors
End of Contract	2	2	4
Left (alternative work)	5	3	1

Table 9 shows the grade of leavers. Fifty four per cent of leavers were consultants.

Section 7: Mind the Gap Payments

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

Table 1	AMH	CYPS	MHOSP	LD	FMH	FLD	Total
D&D	10.75	4		3.5			18.25
Teesside	6	8.38	7	4			25.38
NY	2.7		4	1			7.7
Forensic					2.75	6	8.75
York	2	1					3
Total	21.45	13.38	11	8.5	2.75	6	**63.08**

Table 1 shows the number of additional PAs under Mind the Gap. This shows that the number of additional PAs has increased since last quarter (50.08). The most dramatic increases are in Adult Mental Health in Durham and Darlington. However, CYPS in Durham and Darlington and Teesside have reduced slightly. Teesside makes up 40% of the total additional payments.

Section 8: Medical Education Report

GMC Survey 2016

Each year the GMC undertake a national Junior Doctor survey to gain feedback upon the provision of quality training and support. In 2016 there was a high national response of 98.60%.

The survey has fifteen indicators:

- Overall satisfaction
- Clinical supervision
- Clinical supervision out of hours
- Reporting systems
- Handover
- Induction
- Adequate experience
- Supportive environment
- Workload
- Educational supervision
- Access to educational resources
- Feedback
- Local teaching
- Regional teaching
- Study leave

The feedback reports upon core and senior registrar, foundation doctors and GP registrar programme's with comparisons against local providers and national benchmarking.
It should be noted that York & Selby services transferred to TEWV in October 2015. During the initial transition period morale was low amongst Junior Doctors largely attributed to rota patterns. Following resolution the feedback remains consistently positive.

It has also been a challenging year with industrial relations and the introduction of the new Junior Doctor contract. National discussions with the BMA and NHS Employers may have adversely impacted upon morale which may have affected feedback.
Furthermore in 2016, we have seen the introduction of a national Trainer survey with seven indicators:

- Organisational Culture
- Supervisor Training
- Appraisal
- Time for Trainers
- Educational Governance
- Resources for Trainers
- Support for Trainers

Overall the Trust hosted (enter exact number) Junior Doctors placements for the following training programmes detailed in the table below:

Programme	Adult	MHSOP	CAMHS	LD	Forensic	Total
FP1	**27**	**16**	**0**	**0**	**0**	**43**
FP2	30	9	0	0	3	**42**
CT	**32**	**11**	**6 (1)**	**6**	**3 (2)**	**49**
GP	**30**	**10**	**0**	**0**	**0**	**40**
HT	**16**	**7**	**9**	**4**	**3**	**39**
TOTAL	**135**	**53**	**9**	**10**	**6**	**213**

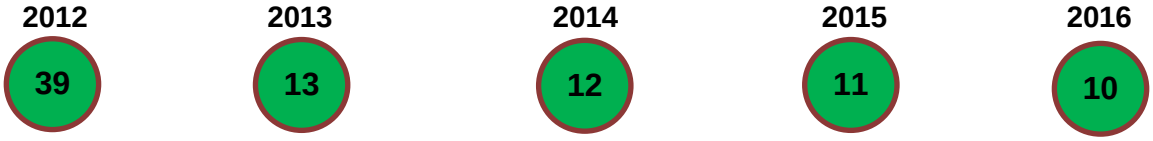
Those in brackets are on a service level agreement from LYPFT.

TEWV have achieved excellent feedback from the GMC Trainee survey consistently over the last four years and is now ranked one of the top ten trusts in the UK. The feedback has informed the strategic direction and shaped the Quality Improvement Plan for 2016 / 2017 to support the continued delivery of medical education and training.

Overview of national and local rankings

The following illustration ranks TEWV against 205 Trusts nationally and against regional organisations in HEE NE and HEE Y&H.

National Rankings by all Trusts (1-205)



Regional Rankings by all Trusts in North East (1-11)

Trainee Surveys

The Yorkshire & Humber medical school have run their own Junior Doctor survey which closed at the end of October 2016, the results are anticipated to be released at the end of January 2017.

Review of Faculty of Medical Education Roles

A full review took place in 2016 and all new faculty posts have been appointed to.

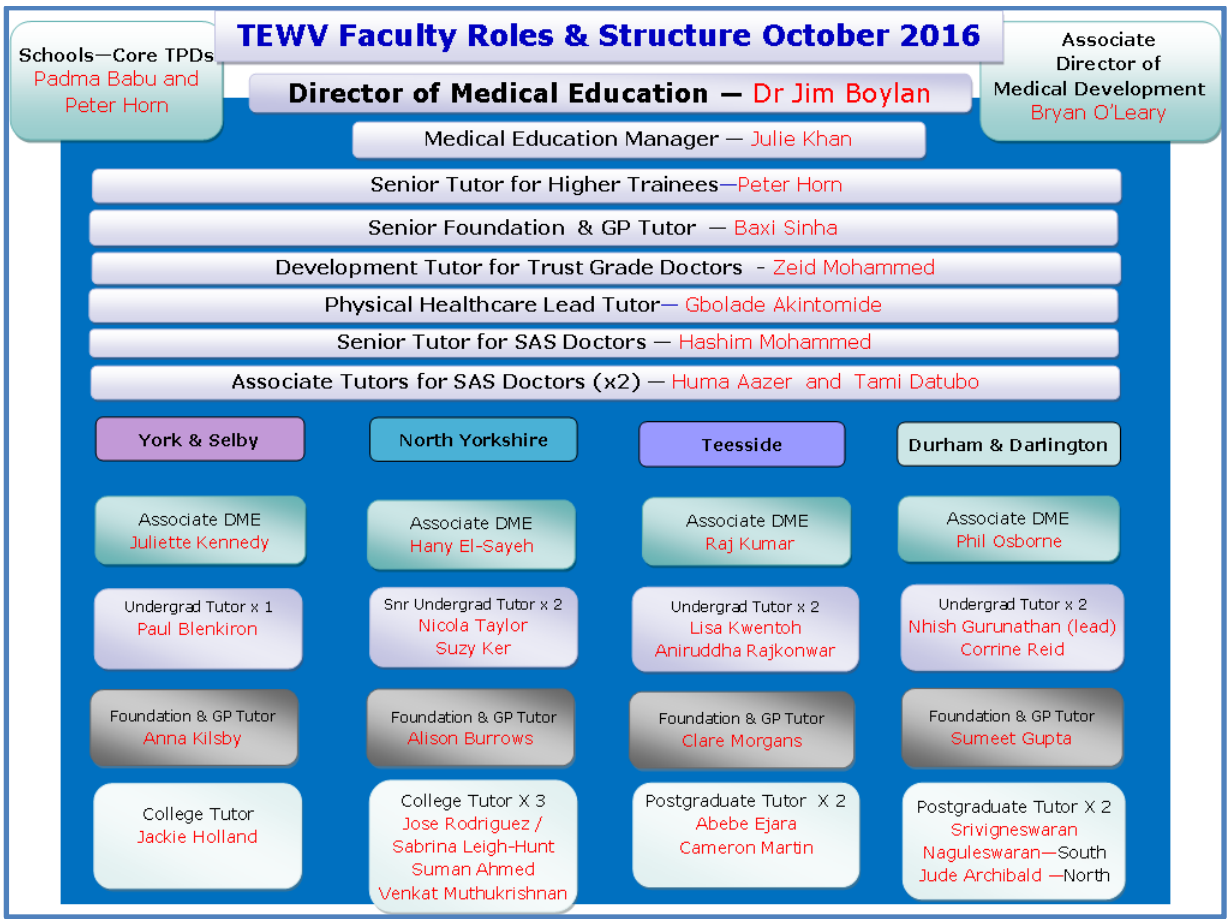
The Faculty is now made up of 7 Trustwide Roles, overseen by The Director of Medical education Dr Jim Boylan. Each of the four localities has their own structure of tutors that fully support the Undergraduate and Postgraduate Programmes.

The previous faculty structure was in place for four years and it was therefore an appropriate time to reflect and consider its relevance and how it could support the strategic drivers for the faculty over the next few years. It was also important to have a structure that complied with the new GMC standards set out in "*Promoting Excellence - standards for medical education and training" ,* and the Trust strategic direction.

Following consultation and workshops, significant changes were introduced. A weekly report out occurs in medical education which monitors operational targets and those set by each of the medical educational committees. There is a new cycle for all committees to meet with each having a clear agenda with actions and reports that flow in a timely manner into the senior strategic committee.

New tutor posts have been created to lead on key workforce and educational agendas, including: - ***Development Tutor for Trust doctors - Physical Healthcare Lead Tutor - Senior Tutor for Higher Trainees - Associate Tutors for SAS doctors x 2***

The new structure will enable the Trust to enhance and increase the level of operational support available to trainees and trainers. This aims to foster the key strategic and QIP objectives in medical education for quality assurance.



Medical Education Events - July to December 2016

The second half of the year, particularly November, turned out to be very busy with events, some of which had to be re-scheduled due to the Jnr Doctors Industrial action. However, our events officer managed to plan and reschedule them without too many casualties along the way!

Annual Medical Conference

In 2016 the Trainee Led Annual Medical Conference was cancelled as a result of industrial action related to the Junior Doctor contract. This has now been rescheduled to June 2017 with planning due to commence in January.

Faculty Development Day

In November we held the Faculty Development day which was attended by all tutors including new appointments.

Grand Round Teaching

November also saw the next session of the Grand Round Teaching event which was held at The Durham Centre, led by Dr Padma Babu, themed "Swimming against the Tide – Managing Difficult Decisions".

Annual Medical Education Awards

At the end of November, the department celebrated their Medical Education Annual Awards Event. Dr Jim Boylan hosted the evening at Judges Hotel. This year saw nominations for 12 separate categories relating to various Medical Education Roles within the Faculty of Medical Education. Guest of Honor was Dr Paul Rowlands, Head of School of Psychiatry for Yorkshire and Humber, whilst our very own Medical Director Dr Nick Land presented the Awards to our worthy winners. The event was also supported by members of the Medical Development Team.

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31st January 2017**
TITLE:	**Single Oversight Framework**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Decision**

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

Executive Summary:

The Single Oversight Framework (SOF) sets out NHS Improvement's approach to identifying the potential support needs of providers as they emerge.

It came into effect on 1st October 2016 replacing the Risk Assessment Framework.

The purpose of this report is to examine the data available to support internal monitoring of the Trust's position against the performance requirements of the SOF and to enable the Board to consider its assurance requirements and future reporting arrangements.

The report also highlights a potential risk in relation to the Trust's performance against one of the operational metrics included in the SOF and the action being taken to address this.

Recommendations:

Taking into account the information provided in the report, the Board is asked to consider its assurance requirements and future reporting arrangements in relation to the in-year information used by NHSI to monitor providers.

MEETING OF:	**The Board of Directors**
DATE:	**31st January 2017**
TITLE:	**Single Oversight Framework**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is:

(a) To examine the data available to support internal monitoring of the Trust's position against the performance requirements of the Single Oversight Framework (SOF).

(b) To enable the Board to consider its assurance requirements and future reporting arrangements.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Board Members will be aware that NHS Improvement (NHSI) published the SOF (replacing the Risk Assessment Framework) on 1st October 2016.

2.2 A summary of the main differences between the SOF and the Risk Assessment Framework (RAF) is provided in Annex 1 to this report.

2.3 The SOF covers five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability

This report focusses on the in-year performance information used by NHSI to monitor the quality of care, operational performance and the leadership and improvement capability (organisational health) themes.

2.4 The Board is asked to note that:

(a) NHSI will be developing its approach to identifying support needs under the strategic change theme; however, in the interim, it will be focussing on providers' contributions to developing, agreeing and delivering sustainability and transformation plans (STPs).

(b) Assurances on the Trust's position against the targets supporting the finance and use of resources theme are provided in finance reports.

2.5 NHSI has confirmed that the Trust has been placed in segment 1 (maximum autonomy).

3. KEY ISSUES:

3.1 It is considered that the Board will expect timely reports to provide assurance on the Trust's position against the triggers for support under the SOF and to highlight risks to the Trust's position in segment 1.

3.2 Board Members will be aware that, previously, the Board received reports to approve the quarterly governance returns required by NHSI in relation to performance against the indicators, etc. contained in the RAF. However, these governance returns are no longer required with NHSI, where practicable, using nationally available data in order to reduce the burden on providers.

3.3 In the absence of these returns, the Performance Team has undertaken an analysis of the data used by NHSI to monitor performance against the quality and operational metrics contained in the SOF. These scorecards are provided as Annexes 1 and 2 to this report.

3.4 In summary the key issues identified from this work are as follows:

(a) Although the SOF identifies data sources, the construction of a number of indicators is unknown or the relevant data has yet to be made publically available. This has led to uncertainty about how NHSI will assess the Trust's position.

(Note: The Performance Team has sought to identify where data is currently available (from either internal and/or external sources) in order to provide a rough indication of the Trust's likely position against those metrics.)

(b) Some discrepancies have been identified between internal data and that published in national datasets. This is being considered by the Trust's Data Quality Group.

(c) There are indicators where no data is available, either externally or internally, to support the assessment of the Trust's position.

3.5 Taking into account the issues highlighted in section 3.4 the Board is asked to note that:

(a) **Quality Metrics**

There are no targets for the quality metrics and NHSI uses "concerns arising from trends" to trigger potential support needs.

The analysis provided in Annex 2 gives some assurance that performance against the metrics is relatively stable.

It is, therefore, considered that the risks of the Trust being downgraded from segment 1 are low in relation to these indicators.

(b) **Operational Metrics**

The trigger in relation to operational metrics is failure to meet any standard for at least two consecutive timeframes (i.e. months or quarters depending on the frequency of monitoring); however, NHSI will, in determining segmentation, make a judgement based on its understanding of a provider's circumstances.

The key area of risk is considered to be in relation to the Trust's performance against the IAPT target "Proportion of people completing

treatment who move to recovery" as the target has not been met (based on both internal and external data) during 2016.

This matter will need to be addressed by the end of Quarter 4 (two consecutive quarters since the introduction of the SOF).

The Board is asked to note that:

- The County Durham and Darlington Locality has been asked to provide Commissioners with additional information and an action plan by the end of January 2017.
- Performance has improved significantly since the Trust became responsible for the IAPT service in York and Selby. At the request of the Vale of York CCG and the Trust, the national Intensive Support Team (IST) will be working with the Locality to support learning. The Chief Executive has also asked the IST to look at the provision of the service in North Yorkshire, generally, in view of variable performance.
- Work is also being undertaken to improve oversight of performance against this metric by the Operational Management Team.

In addition Board Members will note that the Trust did not achieve target for the indictor "Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards" in December 2016. This metric is monitored quarterly and assurance has been received that the required standard has been achieved for Quarter 3, 2016/17.

3.6 Notwithstanding the limitations highlighted in paragraph 3.4 above, it is recognised that there is a need to improve reporting to the Board on its position against the requirements of the SOF. It is proposed to do this in two ways:

(a) By exception in the monthly Performance Dashboard reports.

(b) Through quarterly reports on the in-year information used by NHSI against the quality of care, operational performance and the leadership and improvement capability (organisational health) themes. This will include both the quality and operational metrics and, by exception, third party information with governance implications.

The Board is asked to support this approach noting that, over time, it is expected that further information will be available from national data sources and data quality issues will be addressed.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** There are no direct CQC implications arising from this report; however NHSI's aim is to help providers attain and maintain CQC ratings of "good" or "outstanding".

4.2 **Financial/Value for Money:** Assessments of the Trust's position against the SOF's theme of finance and use of resources are provided in the Finance Reports.

4.3 **Legal and Constitutional (including the NHS Constitution):** The legal basis for enforcement action in relation to NHS foundation trusts remains unchanged. This means that, for example, a Foundation Trust will only be in segments 3 or 4 where it has been found to have been in breach or suspected breach of its licence.

4.4 **Equality and Diversity:** Information on delivering Workforce Race Equality Standards (WRES) will be used as part of assessments under the Leadership and improvement capability theme; however, no further information on this matter in included in the SOF.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks arising from the Trust not being able to accurately assess its position against the requirements of the SOF in view of the lack of information on the construction of metrics; information not being available from the national sources identified; and/or data quality issues.

5.2 There is also considered to be a risk to the Trust remaining in segment 1 due to performance against the IAPT indicator **"**Proportion of people completing treatment who move to recovery."

6. CONCLUSIONS:

6.1 The report highlights the present difficulties in assessing the Trust's position against the quality and operational metrics included in the SOF.

6.2 Notwithstanding these difficulties, and in anticipation that they will be addressed over time, it is considered that improvements should be made to the reporting arrangements to the Board on the in-year information used by NHSI to monitor providers.

6.3 The report also highlights underperformance against one of the SOF metrics and provides assurance on the action being taken to address this.

6.4 I would like to place on record my appreciation for the work undertaken by the Performance Team on the SOF scorecards which has been challenging.

7. RECOMMENDATIONS:

7.1 The Board is asked to:

(a) Receive and note this report.

(b) Support the proposals (as set out in paragraph 3.6) for future reporting on the in-year information used by NHSI to monitor providers.

(c) Note the risks arising from the report and the actions being taken to mitigate them.

Phil Bellas, Trust Secretary

Background Papers:
Single Oversight Framework published by NHS Improvement on 30th September 2016

Annex 1

Key differences between the Single Oversight Framework and the Risk Assessment Framework

	SOF	RAF
Scope	The SOF covers both Foundation Trust and NHS Trusts	Foundation Trusts only
Purpose	To help NHSI identify the potential support needs of providers as they emerge. To allow NHSI to tailor support packages to the specific needs of providers in the context of their local health systems.	To assess a NHS foundation trust's compliance with two specific aspects of its provider licence: the continuity of services and governance licence conditions.
Themes	▪ Quality of care ▪ Finance and use of resources ▪ Operational performance ▪ Strategic Change ▪ Leadership and improvement capability	▪ Financial sustainability ▪ Governance
Rankings	Providers placed in segments based on support needs: ▪ Segment 1 – Maximum autonomy ▪ Segment 2 – Targeted support ▪ Segment 3 – Mandated support ▪ Segment 4 – Special measures	Financial sustainability: 4 (no evident concerns) to 1 (material risk) Governance: Green (no governance concern evident) to red (enforcement action being taken)
In year monitoring information	▪ Quality metrics to identify areas for improvement ▪ Operational performance information ▪ Organisational health indicators ▪ Third party information (e.g. CQC, ombudsman, complaints, whistleblowers) with governance implications ▪ Delivery of STPs and progress on new care models (to be developed) ▪ Monthly finance returns	▪ Access and outcomes metrics (limited number for mental health) ▪ Third party reports ▪ Quality Governance indicators ▪ Finance and value for money metrics
Data Collection	Use of nationally collected and evaluated datasets, in particular for operational performance, wherever possible.	Generally through provider submissions

Triggers in relation to quality and operational indicators	**Quality metrics** - Concerns arising from trends in the quality indicators (Annex 2) **Operational metrics** (Annex 3) – Failure to meet any standard for at least two consecutive reporting periods; however, NHSI will make a judgement based on its understanding of providers' circumstances.	**Quality Governance indictors –** Material changes. **Access and outcome metrics -** Breach of a single metric in three consecutive quarters or four or more metrics breached in a single quarter.

SINGLE OVERSIGHT SCORECARD - QUALITY INDICATORS - 2016/17

All Providers													
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Comments**
Staff Sickness	NHS Digital	ESR Data Warehouse	M & Q	4.77%	4.59%	4.64%							The guidance identifies that NHS Digital is the source for this indicator; however, this does not match our internal data or the monthly finance submission to NHS Improvement. It is believed the reasons for this are linked to when the data is extracted.
		Finance Return to NHSI	M & Q	4.82%	4.70%	4.56%	4.62%	4.71%	4.84%	4.73%			
		Trust Dashboard (month behind)	M & Q	4.87%	4.76%	4.61%	4.69%	4.87%	4.92%	4.81%			
Staff turnover (Finance Return)	NHS Digital	Finance Return	M & Q	0.69%	1.03%	0.74%	0.73%	0.59%	0.81%	0.87%			No public data available, data taken from Finance Return
Executive Team turnover	Provider Return	n/a	M							0.00%	0.00%	0.00%	
NHS Staff survey	CQC	n/a	A	Construction unknown									The results of the 2016/17 survey are due to be recevied in February. In previous years the Trust's results have been better than average compared to other mental health and learning disability trusts
Proportion of temporary staff	Provider Return	n/a	Q	1.43%			1.50%						Finance Return to NHS Improvement (tbc)
Aggressive cost reduction (million)	Provider Return	n/a	Q	1.491			1.480						Finance Return to NHS Improvement (tbc)
Written complaints - rate	NHS Digital	n/a	Q	8.87			8.11						1st quarter NHS Digital, 2nd quarter internal data
Staff and Friends and Family test % recommended - care	NHSE	n/a	Q	83%									
		Strategic Direction Perf. Report	Q	82%			81%						It is believed the 1 percentage point difference is due to rounding.
Occurrence of Never Event	NHS Improvement	Governance	M	0	0	0	0	0	0	0	0		Data only published up to August 16, August onwards internal data
NHS England/NHS Improvement Patient Safety Alerts outstanding	NHS Improvement	Governance	M	0	0	0	0	0	0	0	0		Data only published up to August 16, August onwards internal data

Mental Health Providers													
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Comments**
CQC inpatient/mental health and community survey	CQC	n/a	A	Construction unknown									Information on the national patient survey has been received but as reported to the Board its format has changed. Work is being undertaken to provide a better assessment of the Trust's position. Generally the Trust's results from the survey have been good in previous years.

Quality Indicators	SOF Source	Other known source	Freq.	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
Mental Health scores from Friends and Family Test - % positive	NHSE	n/a	M	87.38%	86.93%	83.38%	86.69%	85.23%					
Admissions to adult faciliites of patients who are under 16 years old	NHS Digital	n/a	M										No public data available
		PARIS	M	0	0	0	0	0	0	0	0		
CPA follow up - proportion of discharges from hospital followed up within 7 days	NHS Digital	n/a	M	-	-	97.54%	-	-	-	-	-	-	The SOF references NHS Digital as the source and the frequency as monthly, however the data published states the source as UNIFY, which has quarterly data submitted. The quarterly Unify submission is based on validated data. Our internal data both pre validated and validated is available monthly; however there is a significant difference in this which needs to be addressed.
		UNIFY	M			97.54%			97.76%				
		pre validated IIC	M	91.19%	95.14%	`	97.83%	94.62%	94.58%	95.95%	93.48%		
		post validated IIC	M	96.35%	97.28%	97.21%	98.36%	96.77%	98.79%	97.69%	97.25%		
% clients in settled accommodation	NHS Digital	n/a	M			52.49%							The SOF identifies NHS Digital as the source but limited information is available. Internal data is available for patients on the CPA, which is provided. The construction of the SOF indicator is unclear at present.
		IIC	M	86.98%	86.88%	86.66%	86.72%	86.63%	86.26%	86.10%	85.81%		
% clients in employment	NHS Digital	n/a	M			7.10%							The SOF identifies NHS Digital as the source but limited information is available. Internal data is available for patients on the CPA, which is provided.
		IIC	M	11.15%	11.58%	11.67%	12.06%	12.35%	12.57%	12.51%	12.67%		
Potential under-reporting of patient safety incidents	NHS England Dashboard	n/a	M										The construction of the SOF indicator is unclear at present.

SINGLE OVERSIGHT SCORECARD - OPERATIONAL PERFORMANCE METRICS - 2016/17

Mental Health Providers														
Operational Performance Metrics	**SOF Identified source**	**Other Identiifed Source**	Freq.	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Comments**
Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	UNIFY2 and MHSDS	UNIFY	**Q**	**95%**			**96.77%**			**96.69%**				The SOF references NHS Digital as the source and the frequency as monthly, however the data published states the source as UNIFY, which has quarterly data submitted. The quarterly UNIFY submission is based on validated data. Our internal data both pre validated and validated is available monthly; however there is a significant difference in this which needs to be addressed.
		pre validated IIC			**86.00%**	**89.02%**	**83.02%**	**88.19%**	**81.46%**	**88.28%**	**83.85%**	**88.82%**		
		post validated IIC			**97.30%**	**97.56%**	**95.48%**	**97.10%**	**95.92%**	**97.14%**	**96.83%**	**93.92%**		
People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral	UNIFY2 and MHSDS	n/a	**Q**	**50%**	**50.79%**	**58.33%**	**67.31%**	**73.44%**	**73.68%**	**82.61%**	**71.70%**	**81.40%**		This data is currently published from the UNIFY submissions that are made monthly
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **inpatient wards**	Board declaration but can be triangulated with results of CQUIN audit	n/a	**Q**	**90%**										Work is currently ongoing to enable reporting of this data.
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **early intervention in psychosis services**			**Q**	**90%**										
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **community mental health services (people on CPA)**			**Q**	**65%**										
Complete and valid submissions of metrics in the monthly MHSDS submissions to NHS Digital - identifier metrics	MHSDS	IIC	**M**	**95%**	**99.36%**	**99.40%**	**99.41%**	**99.44%**	**99.48%**	**99.45%**	**99.43%**			No public data available, data shown is internal
Complete and valid submissions of metrics in the monthly MHSDS submissions to NHS Digital - priority metrics	MHSDS	n/a	**M**	**85%**										No public data available and construction unknown
IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	IAPT minimum dataset	n/a	**Q**	**50%**	**48.20%**	**41.92%**	**45.00%**	**44.79%**	**41.83%**	**42.58%**				Data only available until September on IAPT minimum dataset The SOF identifies the IAPT minimum dataset as the source for these indicators; however, the data does not match our internal data. It is believed the reasons for this are linked to the transfer of services from IAPTUS to PARIS for North Yorkshire and York & Selby.
		Internal Reports		**50%**	**49.95%**	**47.23%**	**49.56%**	**49.20%**	**45.87%**	**46.43%**	**47.68%**	**48.00%**		
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 6 weeks**	IAPT minimum dataset	n/a	**Q**	**75%**	**87.18%**	**92.53%**	**92.05%**	**91.46%**	**90.58%**	**95.68%**				
		internal IAPT reports		**75%**	**91.83%**	**94.90%**	**92.96%**	**94.78%**	**94.78%**	**96.55%**	**87.23%**	**96.97%**		
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 18 weeks**	IAPT minimum dataset	n/a	**Q**	**95%**	**88.24%**	**95.86%**	**96.43%**	**94.74%**	**94.00%**	**99.06%**				
		internal IAPT reports		**95%**	**96.83%**	**99.23%**	**97.33%**	**99.23%**	**99.64%**	**99.72%**	**99.24%**	**99.54%**		

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31st January 2017**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**31st January 2017**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
273	21.11.16	Extension to Standstill Agreement in relation to the Roseberry Park PFI scheme.	Brent Kilmurray, Chief Operating Officer Phil Bellas, Trust Secretary
274	29.11.16	Escrow Deed relating to land at Beckwith Knowle, Harrogate.	Colin Martin, Chief Executive Drew Kendall, Interim Director of Finance and Information
275	29.11.16	TP1 form relating to land at Beckwith Head Road, Harrogate.	Colin Martin, Chief Executive Drew Kendall, Interim Director of Finance and Information
276	29.11.16	Agreement in relation to the appointment of architect/lead consultant/principal designer services for the design of the York inpatient facility.	Colin Martin, Chief Executive Drew Kendall, Interim Director of Finance and Information
277	29.11.16	Warranty agreement relating to the provision of architect/lead consultant/principal designer services in connection with the York inpatient facility.	Colin Martin, Chief Executive Drew Kendall, Interim Director of Finance and Information

278	9.12.16	Extension to Standstill Agreement in relation to the Roseberry Park PFI scheme.	Colin Martin, Chief Executive Phil Bellas, Trust Secretary
279	11.1.17	Lease relating to The Dales, Durham Road, Stockton.	Colin Martin, Chief Executive Phil Bellas, Trust Secretary
280	11.1.17	Licence to carry out works relating to The Dales, Durham Road, Stockton.	Colin Martin, Chief Executive Phil Bellas, Trust Secretary

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

4.2 **Financial/Value for Money:** None identified.

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

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution (October 2015)
Seals Register

ITEM NO.16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31 January 2017**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

1 new policy has been developed and requires ratification:

- PHARM-0076-v1 Patient Group Direction (PGD) Overarching Policy

5 policies have undergone full review and require ratification:

- HR-0008-v4 Medical Remediation and Disciplinary Policy
- HS-0001-v9 Health and Safety Policy
- FG4.0 Restrictive Practices Framework
- IT-0022-v3 Telephone Usage Policy
- IT-0007-v6 Internet Policy

1 policy has undergone minor amendment and requires re-ratification:

- HR-0012-v7.5 Staff Development Policy

1 procedure that has undergone minor amendment and requires approval:

- CLIN-0076-V3 Guidelines for Early Warning Score (EWS) and Early Detection of the Deteriorating Patient

2 policies that have undergone full review but require no change. The review date is therefore to be extended 3 years.

- HS-0016-v1 Food Hygiene Policy
- CORP-0006-v6 Information Governance Policy

2 strategies and 8 policies requiring an extension to the review date:

- STRAT-0027-v1 Volunteering Strategy
- STRAT-0028-v1 Equality Strategy
- CLIN-008-v6 Non Compliance with Treatment Policy
- CLIN-0019-v5 Positive Approaches to Supporting People Whose Behaviour is Described as Challenging
- CLIN-0047-v5 Bed rails – safe and effective use policy
- CLIN-0029-v3 Management of Substance Misuse on Trust Premises
- HR-0011-v5 Disclosure and Barring Service Policy
- CLIN-0007-v5 Did Not Attend (DNA) Policy
- CLIN-0080-V1.1 Young people admitted to adult in-patient wards policy

Recommendations:

The Board are asked to ratify the decisions made by EMT on 11 January 2017

DATE:	**31 January 2017**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

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

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

3. KEY ISSUES:

3.1 The following new policy has been developed and requires ratification:

PHARM-0076-v1 Patient Group Direction (PGD) Overarching Policy
Review date: 11 January 2020

Best practice is to have an overarching policy for the development of Patient Group Directions (PGDs). This policy has been developed to assist services who may want to introduce PGD's as to the process, paperwork and systems around their use.

3.2 The following have undergone full review and require ratification:

HR-0008-v4 Medical Remediation and Disciplinary Policy
Review date: 07 December 2019

This policy has undergone full review to outline the Trust's procedure for handling concerns about doctors' conduct and capability in line with current best practice.

HS-0001-v9 Health and Safety Policy
Review date: 11 January 2020

This policy has undergone review and been updated with current legislative requirements.

FG4.0 Restrictive Practices Framework
Review date: 17 November 2016

This framework has been reviewed by Forensic Services SDG's restrictive practice workstream and as part of the 2016/17 CQUIN action plan and the following changes made:

- References to Kirkdale ward have been removed as the ward is no longer within the Forensic Locality.
- References to specific restrictions associated with smoking have been removed and a new section added on the Trust's smoke free status and why e-cigarettes are not permitted within the secure wards.
- Blanket restriction on mobile phones has been removed since they are now allowed on low secure units.

IT-0022-v3 Telephone Usage Policy
Review date: 11 January 2020

This policy has undergone full review and the following changes made:

- Removed 3.16 Best Practice and replaced with 3.16 Data Usage
- Updated Definitions
- Minor spelling errors corrected, Section 3.15 re-worded
- Section 3.26 Call Forwarding added

IT-0007-v6 Internet Policy
Review date: 11 January 2020

This policy has undergone full review and the following changes made:

- Section 2.1 amended to reflect multiple ways to access the Internet from the Trust network, specifically the Guest Wi-Fi. Also made reference to PATTI access being separate.
- Some minor grammatically and spelling amendments.
- Section 3.4, method of communicating down time changed.

3.3 The following underwent minor amendment:

HR-0012-v7.5 Staff Development Policy
Review date: 07 May 2017

The Training Needs Analysis section has been reviewed and updated.

CLIN-0076-V3 Guidelines for Early Warning Score (EWS) and Early Detection of the Deteriorating Patient
Review date: 11 January 2017

This procedure has been amended following revision to the Rapid Tranquilisation Policy. Due to the need to approve this procedure in a timely manner and Physical Health and Wellbeing Group meeting every two months, EMT are requested to approve the minor changes which are:

- Removal of: Physiological observations should be monitored every 30 minutes until patient is ambulatory on oral administration. If neuroleptic naive then follow parameters as for parenteral from section 4.4.2 Frequency of Monitoring (Rapid Tranquilisation). Appendices have been updated appropriately to reflect this change in line with the approved Rapid Tranquilisation Policy.
- Inclusion of: Assess temperature, heart rate, respiratory rate, blood pressure, level of consciousness and oxygen saturation in young people and adults with suspected sepsis and complete the EWS. Examine people with suspected sepsis for mottled or ashen appearance, cyanosis of the skin, lips or tongue, non-blanching rash of the skin, any breach of skin integrity (for example, cuts, burns or skin infections) or other rash indicating potential infection (NICE 2016 Sepsis: recognition, diagnosis and early management) to section 4.4.3 Additional consideration when monitoring and interpreting EWS, in line with updated Sepsis NICE guidance.

3.4 The following underwent full review but require no changes. The review date is therefore to be extended 3 years.

HS-0016-v1 Food Hygiene Policy
Review date: 11 January 2020

CORP-0006-v6 Information Governance Policy
Review date: 11 January 2020

3.5 The following required an extension to the review date:

STRAT-0027-v1 Volunteering Strategy
Review date: 31 December 2017

STRAT-0028-v1 Equality Strategy
Review date: 31 December 2017

CLIN-008-v6 Non Compliance with Treatment Policy
Review date: 31 March 2017

Extension to the above policy is required whilst the current version is under review.

CLIN-0019-v5 Positive Approaches to Supporting People Whose Behaviour is Described as Challenging
Review date: 31 March 2017

The above policy has undergone full review and is currently out to Trust-wide consultation. Extension is required to allow time for the approval and ratification process.

CLIN-0047-v5 Bed rails – safe and effective use policy
Review date: 05 November 2017

Extension to this policy is requested whilst it undergoes full review and rewrite.

CLIN-0029-v3 Management of Substance Misuse on Trust Premises
Review date: 31 March 2017

The above policy is in the process of being rewritten. Extension is requested until this work is completed.

HR-0011-v5 Disclosure and Barring Service Policy
Review date: 31 December 2017

A review of this policy required no amendments and extension is requested for 12 months.

CLIN-0007-v5 Did Not Attend (DNA) Policy
Review date: 31 March 2017

The policy has undergone full review and is currently out to consultation. An extension to the review date is requested while this work is completed.

CLIN-0080-V1.1 Young people admitted to adult in-patient wards policy
Review date: 31 March 2017

The policy has undergone full review and is currently undergoing clinical approval. An extension to the review date is requested while this work is completed.

3.6 The two documents CORP-0001 Governance of Policies and Procedures and CORP-0001-01 Policies, Procedures, Protocols and Guidelines – Guidance for Writers are currently in the process of being merged into one document to meet an audit recommendation. The revised policy was ratified at the Executive Management Team at the meeting held on 18th January 2017.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

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

4.4 Equality and Diversity:

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

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meeting on 11 January 2017 have been presented for ratification.

7. RECOMMENDATIONS:

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

Author: Colin Martin
Title: Chief Executive