AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 21ST JUNE 2016
VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON
AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meeting of the Board of Directors held on **24th May 2016**.		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 7	To consider the Nurse Staffing Report including the outcome of the trial of the Hurst and Telford approaches to safe staffing at West Park Hospital.	**EM**	**Attached**
Item 8	To receive and note a report on the Trust's approach to the recruitment, development and retention of nurses.	**DL**	**Attached**

Performance (10.35 am)

Item 9	To consider the Finance Report as at 31st May 2016.	**DK**	**Attached**
Item 10	To consider the Trust Performance Dashboard as at 31st May 2016.	**SP**	**Attached**

Items for Information (10.50 am)

Item 11 Policies and Procedures ratified by the Executive Management Team. **CM** **Attached**

Item 12 To note that the next meeting of the Board of Directors will be held on Thursday **21st July 2016** in Room J007/8 Cleveland Way, Roseberry Park, Middlesbrough at 9.30 am.

Confidential Motion (10.55 am)

Item 13 **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 any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

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

Any 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
15th June 2016

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 24TH MAY 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
Mrs. B. Matthews, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. D. Kendall, Acting Director of Finance and Information
Mr. B. Kilmurray, Chief Operating Officer
Dr. N. Land, Medical Director
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mrs. M. Booth, Public Governor for Middlesbrough
Mr. P. Bellas, Trust Secretary
Mrs. J. Illingworth, Director of Quality Governance
Mrs. J. Jones, Head of Communications

Ms. D. Adams, Ms. S. Birkbeck and Ms. H. Boagey, student nurses.

16/117 APOLOGIES

Apologies for absence were received from Mrs. E. Moody, Director of Nursing and Governance.

16/118 MINUTES

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

16/119 PUBLIC BOARD ACTION LOG

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

Mr. Levy sought the Board's permission to defer taking out a paid for advertisement in the York Press linked to the Peppermill Court refurbishment (minute 16/36 - 23/2/16 refers) to June 2016 as a report on recruitment in the York and Selby Locality was due to be considered by the Executive Management Team early in that month. This was agreed.

Mr. Bellas undertook to make the above change to the Action Log.

Action: Mr. Bellas

16/120 DECLARATIONS OF INTEREST

Mr. Kendall declared an interest in a matter included in the report of the Nomination and Remuneration Committee (item 10 of the private agenda).

No discussion took place on the report and Mr. Kendall was not required to leave the meeting.

16/121 CHAIRMAN'S REPORT

The Chairman:

(1) Drew attention to her report to the meeting of the Council of Governors held on 19th May 2016.

(2) Reported that on Monday 23rd May 2016 she had spent an enjoyable afternoon with the Experts by Experience.

Mrs. Bessant considered that it would be beneficial to invite Dr. Alison Brabban (Recovery Lead) to provide a briefing to the Board on the recovery programme when the business case for the next phase of its implementation was due to be considered.

Action: Mr. Kilmurray/Mr. Bellas

Board Members also considered that it would be useful to invite the Experts by Experience to attend Board Seminars to provide their stories.

Action: Mr. Kilmurray/Mr. Bellas

16/122 GOVERNOR ISSUES

No issues were raised.

16/123 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 7th April 2016 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 5th May 2016.

Dr. Griffiths, the Chairman of the Committee, drew attention to the following matters included in the report:

(1) The plan to commission external support to undertake a thematic review, in response to the apparent increase in serious incidents relating to patients on planned leave, in order to identify common learning points to be shared across the Trust.

(2) The proposal that a briefing should be provided to a Board Seminar on human rights.

Mr. Levy considered that it would be useful to invite a representative of the British Institute of Human Rights to provide the briefing and this should be focussed on

how the Human Rights Act related to the Trust's day to day activities and the key issues of which the Board needed to be aware.

Board Members supported this approach.

Action: Mr. Levy and Mr. Bellas

Mr. Bellas undertook to discuss the issues highlighted by the Non-Executive Directors about the availability and completeness of the report with staff in his Department.

Action: Mr. Bellas

16/124 NURSE STAFFING REPORT

The Board received and noted the report on nurse staffing for April 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. Illingworth highlighted the following matters contained in the report:

(1) The nett increase in the number of rosters from 66 in March to 69 in April 2016 as a result of the inclusion of the York and Selby Locality and service changes (e.g. the merger of Earlston House with Willow Ward) during the reporting period.

(2) The month on month trend being "green" across all fill rates.

It was noted that this was largely due to the inclusion of data for the York and Selby Locality.

(3) The decrease in the number of wards rated "red" from 55 in March to 38 in April 2016.

(4) Forensic services having the highest number of "red" rated wards, at 13, but that this represented a reduction on the March 2016 position.

(5) White Horse View having the lowest fill rate.

It was noted that this unit had now closed.

(6) Bek, Talbot and Ramsey Ward having the second lowest fill rate due to a reduction in the number of beds as a result of the Transforming Care agenda.

(7) Westerdale South having the highest fill rate.

It was noted that the Ward's budgeted establishment had been increased to support enhanced observations.

(8) Cedar Ward, Westerdale South and Merlin Ward having bank usage in excess of 50%.

(9) Agency usage for the month equating to 1% of the total hours worked with two wards, Worsley Court and Springwood, using agency staff.

(10) The triangulation of staffing and quality data including:

- (a) PALS related issues being raised on Merlin Ward and Cedar Ward with both wards having high bank usage and the former having a high fill rate.
- (b) The Westwood Centre being the highest user of control and restraint but the number of incidents, 53, representing a significant reduction on the March 2016 position.

(11) The 1,146 shifts during the month where a break had not been taken.

Mr. Kilmurray advised that the position included areas where breaks were not rostered e.g. at Bankfields Court where staff had their meals with patients;

however, he recognised that there were some units where staff had difficulties taking breaks at night and this matter was the subject of ongoing discussions with Staff Side.

(12) The 14 DATIX incidents citing staffing levels raised during the month which were summarised in the report.

Overall it was noted that the triangulation of staffing and quality data had not identified any direct risks or implications to patient safety or experience within the reporting period.

Board Members:

(1) Sought clarity on:

(a) The actions which had contributed to the improved position on safe staffing shown in the report.

On this matter Mr. Kilmurray advised that recruitment had improved but it was too early to judge whether the improvements shown in the report constituted a trend.

It was also noted that:

- Some of the improvements were as a result of the inclusion of data for the York and Selby Locality.
- A new feature was the recruitment of staff for forensic learning disability services through agencies.
- Ongoing staffing issues in the North Yorkshire Locality remained a concern.

(b) The relationship between the "RAG" ratings for safe staffing fill rates.

Mrs. Illingworth explained that, although each fill rate in the month on month trend report for all Localities was rated "green", there were some "red" rated wards.

The Non-Executive Directors highlighted the importance of maintaining granularity in reporting.

(c) Whether reporting using the DATIX system was consistent.

Mrs. Illingworth advised that reporting was variable and there was evidence of some issues being reported through the system which should have been escalated through management routes.

It was noted that the Operational Management Team had considered the adoption of a standard approach to staffing escalation processes.

(2) Raised the issue of "annual leave" and "unknown" continuing to be given as reasons for bank usage as this had previously been deemed unsatisfactory by the Board.

In response it was noted that annual leave should not be the primary reason for bank usage but it might be appropriate in combination with other factors e.g. where units were experiencing pressures and staff had difficulty arranging leave.

(3) Discussed a DATIX incident where a staff member had accompanied the nurse in charge, who was pregnant, when escorting a patient from a ward for a cigarette, to ensure security, in the context of the appropriate use of staff time and compliance with the Smoking Cessation and Nicotine Management Policy.

In terms of future reporting arrangements, at the request of Board Members, Mrs Illingworth undertook to discuss with the Head of Quality Data:

(1) Whether issues arising from the compilation of rosters (e.g. fill rates where bed closures had taken place) could be removed from future reports.
(2) The use of rolling 12 month reporting in the graphs included in the report to aid comparison.
(3) The inclusion of the outcomes of investigations into serious incidents where staffing issues were found to have been a contributory factor.

Action: Mrs. Illingworth

Mr. Levy also advised that issues identified by the task and finish group which was focussing on missed breaks and compliance with EU Working Time Directives could be fed into future reports to complement the information provided.

16/125 MENTAL HEALTH LEGISTLATION COMMITTEE REPORT

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

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

Mr. Simpson, the Chairman of the Committee, highlighted the following matters:

(1) The Committee had not received reports on seclusion at its last couple of meetings since recording of this matter had become part of the electronic clinical record.

He advised that the issues were being addressed and the reports should be available in the future.

(2) The Trust had sought to respond to a consultation on proposals to amend Section 136(2) of the Mental Health Act (MHA) as part of the Policing and Crime Bill but the deadline for responses had been brought forward. Alternative means of presenting the Trust's views on the proposed changes were being explored.

In response to a question, Dr. Land explained that the advice provided by street triage services enabled the police to make more informed decisions on whether or not a person needed to be taken to a place of safety and should, therefore, reduce the use of Section 136 of the MHA.

16/126 WAITING TIMES ACTION PLAN

Further to minute 15/320 (24/11/15), the Board received and noted a progress report on the Trustwide Waiting Times Action Plan (Appendix 1 to the report).

In introducing the report Mr. Kilmurray advised that:

(1) As shown in the Performance Dashboard as at March 2016 (Appendix 2 to the report) there had been a slight deterioration on waiting times during 2015/16.

(2) The original Trustwide action plan had focussed on adult mental health services. This had mostly been completed and there had been improvements in performance. The majority of those teams that were not achieving target were, at present, part of the "Teams in Difficulty" process.

(3) There was ongoing pressure on waiting times in children and young people's services (C&YPS). Whilst there had been increases in referrals across all the Localities, the reasons for not achieving the target were different in each service. The position in each Locality was as follows:

(a) Despite difficulties, steady improvement had been made in Tees C&YPS in recent months and all new referrals had been seen within four weeks since April 2016. However, there were a number of young people waiting who had been referred earlier and it was anticipated that this backlog would be cleared by the end of the Quarter.

(b) C&YPS in North Yorkshire had struggled to match capacity with demand. Action to address staffing pressures, which had compounded the situation, was progressing. It was considered that the development of a "Single Point of Access" for all C&YPS referrals would be likely to have the most significant impact on waiting times.

(c) The position in County Durham and Darlington was the most concerning due to staffing gaps within the service. Through a more proactive approach to management, following a change to the leadership of the service and the appointment of the new Director of Operations, it was expected that there would be a marked improvement in waiting times by the Autumn.

It was noted that:

- A new action plan to address waiting times in the service had been developed (Appendix 3 to the report).
- The Locality would also be implementing a 'Single Point of Access' approach.
- The Specialty was reviewing and seeking to shorten the pathway for Autism Spectrum Disorder (ASD) assessments in view of evidence that present arrangements contributed to a large number of those waiting for more than four weeks.

(d) Early indications, following the recent successful implementation of the PARIS system, were that there was likely to be a large number of long waiters in the York and Selby Locality and this was expected to impact on performance at a Trustwide level.

(4) The Purposeful and Productive Community Services (PPCS) programme was aimed at addressing key service pressures, freeing up capacity and allowing

more purposeful and less wasteful activities. The implementation of the programme was, therefore, expected to have a positive impact on waiting times.

Arising from the report:

(1) Mrs. Pickering advised that the number of people waiting longer than four weeks was reducing. However, as the indicator was based on those people seen who had waited less than four weeks, once these people had been seen there was likely to be a short-term dip in performance.

(2) Dr. Land reported that feedback on the implementation of the first six products of the PPCS programme had been encouraging with teams reporting improvements in morale and reductions in sickness absence.

He observed that the PPCS programme was aimed at supporting teams achieve optimal productivity and, once they reached that position, any increase in referrals would need to be matched by additional investment.

(3) The Non-Executive Directors raised concerns about:

(a) Whether reductions in waiting times could be sustainable in the context of increasing demand.

(b) The impact of increasing demand on the Trust's ability to respond to those young people in the most need.

In response Mr. Kilmurray advised that:

(a) The Trust had sought to respond positively to service reductions by other organisations and to help children and young people in difficulty but resources were limited.

(b) The PPCS programme was improving productivity but a point would be reached where services were as efficient as possible.

(c) The development of "Single Points of Access" was critical in order that, following initial assessments, referrals could be directed to the most appropriate provider (e.g. the third sector) and enable the Trust to focus on those cases where it could add the most value.

However, with regard to this matter, the Chairman raised concerns about whether the proposed approach was realistic in the face of reductions to local authority budgets and the funding of third sector organisations.

(4) In response to questions from Non-Executive Directors, it was noted that:

(a) Action plans were in place for the "teams in difficulty" and these were subject to ongoing review.

(b) Failure to achieve expected waiting times in York and Selby would not lead to penalties for the first 18 months of the contract as a settling in period had been agreed with the CCG; however, there were risks that the service might not have sufficient capacity to achieve target in the longer term as the true level of demand became apparent.

(c) A briefing was to be provided to the Board Seminar in July 2016 on the PPCS programme.

Agreed *-*

(1) that the closure of the original working times action plan (Appendix 1 to the above report) be approved; and

(2) that a progress report on the work being undertaken to address waiting times in child and adolescent mental health services, including an update on the position in the York and Selby Locality, be provided to the Board at its meeting to be held on 27th September 2016.

Action: Mr. Kilmurray

16/127 COMPOSITE STAFF ACTION PLAN

Consideration was given to:

(1) A progress report on the Staff Feedback Action Plan and Locality Action Plans (Appendix 1 to the covering report).

(2) A proposed Trust action plan (the "Composite Staff Action Plan") which had been developed in response to the 2015 annual staff survey opinion results (minute 16/39 - 23/2/16 refers); the last three Staff Friends and Family Test (FFT) results; and the Investors in People assessment report 2014 (Appendix 2 to the covering report).

In his introduction to the report Mr. Levy highlighted the progress made in responding to issues raised in the staff surveys.

It was noted that:

(1) A review of the Trust staff survey results from 2010 to 2015 had highlighted that progressively fewer key findings could be compared year on year throughout the period due to frequent changes in their composition.

(2) Eight of the topics included in the 2015 action plan represented long term issues. Of these, the staff survey results relating to work related stress had been volatile but the remainder had been relatively stable. Although noticeable improvements had been made in 2011/12 only limited progress had been made since that time.

(3) A real issue in compiling the Composite Staff Action Plan had been the extent to which the Trust could achieve a real difference or whether it had reached a level where it was difficult to make further progress.

Mr. Levy advised that the action plan covered 9 themes and included over 50 actions; however, he believed that all of these were relevant and worth doing. Based on the findings of the review it had also been recognised that there was a need to have a greater understanding of issues before attempting to address them and this approach featured more prominently in the action plan.

The Board discussed the intended outcomes of the action plan.

The Chairman considered that it would be more beneficial to focus on delivering measurable improvements to the identified themes rather than focussing on improving related responses to the 2017 Staff Survey results and Staff FFT results, as stated in the action plan.

It was also noted that the staff survey results were based on perceptions and using performance measures in communications might help change staff views.

Mr. Levy responded that metrics were in place to support some of the themes and further ones could be developed; however, he cautioned that there were risks in placing too much reliance on these measures as the staff survey results had highlighted underreporting.

Action: Mr. Levy

The Board also discussed whether the FFT was having an impact in view of the need to improve this being identified as theme 9 of the action plan.

Mr. Martin advised that there were two elements: ensuring visibility of those teams where staff were not completing the FFT so that they could be targeted; and using the FFT results to make improvements. He suggested that the theme should be stated in two parts to reflect this.

Action: Mr. Levy

The Chairman asked the Executive Directors to reflect on whether there was sufficient capacity to deliver the action plan given other priorities.

Agreed -

(1) that the Composite Staff Action Plan (Appendix 2 to the above report), as amended, be approved; and

(2) that a progress report on the Composite Staff Action Plan be presented to the Board meeting to be held on 29th November 2016.

Action: Mr. Levy

16/128 APPOINTMENT OF THE FREEDOM TO SPEAK UP GUARDIAN

Further to minute 16/C/76 (22/3/16) consideration was given to a report on the proposed arrangements for the appointment of a "Freedom to Speak Up Guardian" for the Trust including a role description provided by the National Guardian's Office (Appendix 1 to the report).

Mr. Levy reported that:

(1) Amongst the recommendations of the "Freedom To Speak Up" review (2015), led by Sir Robert Francis QC, were that:

(a) A National Freedom to Speak up Guardian should be appointed and that every Trust should have a local Freedom to Speak Up Guardian. This recommendation had been accepted by the Secretary of State for Health.

(b) A national policy on raising concerns should be produced and adopted by all Trusts.

It was noted that, within the Trust, a Policy Sub-group had been asked to make proposals on the incorporation of the national policy (attached as Appendix 2 to the report) within the Trust's procedure for consideration by the Audit Committee, the Joint Consultative Committee and the Executive Management Team.

(2) Until recently Trusts had been given until September 2016 to finalise local plans and to appoint a Local Freedom to Speak Up Guardian before the end of March 2017; however, there was now a requirement for Local Guardians to be nominated by 1st October 2016.

(3) Guidance about establishing a Trust Freedom to Speak Up Guardian had been published by the National Guardian's Office in March 2016. This recognised that arrangements were likely to vary between organisations and individual Trusts were encouraged to undertake consultation prior to finalising their approach to fulfilling the national requirements.

(4) It was proposed to undertake consultation on the new role during June/July with a paper being presented to the Board at its meeting in July 2016. This would enable a Local Guardian to be nominated by the required date.

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

(1) The scope and purpose of, and arrangements for, the proposed consultation exercise.

Mr. Levy advised that:

(a) The consultation was intended to focus on how the role should be undertaken in the Trust.

(b) Feedback could be sought both electronically and from relevant groups if they were due to meet during the consultation period.

(c) In view of the limited timescale it was proposed to seek general feedback rather than views on actual proposals.

(2) The requirements placed on the Trust.

Mr. Levy confirmed that the Trust needed to identify an individual as the Trust's Local Guardian by 1st October 2016.

(3) The approach being taken by other Trusts to the nomination of their Local Guardians.

Mr. Levy reported that:

(a) Some Trusts had already appointed their Local Guardians but no single model for this had emerged.

(b) The Trust had decided, previously, not to progress the development of the role until the publication of national guidance and to enable the experiences of other Trusts to be taken into account.

(4) The potential penalties which could be imposed on Trusts if they failed to meet the requirement to nominate a Local Guardian by 1st October 2016.

It was noted that the requirement was included in the 2016/17 NHS Contract.

Agreed -

(1) that the proposal to undertake consultation with staff on arrangements for the Local Freedom to Speak Up Guardian during June and early July 2016 be endorsed; and

(2) that a report, with final proposals for the establishment of a Trust Freedom to Speak Up Guardian, be presented to the Board meeting to be held on 21st July 2016.

Action: Mr. Levy

16/129 ANNUAL REPORT AND ACCOUNTS 2015/16

For the financial year 2015/16 consideration was given to:

(1) The draft Annual Report including:
  (a) The Performance Report.
  (b) The Accountability Report.
  (c) The Quality Account/Report.
  (d) The Annual Governance Statement and other required governance statements.
  (e) The Remuneration Report.
  (f) The Annual Accounts.

(2) The draft Letter of Representation.

Details of two minor amendments to the Annual Report and Accounts were tabled at the meeting.

With regard to the above matters the Board took into account:

(1) The External Auditors' Audit Completion Report (ISA 260) and subsequent letter on the resolution of outstanding matters dated 19th May 2016.

(2) The External Auditors' draft report on the contents and indicators included in the Quality Report 2015/16 and their limited (scope) Assurance Opinion.

(3) The report of the Director of Finance on the Accounts.

(4) The report of the Chairman of the Audit Committee on the Committee's review of the Annual Report, the Quality Report and the Annual Accounts and related matters, taking into account the reports of the External Auditors, at its meetings held on 12th and 19th May 2016.

It was noted that:

(1) The Annual Governance Statement had been reviewed by the Committee and suggested amendments had been incorporated in the version included in the draft Annual Report.

(2) On the recommendation of the Committee, the Board, at its meeting held on 26th April, 2016, had received assurance that the Trust remained a "going concern" and had agreed that the Annual Accounts should be prepared on that basis.

(3) In its review of the Annual Report and Accounts the Committee had paid particular attention to:
  (a) The External Auditors' audit conclusions in relation to the significant risks and key areas of management judgement outlined in the Audit Strategy Memorandum.
  (b) Internal control issues identified from the transfer of staff from the York and Selby area and management's response to them.
  (c) Property valuation, noting that the impairments in 2015/16 had been previously reported and explained to the Board.

(4) Based on their work the External Auditors expected:
  (a) To be able to issue an unqualified opinion on the Annual Report and Accounts.

(b) To be able to conclude that:
"Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- *the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;*
- *the Quality Report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2015/16; and*
- *the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance."*

The Chairman asked for a full and final version of the Annual Report and Accounts to be circulated to Board Members.

Action: Mr. Bellas

Members of the Board confirmed that, to their knowledge, there was no relevant information of which the Trust's Auditors were unaware.

Agreed –

(1) *that the Annual Report 2015/16 including the Quality Report, Annual Governance Statement and Remuneration Report be approved;*

(2) *that the Annual Accounts 2015/16 be adopted;*

(3) *that the Chairman, the Chief Executive and the Director of Finance be authorised to sign, as appropriate, the Annual Report (including the Performance and Accountability Reports), the Accounts, the Statement of Financial Position as at 31st March 2016, the Annual Governance Statement, the Remuneration Report, the Statement of the Chief Executive as Accounting Officer, the Chief Executive's Statement on the Quality Report/Account, the Statement on the Responsibilities of Directors for preparing the Quality Report/Account, the Letter of Representation and any other necessary statements and certifications;*

Action: Mrs. Bessant, Mr. Martin and Mr. Kendall

(4) *that the Annual Report 2015/16 including the Annual Accounts and the Quality Report be submitted to NHS Improvement and Parliament; and*

Action: Mr. Martin and Mr. Bellas

(5) *that the Quality Account 2015/16 be submitted to the Department of Health.*

Action: Mrs. Pickering

16/130 ANNUAL REPORT AND ACCOUNTS OF THE CHARITABLE TRUST FUNDS 2015/16

Consideration was given to the Annual Report and Accounts of the Charitable Trust Funds 2015/16 taking into account:

(1) The recommendation from the Audit Committee, arising from its meeting held on 19th May 2016, that the above documents should be approved.
(2) The report of the Director of Finance.
(3) The summary report of findings arising from the External Auditors' independent examination of the Annual Report and Accounts.

The Board noted the Independent Examiner's statement made for and on behalf of Mazars LLP that:

"In connection with my examination, no matter has come to my attention:

(1) which gives me reasonable cause to believe that in any material respect the requirements to keep accounting records in accordance with section 130 of the 2011 Act; and to prepare accounts which accord with the accounting records and comply with the accounting requirements of the 2011 Act have not been met; or

(2) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached."

Agreed -

(1) that the Annual Report and Accounts for the Charitable Trust Funds 2015/16 be approved;

(2) that the Statement of Trustee Responsibilities and the Balance Sheet within the Charitable Trust Fund Accounts be signed and dated on behalf of the Board; and

Action: Mrs. Bessant and Mr. Martin

(3) that the Annual Report and Accounts of the Charitable Trust Funds 2015/16 be submitted to the Charities Commission.

Action: Mr. Kendall

16/131 FINANCE REPORT AS AT 30TH APRIL 2016

Consideration was given to the Finance Report as at 30th April 2016.

Mr. Kendall reported that:

(1) The Trust's financial position was ahead of Plan.
(2) The CRES position was in line with Plan.
(3) The Financial Sustainability Risk Rating for the month had reduced to 2 as a result of the planned repayment of loan capital but was due to recover to 4 in May 2016.

The Chairman noted that the total for the key financial drivers was at 100.8% for the month and hoped that this would reduce by May 2016.

16/132 PERFORMANCE DASHBOARD AS AT 30TH APRIL 2016

The Board noted that this report had been withdrawn from the agenda.

Mrs. Pickering reported that:

(1) Difficulties had been experienced in producing the Dashboard as a result of the meeting being held earlier in the month than usual and it being the first to feature the new indicators for 2016/17.
(2) It was intended that copies of the report would be circulated to Board Members, under separate cover, by the end of the month.
(3) Data for the previous year would be included in the report for the new indicators to provide contextual information.

16/133 STRATEGIC DIRECTOR PERFORMANCE REPORT AS AT QUARTER 4, 2015/16

Consideration was given to the Strategic Direction Performance Report as at Quarter 4, 2015/16.

Mrs. Pickering advised that:

(1) The report, based on a year on year comparison, showed an improving position.
(2) Although a number of the metrics included in the Scorecard were rated "red" in most cases performance on these was close to target.
(3) Performance on waiting times was the most significant issue highlighted in the report.
(4) The qualitative feedback included in the report, with regard to Strategic Goals 1 and 2, provided a level of confidence even if the Trust was not achieving individual targets.
(5) Significant progress had been made on delivering the Business Plan; however, requests had been received to extend the timescales for the implementation of a few priorities. It was not considered that these exposed the Trust to significant risk.

The focus of the Board's discussions was on metric 26 ("Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above)" which, with an actual score of 14.29% for the Quarter against a target of 40%, was rated "red".

Mr. Levy:

(1) Advised that, overall, the Trust had a good record of recruiting from within the organisation
(2) Acknowledged that there were risks that the pool of suitably qualified internal candidates for posts at Band 7 and above was drying up and action to address this was being taken through talent management processes.

Dr. Land observed that there could be a generational effect with staff at Band 6 being more comfortable and not willing to take on the additional responsibilities which came with promotion. This view was echoed by the feedback the Non-Executive Directors had received during their visits to services.

In response to a question it was noted that there was some anecdotal evidence of staff not willing to seek promotion by working outside their Locality.

In addition the Non-Executive Directors:

(1) Sought clarity on whether there was a correlation between a team's performance against the metric "Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days" and other indicators of quality e.g. participation in the "teams in difficulty" programme.

The Board noted that it was not known whether performance against the metric had been triangulated with other quality indicators but there were a number of reasons for delays in completing action points including the workloads of, and competing demands on, individual staff.

(2) Highlighted that the Board's permission was being sought to re-scope the business plan priority "Develop and implement plans to deliver significant service changes/developments required for each service - Improve the way community CYP services are delivered (Locally Accessible Services)" and emphasised the importance of getting traction on this issue in the context of the discussions on the waiting times action plan (minute 16/126 refers).

Agreed -

(1) that the proposed changes to the Trust Business Plan (as set out in Appendix 1 to the report) be approved:

(2) that the suggested amendments to key performance indicators 23, 25 and 34 be approved.

Action: Mrs. Pickering

16/134 ANNUAL BOARD CERTIFICATES AND STATEMENTS

Consideration was given to a report on the annual Board Certificates and Statements required by NHS Improvement.

Based on the recommendation of the Audit Committee, following its review of assurances at its meeting held on 12th May 2016, it was:

Agreed –

(1) that the Certificate on Compliance with General Condition 6 of the Provider Licence be approved based on confirmation of both the following statements:

(a) "Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

(b) "The board declares that the Licensee continues to meet the criteria for holding a licence."

(2) that the Corporate Governance Statement based on confirmation of each component (as set out in Annex 1 to the above report) be approved;

(3) that NHS Improvement be informed that the Certificate on Academic Health Science Centres (AHSCs) and Governance is not applicable to the Trust;

(4) that the Certificate on the Training of Governors be approved based on confirmation of the following statement:
"The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."

(5) that the Chairman and Chief Executive be authorised to sign off the Statements and Certificates for submission to NHS Improvement.

Action: Mr. Bellas

16/135 INFORMATION AND INFORMATION GOVERNANCE STRATEGY UPDATE REPORT

The Board received and noted the Information and Information Governance Strategy Update Report for Quarters 3 and 4, 2015/16.

The Non-Executive Directors highlighted that the report would have benefited from an executive summary.

In response to questions:

(1) It was noted that NICE guidelines were taken into account when developing the pathways which underpinned the Clinical Decision Support Systems.

Dr. Griffiths asked to be provided with an algorithm or practical example of a pathway.

Action: Mr. Kilmurray

(2) Mr. Kendall advised that the database issues which had affected the availability of the Integrated Information Centre (IIC) in March 2016 and the monthly performance run had been resolved; however, the Extract Transport Load would be kept under review as more systems were linked into the IIC in the future.

(3) Assurance was provided that the Trust notified the Information Commissioner's Office, where appropriate, of information security incidents but these were not always followed up by the regulator.

16/136 USE OF THE TRUST SEAL

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

16/137 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.

In response to a question, Mr. Martin undertook to arrange for information on the reasons why the three Patient Group Directions, listed in the report, had been removed and not replaced to be circulated to Board Members.

Action: Mr. Martin

16/138 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting of the Board of Directors would be held, in public, at 9.30 am on Tuesday 21st June 2016 in the Board Room, West Park Hospital Darlington.

16/139 CONFIDENTIAL MOTION

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

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 12.25 pm.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st June 2016**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

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

Date	Minute No.	Action	Owner(s)	Timescale	Status
26/05/2015	15/133	Consideration to be given to providing greater flexibility within the Trust's 12 hour shift system as part of the Working Longer Review	DL	~~Jun-16~~ Jul-16	
23/06/2015	15/170	Information on the three wishes raised by teams to be included in future reports on Directors' visits	BK	Jul-16	
24/11/2015	15/321	In future assurance on the self-assessment ratings of the Core Standards for Emergency Preparedness, Resilience and Response to be provided to the Board by the Audit Committee	BK	Sep-16	
15/12/2015	15/346	Reporting of the culture metrics, including the provision of information on trends, to be reviewed	DL	Jul-16	
26/01/2016	16/12	The Equality Data Document to be used in the 2016/17 Annual Planning Cycle	SP	Oct-16	
23/02/2016	16/36	A paid for advertisement, linked to the Peppermill Court refurbishment, to be taken out in the York Press	DL	Jun-16	
22/03/2016	16/64	Report to be provided to the Board on the Trust's approach to improving the recruitment, development and retention of nurses, and to provide assurance that longer term plans were not impacting on the present actions to address these issues in services	DL	Jun-16	See agenda item 8

Date	Minute No.	Action	Owner(s)	Timescale	Status
22/03/2016	16/65	The action plans and governance arrangements to take forward the Trust's equality objectives for 2016/2020 to be more explicit on the carrying forward and embedding of work to support the 2012 objectives	DL	Sep-16	
26/04/2016	16/94	Report to be provided to the Board on the outcome of the trial of the Hurst and Telford approaches to safe staffing at West Park Hospital	EM	Jun-16	See agenda item 7
26/04/2016	16/94	Report to be provided to the Board on the impact and lessons learnt from the Safe Staffing Project	EM	Nov-16	
26/04/2016	16/94	Consideration to be given to the feasibility of reporting data on missed breaks as both absolute numbers and percentages	EM	Jun-16	
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/PB	Dec-16	
24/05/2016	16/121	The Experts by Experience to be invited to attend Board Seminars to provide their stories	BK/PB	Sep-16	To be considered during the development of the 2016/17 Board Seminar Programme
24/05/2016	16/123	A briefing on human rights to be provided to a future Board Seminar	DL/PB	Nov-16	
24/05/2016	16/124	Discussions to be held with the Head of Data Quality in relation to future reporting on nurse staffing as follows: - Whether issues arising from the compilation of rosters could be removed from future reports - The use of 12 month rolling reporting in graphs - The inclusion of the outcomes of investigations into serious incidents where staffing issues were found to be a contributory factor	JI	-	Completed (Changes to be incorporated in the July 2016 Nurse Staffing Report)
24/05/2016	16/126	Approval to close the original waiting times action plan	BK	-	Approved
24/05/2016	16/126	A progress report on the work being undertaken to address waiting times in CAMHS, including an update on the York and Selby position, to be provided to the Board	BK	Sept-16	
24/05/2016	16/127	Approval of the composite staff action plan, as amended, to include: - performance metrics to support the identified themes - The division of theme 9 into two parts: improving staff awareness; and improving the impact of the Friends and Family Test	DL	-	Approved

Date	Minute No.	Action	Owner(s)	Timescale	Status
24/05/2016	16/127	A progress report on the Composite Action Plan to be presented to the Board	DL	Nov-16	
24/05/2016	16/128	Approval of the proposal to undertake consultation with staff on arrangements for the Local Freedom To Speak Up	DL	-	Approved
24/05/2016	16/128	Report on the final proposals for the establishment of a Local Freedom To Speak Up Guardian to be presented to the Board	DL	Jul-16	
24/05/2016	16/129	Approval of the Annual Report, including the Quality Report, and Accounts 2015/16 and their sign off including the Letter of Representation	Chairman/CM/DK	-	Approved
24/05/2016	16/129	The Annual Report, including the Quality Report, and Accounts 2015/16 to be submitted to NHS Improvement and Parliament	DK/PB	Jun-16	
24/05/2016	16/129	The Quality Report 2015/16 to be submitted to the Department of Health	SP	-	Completed
24/05/2016	16/130	Approval of the Annual Report and Accounts of the Charitable Trust Funds and authorisation to sign the Statement of Trustees Responsibilities and the Balance Sheet	Chairman/CM	-	Approved
24/05/2016	16/130	The Annual Report and Accounts of the Charitable Trust Funds 2015/16 to be submitted to the Charities Commission	DK	-	Completed
24/05/2016	16/133	Approval of changes to the Trust Business Plan and three KPIs in the Strategic Performance Scorecard	SP	-	Approved
24/05/2016	16/134	The completed Annual Board Statements to be submitted to NHS Improvement	PB	-	Completed
24/05/2016	16/135	Dr. Griffiths to be provided with an algorithm for, or practical example of, a pathway	BK	Jul-16	
24/05/2016	16/137	Information on the reasons for three Patient Group Directions being removed from the policy portfolio and not replaced to be circulated to Board Members	DK	-	Completed

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item 6

FOR GENERAL RELEASE

Board of Directors

DATE:	**Tuesday, 21 June 2016**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Assurance statement pertaining to QuAC meeting held 02 June 2016:
The Quality Assurance Committee have consistently reviewed all relevant Trust quality related processes in line with the Committee's Terms of Reference. Issues to be addressed have been documented, are being progressed via appropriate leads and monitored via the appropriate sub-groups of QuAC.

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

- LMGB reports were received from 3 localities (Tees, Durham & Darlington and York & Selby). Key issues raised were recruitment and retention, staffing pressures, waiting times, delayed discharges and out of locality admissions.
- Updates were received from the Patient Safety Group and the Patient Experience Group, as well as the Clinical Audit & Effectiveness Performance Report (Q4).
- The regular monthly update around CQC Compliance was received and the Safeguarding & Public Protection exception report.

- Quarterly reports were received from Workforce Staffing and Health & Safety and a 6 monthly update from the Research Governance Group.

- Exception reporting relating to concerns in services at Scarborough were noted along with an update on continuity arrangements in place to manage the significant bed pressures across the organisation.

Recommendations:

That the Board of Directors receive and note the report of the Quality Assurance Committee from its meeting held on 02 June 2016.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 21 June 2016**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 02 June 2016.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

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

3.1 **Tees LMGB** – where key issues raised were:

1. Recruitment and Retention of nursing and medical staff and initiatives to support this.
2. Bed occupancy at Roseberry Park at present was currently high and clinically challenging, together with managing patients from different localities.
3. The change in education provision at West Lane had caused significant impact on the children and staff, however exams had taken place and new teachers would work with the children on the site offering a reduced level of education.
4. Nursing home availability continued to decrease with another closure recently in Stockton, where dementia patients were cared for.

3.2 **Durham and Darlington LMGB** - where key issues raised were:

1. Waiting times in Adult Mental Health and Children & Young People's Services. The locality had the highest number of Adult Mental Health waiters over 4 weeks, accounting for 55%.
   On this matter it was noted that there would be an RPIW to look at improving the management of demand on services.

2. A new risk was highlighted relating to staff and patient safety at the PICU at West Park Hospital. The risk is exacerbated by the lack of seclusion facilities, acuity and risk of certain patients and unwillingness of the police to attend incidents.
   On this matter it was noted that the lack of a seclusion room was currently being addressed and initial cost estimates had been worked up. This work will form part of a trust-wide review of PICU.

3.3 York & Selby LMGB - where key issues raised were:

1. A number of Management of Change (MoC) processes have progressed however a number continue affecting large numbers of staff.
2. Adult inpatient services were operating under Business Continuity arrangements since the loss of inpatient wards at Bootham Park Hospital.
   On this matter it was noted that there were concerns around levels of staffing relating to sickness, vacancies and bank/agency use in MHSOP inpatient services. There had recently been successful recruitment to Peppermill Court however vacancies are still a concern.
3. Delays in progressing discharges remained a problem. Discussions were underway with Commissioners and LA representatives to improve processes.

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

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

4.1 Patient Safety Group

1. Enhanced reporting, particularly around unexpected deaths had been agreed following the recommendations of the Southern Health Report, including the request for a 72hr report to be completed on any reported death (regardless of apparent cause).
2. To ensure that all in-patient deaths are recorded via Datix. Current processes robustly capture all unexpected deaths however deaths from natural causes are not always reported.
3. Following identification of a trust-wide theme from incidents, it was agreed a review of unexpected deaths/self-harm whilst patients were on leave would be undertaken in July/August 2016.
4. The latest data from the National Reporting and Learning System (NRLS) had been provided for the Committee and showed that the Trust was in the lowest 25% of reporters nationally.
   On this matter it was noted that this figure did not correlate with the amount of incidents the Trust had actually reported through the Datix system. Work was underway with NRLS to review how incidents were being “pulled through” the system correctly. It was considered that this appeared to be a coding issue, rather than a reporting issue.
5. The Trust appeared to be an outlier in the reporting of self-harm incidents and this would be investigated further.

4.3 Patient Experience Group

1. There had been involvement with the Quality Strategy Review and comments had been fed into the project lead.
2. There had been no major trends in PALS with 125 raised during April 2016, which was an increase of 31 compared to last month. There had been 14 complaints received during April 2016, which was a reduction of 11 compared to March 2016.
3. Consideration would be given for a response to enquiries following "John's Campaign", where it had been suggested that relatives stay with people who have dementia on the Ward.
   On this matter it was noted that protected meal times and visiting times would need to be considered.

4.4 Clinical Audit & Effectiveness Performance

1. The current clinical audit programme completion status as at year end (Q4) was 91%, which was a significant achievement for all those involved in the delivery of the clinical audit programmes.
2. At the Clinical Effectiveness Group meeting held on 16 May 2016, it was noted that there was the requirement for a strategic forum to agree the strategic implementation approach to adopt new NICE guidance. This would include agreeing an implementation lead to oversee the baseline assessment process.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 Compliance with CQC Registration Requirements.

1. Following submission of evidence from all parties to the renewal hearing of the proposed judicial review, TEWV, LYPFT and the Claimants, the Judge had decided that there was no case to answer and the Judicial Review would continue only against the CQC.
2. The decision to include the provision of ECT from Bootham Park was still awaited.

6. GOVERNANCE

6.1 Workforce & Staffing

1. The TEWV Healthcare Assistant Career Framework had been implemented in 2012, however there still remained a large number of HCAs that had not completed the career framework and/or provided evidence of the required competencies.
2. The future operation of the Healthcare Assistant Career Framework would be reviewed, given the recent Government announcements around the apprenticeship levy form April 2017.
3. Student evaluation following placements across various areas of the Trust had been positive, however 2 student nurses had escalated their concerns about patient care and staff attitude and this was now the subject of a disciplinary investigation.
4. The next Workforce & Staffing report would discuss in more detail Equality and Diversity, which would then feed into the Board of Directors Seminar to give more consideration to this matter.

6.2 Safeguarding & Public Protection exception report

1. The MAPPA Serious Case Review in Durham had concluded and recommendations had been made to the MAPPA Strategic Management Board. This has been part of a Serious Case Review that will be published 11th July 2016.
2. A MAPPA serious case review had been started in Teesside around further offences from a person who was being managed under MAPPA. The terms of reference were currently being agreed.
3. There were larger than expected numbers of safeguarding adult alerts in York and Selby and the Safeguarding adult team were supporting this with an action plan in place across all MHSOP wards.
4. In Hartlepool the Serious Case Review relating to the same Serious Incident involving 1 adult and 2 children has commenced due for completion in October 2016.

6.3 Health, Safety, Security and Fire Working Group

1. The 2015/16 work plan had been signed off as complete and a draft work plan for 2016/17 had been approved and was attached for the Committee as an appendices.
2. There were slight concerns around the monitoring of the implementation of the electronic health and Safety work book. This had been launched in June 2015 when an audit of 26 work books had been conducted. The response had been poor at 54% and further audits would be undertaken by the Health & Safety team to improve compliance rates. In the meantime, paper audits would continue until further assurance could be provided through the electronic method.
3. There had been 988 incidents of violence and aggression against staff in 2015/16, compared with 1162 in 2014/15 and 68 incidents reported to the police in 2015/16, compared to 41 in 2014/15.
4. On this matter it was noted that the Trust was pursuing a private prosecution, after contacting NHS Protect regarding an incident where the police had not decided to take matters forward.

6.4 Research Governance Group Assurance

1. There had been a considerable amount of work undertaken to restructure the Research and Development team, led by Sarah Daniel with positive outcomes and a reenergised team.
   There would be locality based research assistants to support objectives of embedding research into the localities.
2. Following a review by Durham University of the Queen's Campus in Stockton the decision had been made to re-site the majority of the undergraduate teaching and research activities to Durham City, with the exception of the School of Medicine, Pharmacy and Health. The Queen's Campus would become an International Foundation Centre.

6.5 Exception Reporting (LMGBs, QuAC Sub Groups)

1. The current concerns and issues around services in Scarborough and significant bed pressures across the organisation were noted.

2. This had been raised at the Board of Directors on 24 May 2016 and continuity arrangements had been put in place with regular bed management discussions taking place at senior level with Heads of Nursing and Clinical Matrons, with some reduction in those pressures becoming apparent.
3. The outcome of 3 disciplinary investigations at Scarborough was imminent, which would alleviate some of the rostering difficulties.

7. IMPLICATIONS

7.1 Quality

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

7.2 Financial/value for money

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

7.3 Legal and Constitutional (including the NHS Constitution)

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

7.4 Equality and Diversity

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

8. CONCLUSIONS

The Quality Assurance Committee considered and noted the corporate assurance and performance reports that were received. The Committee were assured that all risks highlighted were being either managed or addressed with proposed mitigation plans.

9. RECOMMENDATIONS

That the Board of Directors note the issues raised at the Quality Assurance Committee meeting on 2 June 2016 and to note the confirmed minutes of the meeting held on 5 May 2016 (appendix 1).

Mrs Elizabeth Moody
Director of Nursing & Governance

Appendix 1

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 5 MAY 2016, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Mrs Jennifer Illingworth, Director of Quality Governance
Mr David Jennings, Non-Executive Director
Mr Brent Kilmurray, Chief Operating Officer
Dr Nick Land, Medical Director
Mr Colin Martin, Chief Executive
Mrs Barbara Matthews, Non-Executive Director
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr David Jennings, Non-Executive Director
Mr Jim Tucker, Non-Executive Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing & Governance (for minute 16/63)
Mrs Adele Coulthard, Director of Operations, North Yorkshire (for minute 16/59)
Dr Ahmad Khouja, Clinical Director, Forensic Disability Services (for minute 16/58)
Dr Jo Nadkarni, Consultant Psychologist - Children & Young People Services (CYPS)
Mrs Donna Oliver, Deputy Trust Secretary
Mrs Rachel Weddle, Head of Nursing, Forensic Services
Students: T-Jay Jones, Hannah Jubb, Christine Kirby, Natalie Lowery and Lauren Waites.

16/55 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Ingrid Whitton, Deputy Medical Director for Co Durham & Darlington and Mr Levi Buckley, Director of Operations, Forensic Services.

16/56 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 7th April 2016 be signed by the Chairman of the Committee.

16/57 ACTION LOG

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

The following updates were noted:

15/192 Data to be obtained from HR around the number of allegations made against staff that were substantiated, to be included in the next 6 monthly report.
It was noted that the number of allegations made against staff employed by TEWV would be now part of the Safeguarding & Public Protection report, broken down by locality, however the numbers substantiated would feature in the next Safeguarding & Public Protection exception report.

15/232 Need to understand the spike in Q2, July 2015 – Sept 2015 when supine restraint went up to almost 600.
This would be covered under minute 16/67.

Completed

15/232 A representative from Westwood Ward to attend QuAC and give a presentation on the progress with reduction of restraint.
This was covered under minute 16/67

Completed

16/25 Investigate the 2 week seclusion period on Bedale Ward.
The reference to Bedale Ward in this action was an error, due to the information being lifted from the FMH QuAG report and copied into the LMGB report. The issue was around an FMH patient in Northdale (FLD) seclusion that had been reviewed in line with policy, however escalated due to the duration and impact on seclusion availability.

Completed

16/26 Note of explanation to be added to information around level 3 incidents in the Quality Scorecard of the NY LMGB report.
Mrs A Coulthard highlighted that some work was currently underway to check fluctuations in the data of level 3 incidents, as currently the measurement included Tier 4 figures for self-harm.

16/26b Quality of Care and patient safety section of the NY LMGB report should include narrative go give explanation around the numbers reported.
It was noted that this section of the LMGB report also featured in the Patient Safety Report and would not be needed in future NY LMGB reports.

15/45 Review of table on page 8 of the Patient Safety report.
This would be brought back to the June 2016 QuAC meeting.

15/45 Bring back summary of restraint broken down by service directorates.
This was covered under minute 16/67.

16/47 Include an explanation in the Draft Quality Account, table page 22, that measuring can only be started once PARIS operational.

16/48 Analysis of dashboard indicators: to discuss with OMT how to ensure that in investigating breaches we can gain assurance that the care provided was appropriate.
In the absence of Mrs S Pickering this would be brought back to the June 2016 QuAC meeting.

Action: Mr B Kilmurray

16/58 FORENSIC LMGB REPORT

The Committee received and noted the Forensic LMGB report.

Dr Khouja, on behalf of Mr Buckley highlighted the top concerns at present, which were:

1. The use of novel psychotic substances (legal highs) in prison continued to have an impact on patients, as well as staff having to manage behaviours related to this.
   On this matter it was noted that at HMP Northumberland there had been a serious incident where prison staff had been taken hostage at knife point.

2. Ongoing capacity issues for seclusion, which had been escalated to CLODS and a piece of work was underway to look at future solutions to capacity and demand issues across the Directorates.
   On this matter it was noted that Forensic services had been hosting AMH patients, whilst at the same time AMH Bedale seclusion was hosting ALD patients.
3. The continued uncertainty around funding and lack of clarity around the Transforming Care agenda, both nationally and regionally.
4. Agency nurses had been recruited to support patient need in Forensics for the first time to help with ongoing qualified nurse staffing/recruitment issues.
5. Assessment of secure beds for prisoners was underway with some improvement on waiting times, however there were still 5 people in prison waiting for a secure bed with the Trust.

Following discussion it was noted that:

a) There were ongoing issues around patients accessing the internet and discussions over staff assisting patients to access the internet and assist with shopping on line. A Trust policy/procedure was currently being developed.
b) The CQUIN targets for 2015/16 had been fully achieved.
c) There had been some positive feedback around staff attitude in the Women's service, following a CQC visit to Sandpiper Ward.
d) A suicide prevention guide for those arrested for sexual offences had been introduced in the Durham Police force and would eventually be used in Cleveland.
e) The issue raised on page 6 of the LMGB report around the risks of an SUI due to staff shortages in FLD should be replaced with:

> "Concern raised over pressures on nursing staff, especially registered nurses which is resulting in often only 1 registered nurse on shift leading to pressures and possible breaches of seclusion policy in relation to nursing reviews where 2 registered nurses are required. Ward managers are working on shift to support registered nurse cover. The Senior team will meet and discuss this urgent issue as levels are close to crisis point. The report and findings of the Serious Incident review instigated following a lack of registered nurse cover for two night-shifts in December 2015 is expected to be reported in the near future by Patient Safety and the emerging themes are being explored".

f) Staff being turned away from First Response training for being late would be investigated further.

Action: Mr B Kilmurray/Mr L Buckley

g) There would be further investigation into an urgent referral into CAMHS recently where the patient was told there was a 4 week wait. Following submission of a Datix the patient was then offered an appointment in 1 week.

Action: Mr B Kilmurray/Mr L Buckley

16/59 NORTH YORKSHIRE LMGB REPORT

The Committee received and noted the North Yorkshire LMGB report.

Mrs Coulthard highlighted the top concerns at present, which were:

1. Difficulty accessing PICU beds in Middlesbrough, with 2 recent episodes where there had been reluctance by PICU staff to accept North Yorkshire patients. This had been escalated to the AMH risk register and would be discussed further at CLODs.

2. Staffing and recruitment continued to be an issue, with long term sickness and vacancies proving difficult to fill.
3. Funding restraints by the CCG would reduce the amount of investment into the Children's transformation plan, with a contract variation of £384k still awaited for 2016/17. This was linked to the specialist children's eating disorder service.
4. Joint meetings with CAMHs were being held around early intervention psychosis (EIP) to ensure process and pathways comply with CYP and AMH guidance.
5. The education provision had still not been resolved contractually with Middlesbrough Borough Council and Priory Education Group.
   On this matter it was highlighted that the Priory had commenced with legal proceedings against Middlesbrough Council.
6. Capacity issues had resulted in difficulty accessing rapid support for patients admitted from York & Selby. This would be discussed with the locality through the Service Delivery Group.
   On this matter it was noted that there were York & Selby patients occupying North Yorkshire beds.

Following discussion it was noted that:

a) There had been 4 incidents in Scarborough, 2 of which had resulted in a safeguarding investigation. 3 members of staff had been suspended from duty and investigations would now take place.
b) The improvement overall with the standardisation of the locality reports, however further work was required to ensure that the template headlines were consistent across all.

16/60 INFECTION PREVENTION AND CONTROL REPORT

The Committee received and noted the Infection Prevention and Control report for Quarter 4, January – March 2016.

It was highlighted from the report that:

1. There had been a reduction over the last quarter of patients admitted from Acute Trusts with MRSA.
2. Significant assurance had been received from Audit North, following a review of the IPC service
3. There had been a small increase in D&V, which was in line with the national picture.

The Committee received and noted the Annual Infection Prevention and Control Report for 2015/16 and the Annual Infection Prevention and Control Programme for 2016/17.

16/61 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee received and noted the Patient Safety Group Assurance report.

Arising from the report it was highlighted that:

1. New targets were proposed for 2016/17 for the Quality Strategy Scorecard, based on average performance for the last 4 months of 2015/16.
   On this matter it was noted however that other data should be used for benchmarking purposes when setting new targets.
2. Updated "smoke Free" posters would be installed across the Trust at hospital sites and premises. The introduction of smoke free sites had been well received by both staff and patients.

3. Regional work was underway to agree a consistent approach to mortality reviews following recommendations from the Southern Health Report and an event hosted by the Trust and Mazars in April 2016.
   On this matter it was noted that terms of reference had been written and shared and a further meeting would be organised with Mazars.
4. Work was being undertaken to analyse the apparent increase of serious incidents, particularly overdoses, occurring when patients were on planned leave. A thematic review of these incidents was planned, which would be undertaken by an external reviewer, to identify common learning points to be shared across the Trust.

16/62 PATIENT EXPERIENCE GROUP REPORT

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

Arising from the report it was highlighted that:

1. During March 2016 there had been an increase in complaints with 25 received Trust wide, which was an increase of 14 on the previous month.
   On this matter it was noted that 96% of complaints were meeting the 60 day timescale and good feedback had been received following evaluation of handling complaints recently.
2. The procurement process to tender for the new patient experience system was underway, with a decision due by July/August 2016.

16/63 SAFEGUARDING & PUBLIC PROTECTION GROUP REPORT

The Committee received and noted the Safeguarding and Public Protection Group report.

Arising from the report it was highlighted that:

1. There were serious case reviews ongoing, 3 in Hartlepool - 2 children's and 1 adult review. In Redcar & Cleveland there was an ongoing serious case review regarding the exploitation of 3 young people.
2. Compliance with Level 3 safeguarding training stood at 73% and concerns had been raised within the Clinical Quality Review Groups. Actions were in place to improve this figure and would be monitored via the Trust Safeguarding & Public Protection Board.

16/64 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

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

Arising from the report it was noted that:

1. The Trust had received an Order from the High Court granting permission to the Claimants to proceed against the CQC in respect of the Judicial Review, but refused permission against TEWV and LYPFT. However the Claimants had made an application to review the Judge's decision and a hearing for this would take place on 20 May 2016.
2. A request had been made in March 2016 to the CQC Registration Department to change the name of Bootham Park location to include the ECT suite – to date a response had not been received, despite attempts to expedite this.
3. There have been 2 MHA inspections and associated monitoring reports in the last month.
4. A Trust wide programme of mock inspections had taken place, with 43 wards and teams visited, which had been very positive. An overview report would be produced with key areas of good practice and learning highlighted. Each ward/team visited had received an individual action plan to be monitored through locality governance structures.

16/65 DRUG AND THERAPEUTICS COMMITTEE BI-MONTHLY REPORT

The Committee considered and noted the Drug and Therapeutics Committee bi-Monthly report.

The Drug and Therapeutics Committee had met on 24 March 2016 and arising from the report it was highlighted that the use of drugs for rapid tranquilisation in the York 136 suite had been discussed at length and following advice from the MHA office the decision had been made to remove these drugs. This had not impacted on patient care.

16/66 EQUALITY, DIVERSITY AND HUMAN RIGHTS REPORT

The Committee noted the report from the Equality, Diversity and Human Rights Steering Group following meetings held on 27 January 2016 and 13 April 2016.

1. There had been significant differences in the experience between patients of different ethnicities and patients that had identified as being LGBT, despite the presence of 55 clinical staff acting as 'equality experts'. Further work would be undertaken to understand the reasons for this and an action plan would be developed.
2. It was noted that all CQC inspectors would be receiving human rights training to enable them to take a human rights based approach to inspection in the future. This would be linked into the Mental Health Act team to promote a Trust wide narrative for staff around human rights.
3. The Board of Directors would receive a briefing at a future Board Seminar during 2016 to understand the strategic issues of human rights training and the interface with the recovery work underway in the Trust.

Action: Mr C Martin/Mr P Bellas

Following discussion it was noted that:

a) There should be more proactive engagement with local black mental health forums and Asian Women's groups.
b) The number of culture champions across the Trust would be reviewed.

16/67 FORCE REDUCTION QUARTERLY REPORT

The Committee received and noted the quarterly update report on Force Reduction as well as results from the 4th phase on the use of restraint in patient setting, covering CAMHS and LD wards.

It was highlighted from the report that:

1. The Force reduction project remained on track to fully implement the core interventions set out within the restraint reduction plan for 2016/17..
2. There was adequate support for staff who were routinely exposed to challenging patients through supervision and weekly reflective practice groups for nurses.
3. Environmental issues were currently being reviewed to improve alarm sounds on wards with the aim of reducing further potential trauma to surrounding patients, especially those with autism difficulties.
4. The impact on the complexity of patient care, due to the use of legal highs was raised as an issue for consideration, in conjunction with the use of seclusion and this would also be followed up by the Drug & Therapeutics Committee.

Action: Mr B Kilmurray/Mr C Williams

5. The Committee considered and noted the Draft Policy for Harm Minimisation and the Draft Supportive Engagement and Observations Procedure. The Draft Policy and Procedure would go to EMT for formal approval.

16/68 EXCEPTION REPORTING (LMGBs, QuaC sub-groups)

Mrs E Moody highlighted the work around seclusion that had been discussed at EMT recently, with the proposals to establish a framework for the escalation and monitoring of seclusion going forward. These developments would be reported back to QuAC in July 2016.

Action: Mrs E Moody

16/69 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD

There were no matters to escalate.

16/70 ANY OTHER BUSINESS

There was no other business to note.

16/71 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 2 June 2016, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

Email to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 4.50pm

……..

Dr Hugh Griffiths
CHAIRMAN
2 June 2016

ITEM 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st June 2016**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

The purpose of the report is to advise the Board of a 6 monthly review (1st December 2015 to 31st May 2016) of issues, trends and quality indicators in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review).

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

- Noticeable changes to staff in post can be observed within Durham and Darlington, Teesside and York Selby localities following the closures of Earlston House, Park House, Acomb Recovery Unit and Whitehorse View. This is the full year impact of agreed 2015/16 CRES
- Sickness was cited as the biggest factor impacting on staffing with 44 wards. Vacancies (16 wards) and Maternity Leave (13 wards) were cited as the second and third highest.
- Westerdale South were cited as the highest users of additional duties due to an agreed budget uplift which has not been reflected in HealthRoster.
- The 6 month average shows the actual hours worked exceeding the planned hours across all months.
- The month on month trend shows all 4 staffing fill rates reporting as 'green', this is largely due to the inclusion of York and Selby data. In terms of the values in May 2016 all with the exception of HCA days (0.5% decrease) are showing an improvement when compared to December 2015.
- Kingfisher/Heron/Robin are cited as having the lowest fill rate. This is due to the closure of the unit part way through the 6 month review.
- High bank usage relates to 8 wards in 3 localities.

- Agency usage relates to 10 wards but is predominantly used within North Yorkshire and York and Selby. It is important to highlight that this usage is not generating additional expenditure but instead utilising vacancies within existing budgets.
- All wards are using overtime to fill shifts however, those in excess of 4% equates to 22 wards. Forensic Services have been cited as using the most overtime.

- In terms of the triangulation:
  - Cedar (NY) were cited as having an SUI, level 3 incident, a complaint and high user of control and restraint. In addition to using overtime in excess of 4% and agency workers. This ward is reporting as 'green' across all 4 fill rate indicators.
  - Bedale Ward had an SUI, level 3 incident, complaint and high user of control and restraint. In addition overtime in exces of 4% was utilised. RN on days is reporting as 'red' within the fill rate whilst the others are either reporting as 'green' or 'blue'.
  - Westerdale South had an SUI, a level 4 incident and a fall resulting in significant harm in addition to creating additional duties, bank and agency usage. This ward is reporting as either 'green' or 'blue'.
  - Merlin ward were cited as a high user of control and restraint; and medication errors in addition to creating additional duties and and bank usage.
  - Bankfields Court had high levels of control and restraint in addition to creating additional duties.
  - Clover/Ivy had a level 3 incident in addition to creating additional duties and overtime in excess of 4%.
  - Mallard had a complaint in the reporting period in addition to creating additional dueites and bank usage.
  - Cedar Ward were cited as having high levels of control and restraint in addition to creating additional duties and bank usage.
  - Kestrel / Kite had a complaint during the reporting period and were cited as having high bank usage.
  - Robin had an SUI during the reporting period and were cited as having high bank usage
  - Langley had a complaint during the reporting period in addition to high bank usage.
  - Worsley Court had a complaint and were cited as using agency workers
  - Rowan Ward had a complaint, a fall resulting in significant harm and a pressure ulcer. In addition they were cited as using overtime in excess of 4% and using agency workers.
  - Springwood were cited as a high user of control and restraint, overtime in excess of 4% and a pressure ulcer as well as using agency workers
  - Meadowfields had a complaint during the reporting period in addition to using agency workers.
  - Rowan Lea had a complaint, a fall resulting in significant harm and a pressure ulcer in addition to using in excess of 4% overtime.
  - Ward 14 had an SUI in addition to using in excess of 4% overtime.
  - Newtondale had a complaint, medication errors as well as using in excess of 4% overtime.
  - Northdale received a complaint and were cited as using in excess of 4% overtime.
  - Wingfield had a SUI and a level 4 incident I addition to using 4% or more overtime.
  - Tunstall had a level 3 incident and a complaint. In addition to using 4% or more overtime.
  - Westerdale North had a SUI, a level 4 incident and a fall resulting in significant harm in addition to using 4% or more overtime.

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

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

MEETING OF:	**Board of Directors**
DATE:	**21st May 2016**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of a 6 monthly review (1st December 2015 to 31st May 2016) of issues, trends and quality indicators in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review).

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

The format of the report includes the 9 safe nursing indicators as outlined in the NICE Guidance for Safe staffing for nursing in adult inpatient wards in acute hospitals. Although the indicators are acute focussed there are some that can be applied to mental health and learning disabilities settings. In the absence of any guidance specific to mental health and learning disabilities this has provided a foundation to build upon. Further guidance specific to mental health and learning disability services is expected later this year as referred to in section 3.

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

3. KEY ISSUES:

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

3.2 Staffing and Establishments

3.2.1 The Secretary of State has requested a refresh of the existing NQB safe staffing guidance which is expected to be published in the Summer. Work

around safe staffing guidance for mental health and learning disability settings is currently being led by two Directors of Nursing and being consulted on within the national Nurse Directors and leads forum.

3.2.2 The NQB document is expected to include guidance on delivering safe and sustainable high quality care, with a focus on deliverability. The metric of Care Hours per Patient Day which has become currency within Acute Trusts this month as part of the Carter review may extend to other trusts. This metric however does not measure direct patient care and is a simple calculation of total care hours available divided by number of patients. In order to provide assurance, a triangulated approach to include professional judgement, evidence based tools, and national benchmarking will still need to be the focus. Some staffing indicators already appear in the benchmarking club Mental Health Toolkit, and this potential usage of the information will highlight the need for accuracy of information still further. It is likely that at least some sections of the guidance will move beyond the existing focus on nursing staffing to include the contribution of the wider MDT in calculating care hours per patient .

3.2.3 Within the trust we have established a safe staffing project 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 meeting, at monthly intervals, giving the opportunity for senior managers and Operational Directors within services to interface with Corporate colleagues working on the staffing agenda. A safe staffing project group has been established by the Deputy Director of Nursing which will report in to this OMT safe staffing group. There are four main strands to the work:

- A review of systems and compliance around e-rostering, ensuring best use is made of existing resources and considering any further technology based solutions to improve processes
- Consolidating the escalation processes for staffing concerns, both at a local ward based level and in terms of managers oversight of emerging issues, again with links to the technology
- The use of evidence based tools to inform the correct baseline staffing required and to take into account the time nurses spend on care and support, supported by observational studies
- The effective use of temporary and flexible staffing resources

3.2.4 As part of the preparation for this project, pilot studies are testing out tools and frameworks in two of our localities, Durham and Darlington and Teesside, using the Ward multiplier toolkit (as recommended in the existing National Safe Staffing framework) to provide an understanding of our position against the evidence based benchmarks for particular client groups.

The aim of these pilots are to carry out small scale testing of the tools in a variety of settings, to familiarise ourselves with the working methods required

and the issues which emerge in their day to day usage with staff groups. We will also compile the figures which emerge from the pilots to gain an early impression of the Trust position, while recognising at this stage not all testing will be to the full protocol required.

The second phase of this work, during quarter two of the year, will be to use this learning to roll the tools out across a broader range of sites, and then take stock of the emerging findings as reported to the OMT group before agreeing the final work plan. It is expected that the findings will be reported in more detail in the next six monthly Board report alongside an update the workstream overall. It seems likely that the refined national guidance will have emerged by that point also.

3.2.5 The budgeted staffing establishments as at 1st December 2015 and the 31st May 2016 have been obtained from HealthRoster and have been used to compare the actual establishments in post. Attached at appendix 1 of this report is the narrative of the breakdown by ward and locality. The key points are as follows:

- Durham & Darlington – Registered nurses in post has decreased by 8.7WTE and a reduction of 8.4WTE unregistered nurses can be observed. This is following the closure of Earlston House during the reporting period.
- North Yorkshire – An increase of 4.3WTE registered nurses in post can be observed and a reduction of 2.7WTE unregistered nurses is visible. This is attributable to 2 wards (Cedar NY and Westwood)
- Forensic Services – Actual registered nurses in post has reduced by 5.9WTE which is attributable to 5 wards (Sandpiper, Linnet, Newtondale, Northdale and Kestrel/Kite). In terms of unregistered nurses in post a reduction of 8.6WTE is visible, this relates to 4 wards (Swift, Lark, Harrier/Hark, Kingfisher/Heron/Robin) across the locality. The reductions are likely to be related to vacancies due to the number of wards identified that have equated to the total figures.
- Teesside – The actual number of registered nurses in post has decreased by 4.8WTE and a decrease of 1.9WTE can be observed with regards to unregistered nurses. These decreases are following the closure of Park House and the reallocation of staffing across the locality.
- York and Selby – Registered nurses in post has decreased by 21.1WTE and a reduction of 27.1WTE unregistered nurses. This is following the closure of Acomb Recovery Unit and Whitehorse View. The majority of staff have been redeployed into existing vacancies within the locality.

4. Workforce Variances

4.1 Sickness is cited as the biggest factor impacting on staffing availability. Followed by vacancies and maternity leave. Appendix 3 contains the full breakdown.

4.2 Where a patients observation levels change this requires additional duties to be created which are over and above the budgeted establishments. During the reporting period there were 6,612 shifts created which is a decrease on the last 6 monthly report whereby there were 6,925 shifts were created. This information will need to be broken down and considered when reviewing staffing establishments and flexible staffing solutions.

4.3 Westerdale South was highlighted as the biggest user of additional duties with 1,271 shifts (11,442 hours) created in the reporting period. This is in relation to an agreed uplift of budgeted establishments to support enhanced observations which has not been reflected in the HealthRoster system.

5. Planned versus Actual Hours Worked

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

5.2 The 6 month average shows that there were 33 wards who had fill rates of less than 89.9% for registered nurses on daytime shifts and only 4 wards for un-registered.

5.3 The night time position averaged across the 6 month period showed that there were 2 wards who had fill rates of less than 89.9% and for registered nurses and 0 wards for un-registered.

5.4 The month on month trend shows the average fill rate reporting as ‘green’ in May 2016 across all 4 indicators. This is attributable to the inclusion of York and Selby data. In terms of the actual percentages an improvement can be observed in 3 of the indicators when compared to December 2015 which was the timefrme for the previous six month Board report. A decrease can be observed with regards to HCA on day shifts by 0.5% when compared to December 2015.

5.5 Kingfisher/Heron/Robin have been identified as having the lowest fill rate. This is due to the closure of the ward during the reporting period. Therefore this cannot be considered as an outlier within the Trust.

6. Bank, Agency and Overtime

6.1 The highest users of bank equated to 8 wards from 3 localities within the reporting period. The bank usage for these 8 wards range between 40.4% and 67.3%.

6.2 Agency usage is evident from within 10 wards the majority of which are from the North Yorkshire and York and Selby localities.

6.3 All wards are using overtime however those that showing ‘red’ for this indicator i.e. greater than 4% this equates to 22 wards covering all localities. Forensic Services are using the most overtime whilst North Yorkshire and York and Selby are using the least.

7. Quality Indicators

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

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

7.3 Incidents where staffing had been used to categorise an incident on datix has been examined within this report. During the reporting period, 66 incidents were raised of which most were raised in Forensic Services. The majority of incidents cited inadequate staffing levels.

7.4 An escalation process and daily monitoring is a feature of the new safe staffing workstream and is being tested out in Tees locality with a view to gaining greater transparency, consistency and efficient response to staffing issues across the trust.

8. SAFE NURSING INDICATORS

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

8.2 One of the safe nursing indicators relates to missed breaks, a thorough analysis of the HealthRoster system has identified that there was 7,664 shifts within the reporting period where unpaid breaks had not been taken.

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

8.4 Inadequate rest time taken during duty hours is linked to staff burn out, exhaustion and the risk that this may ultimately impact on patient care.

8.5 A task and finish group is currently being led by HR and has been focussing on adherence to EU Working time directives. The monthly safe staffing reporting provides a monthly focus on staff breaks not being taken. It has been reported that the numbers reported on the roster do not always match those that the service records and further work is ongoing to understand this.

8.6 A small pilot of 2 wards (Elm and Maple Wards) has been undertaken within the Durham and Darlington locality whereby they were testing the ward multiplier staffing tools. Early findings have highlighted the following:

- Any findings have to be treated with caution as the trial covered 3 days which is considerably less than the recommended minimum period of 28 days, the aim at this stage being to try the tools out with staff groups,

familiarise with the process and learn lessons for a larger trial to follow, to ensure data accuracy at that point. In addition, some of the assumptions in the Hurst tools such as headroom calculation have not been validated against TEWV expectations. A furthe test is ongoing within Tees locality to repeat the work over a longer period of time and with different wards via the safe staffing workstream group.

- The calculations from the three day test (if applied over a longer period with similar acuity of patients and no arms length observations) demonstrated that the overall recommended WTE would be similar to the current establishment of the two wards however the recommended skill mix would be very different. Even assuming we maintained the position of only wanting 1WTE Clinical Lead, (which Hurst includes in the registered nurse overall calculation) the recommended registered staff ratio is considerably higher than the actual on site at present. In addition, whilst TEWV generally consider that one arm's length observation episode should be managed within the establishment, the Hurst tool recommends a staffing increase at this point which would make a noticeable difference to the baseline calculation where it applied. Within these caveats, the outputs are as follows:

	Current Budgeted Establsihements	Elm Recommendations	Maple Recommendations
Ward Manager	1.00	1.00	1.00
Clinical Lead	1.00	3.10	3.50
Staff Nurse	7.58	8.10	9.10
HCA	11.44	8.40	9.30
Total	21.02	20.70 WTE	22.90 WTE

- The difference between the two wards is explained by a combination of the acuity levels during the period, and the number of beds occupied.

9. IMPLICATIONS:

9.1 Compliance with the CQC Fundamental Standards:

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

9.2 Financial/Value for Money:

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. We are continuing to monitor via the safe staffing workstream 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 workstream to build on the existing safe staffing approach and help prepare for the likely requirements fo the new guidance. This workstream is managed within the OMT meeting as outlined in section 3.2.3 of this report.

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

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

The Trust has complied with these directives to date.

9.4 **Equality and Diversity:**

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

9.5 **Other implications:**

There are no other implications identified

10. RISKS:

We are awaiting the new staffing guidance and which might support the current absence of evidence based tools for workforce planning and monitoring. Its contents are largely unknown at present which may constitute a risk, however it is likely to build on our current approach to safe staffing and we think our new workstreams means we are well placed for the likely outcome.

An emerging risk is arising regarding the potential increase required in the ratio of registered nurses and the availability of such within the existing workforce.

11. CONCLUSIONS:

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

11.2 The safe staffing project and workstreams will review existing processes and prepare for the new requirements and any guidance during the financial year 2016/17. This will affect how data is collected and reported upon in the future.

11.3 There is an extensive analysis of the available data in this report however there are no clear correlations between these strands at present.

12. RECOMMENDATIONS:

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

- The four strands of work contained within the new Safe Staffing workstream will be reported upon outlining any key findings for the next report. There will also be recommendations with regards to the future use of the evidence based tools and the emerging national guidance.

- Bank usage currently turns 'red' at 40%; the original thinking was due to the trusts established nurse bank utilising in part our existing substantive workforce. This should be reviewed ensuring that this remains an acceptable tolerance within the Trust to highlight excessive bank usage.

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

Appendix 1

Safe Staffing Report

1.0 Staffing and Establishments

1.1 The budgeted staffing establishments as at 1st December 2015 and the 31st May 2016 have been obtained from HealthRoster and have been used to compare the actual establishment in post, the findings are as follows:

- ***Durham & Darlington:***
  - The budgeted establishment within Durham & Darlington for registered nurses in December 2015 was 136.30 WTE compared to 127.70 in May 2016; this is a decrease of 0.50 WTE. Actual registered nurses in post in December 2015 was 135.80 WTE compared to 127.10 WTE which is a decrease of 8.7 WTE's. The reduction in staffing is attributable to the closure of Earlston House during the reporting period.

  - The budgeted establishment for unregistered staff in December 2015 was 202.80 WTE compared to 193.40 in May 2016; this is a decrease of 9.4 WTE. Actual unregistered nurses in post as at 1st December 2015 was 196.70 WTE compared to 181.90 in May 2016 which is a reduction of 14.8 WTE's. The reduction in staffing is attributable again to the closure of Earlston House during the reporting period.

- ***North Yorkshire***
  - The budgeted establishment within North Yorkshire for registered nurses in December 2015 was 123.40 WTE compared to 124.40 WTE in May 2016; this is an increase of 1.0 WTE. Actual registered nurses in post in December 2015 were 115.10 WTE compared to 119.40 in May 2016 which is an increase of 4.30 WTE's. The increase is attributable to the Newberry Centre where an additional 3.70 WTE have been appointed.

  - The budgeted establishment for unregistered staff in December 2015 was 155.70 WTE and 154.00 WTE in May 2016. Actual unregistered nurses in post as at 1st December 2015 was 157.20 WTE compared to 154.50 in May 2016 which is a decrease of 2.7 WTE's. There are 2 wards across the locality who have reduce their unregistered nurses (Cedar Ward N/Y by 4.60 WTE and Westwood Centre by 3.50 WTE).

- ***Forensic Services***
  - The budgeted establishment within Forensic Services for registered nurses in December 2015 was 194.00 WTE compared to 185.90 in May 2016; this is a reduction of 8.10 WTE. Actual registered nurses in post in December 2015 were 170.60 WTE compared to 164.70 WTE in May 2016 which is a decrease of 5.90 WTE's. This reduction is not attributable to a single ward but 5 wards across the locality (Sandpiper, Linnet, Newtondale, Northdale and Kestrel/Kite).

  - The budgeted establishment for unregistered staff in December 2015 was 346.10 WTE and 338.80 WTE in May 2016. Actual unregistered nurses in post as at 1st December 2015 was 327.20 WTE compared to 318.60 WTE in May 2016 which is a reduction of 8.60 WTE's. This reduction is not

attributable to a single ward but 4 wards across the locality (Swift, Lark, Harrier/Hawk and Kingfisher/Heron/Robin).

- ***Teesside***
  - The budgeted establishment within Teesside for registered nurses in December 2015 was 126.80 WTE and in May 2016 was 119.00 WTE. Actual registered nurses in post in December 2015 were 127.30 WTE compared to 122.50 WTE in May 2016 which is a decrease of 4.8 WTE's.

  - The budgeted establishment for unregistered staff in December 2015 was 214.60 WTE and 203.60 in May 2016. Actual unregistered nurses in post as at 1st December 2015 was 201.60 WTE compared to 199.70 in May 2016 which is a slight decrease of 1.9 WTE's.

  - The reduction in staffing is largely attributable to the closure of Park House and the distribution of staff across the locality.

- ***York and Selby***
  - The budgeted establishment within York and Selby for registered nurses in December 2015 was 141.90 WTE and in May 2016 it was 40.70 WTE. Actual registered nurses in post in December 2015 were 61.00 WTE compared to 39.90 WTE in May 2016 which is a decrease of 21.10 WTE's. The reduction was attributable to the closure of Acomb Recovery Unit and Whitehorse View.

  - The budgeted establishment for unregistered staff in December 2015 was 107.90 WTE and 55.20 WTE in May 2016. Actual unregistered nurses in post as at 1st December 2015 was 109.30 WTE compared to 82.20 WTE in May 2016 which is a reduction of 27.10 WTE's. The reduction was attributable to the closure of Acomb Recovery Unit and Whitehorse View.

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

2.0 Workforce Variances

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

- 13 wards who had maternity absence greater than 5% loss of the actual hours
- 44 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
- 7 wards who had bank usage greater than 40% of actual hours worked
- 4 wards who had agency usage greater than 4% of actual hours worked

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

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

Month	Number of duties	Number of Hours
December	1,094	11,056
January	1,107	11,249
February	1,087	11,032
March	865	8,952
April	1,129	11,247
May	1,330	13,354
TOTAL	**6,612**	**66,890**

- This table highlights a fluctuating picture per month of the number of additional duties being created.

- 6,612 additional duties were created within the reporting period this is a reduction of 313 duties when compared to the previous 6 month period.

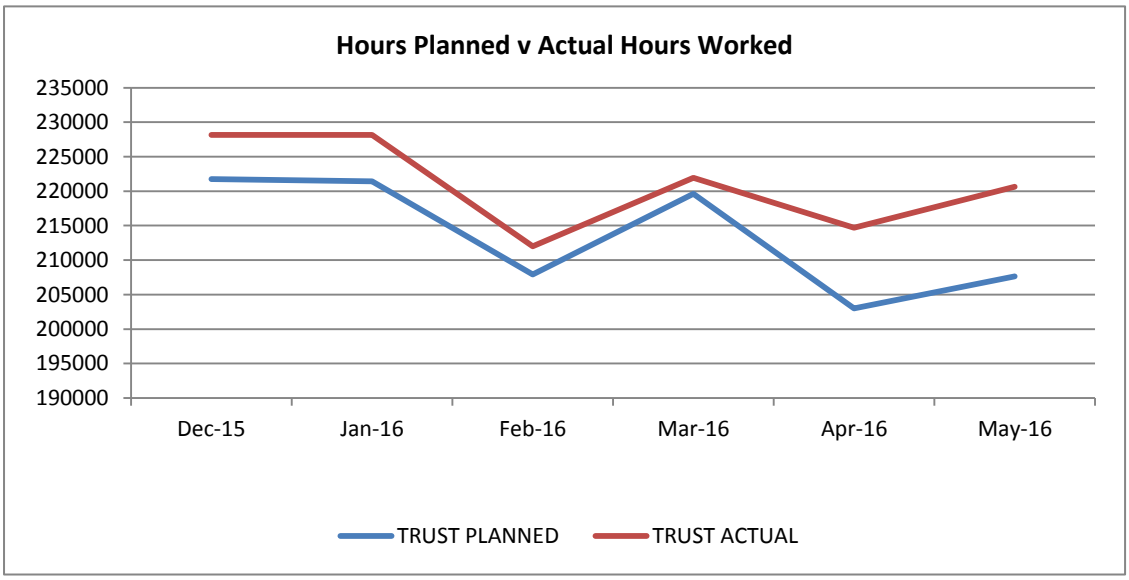
2.4 The highest creators of additional duties with a reason of 'enhanced observations' were in the following areas:

Ward / Team	Number of Duties	Number or Hours
Westerdale South	1271	11442.00
Merlin Ward	641	7098.00
Bankfields Court	334	3936.50
Westwood Centre	328	3504.00
Clover/Ivy	327	3262.00
Linnet Ward	281	3042.00
Mallard Ward	264	2533.00
Cedar Ward	260	3075.00

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

3.0 Planned versus Actual Hours Worked

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



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

3.3. Appendix 4 of the report shows the average fill rate (1st December 2015 to 31st May 2016) for both days and nights for both registered and non-registered staff.

3.4 The 6 monthly position shows that there were 33 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%.

3.5 In terms of the night time shifts the 6 monthly position shows that there were 2 wards who had fill rates of less than 89.9% (shown as red) for registered nurses and health care assistants there were 0 wards who had a fill rate below 89.9%.

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

Month	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
Dec-15	87.70	↓	114.20	↓	96.60	↓	113.30	↓
Jan-16	88.60	↑	114.00	↓	96.40	↓	112.00	↓
Feb-16	88.80	↑	111.40	↓	95.30	↓	111.50	↓
Mar-16	86.70	↓	110.00	↓	97.00	↑	110.00	↓
Apr-16	92.90	↑	113.50	↑	99.60	↑	113.00	↑
May-16	93.80	↑	113.70	↑	99.70	↑	113.50	↑

From the table it is important to highlight the following:

- York and Selby data was incorporated into the TEWV position from 1st April 2016 and therefore will have influenced any increases to the fill rates.

- The average fill rate for registered nurses on day shifts has improved from 87.70% in December 2015 when compared to 93.80% in May 2016 (6.1% increase).

- The average fill rate for health care assistants on day shifts has deteriorated from 114.20% in December 2015 to 113.70% in May 2016 (0.5% decrease). Although this calculation shows a deterioration this is still within acceptable tolerance.

- The average fill rate for registered nurses on night shifts has increased from 96.60% in December 2015 when compared to 99.70% in May 2016 (3.1% increase).

- The average fill rate for health care assistants on night shifts has improved from 113.30% in December 2015 when compared to 113.50 in May 2016 (0.2% improvement).

3.7 The overall total red rated occurrences utilising the average fill rate (i.e. less than 89.9%) was 48 occurrences. The table below shows the breakdown by locality:

Locality	Total Number of Red Occurrences
Durham & Darlington	6
Teesside	6
North Yorkshire	5
Forensic Services	21
York and Selby	10

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

3.8 The 6 month average highlights Kingfisher/Heron/Robin as having the lowest fill rate of 41.0% for registered nurses on days. The low fill rate is following a reduction of beds as part of the transforming of care agenda. The ward has since closed and therefore this example alone cannot be used as an outlier within this 6 monthly report due to the reasons given.

3.9 The second lowest fill rate utilising the 6 month average highlights Recovery Unit Acomb with a fill rate of 52.5% for registered nurses on night shifts. This is due to the temporary closure of the unit, the number of patients has reduced freeing up staff to work in other areas within the locality.

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

Ward	Red Fill Rate	Comments
The Orchards	61.6% RN on Nights	The ward have articulated historically that they have a number of vacancies that they are recruiting to.
Whitehorse View	65.0% for RN on Days; and 79.8% for HCA on Days	The unit has since closed and therefore the average is low as a result of there not being a full 6 months worth of data.
Meadowfields	68.3% for RN on Days	This is as a result of vacancies and a

		combination of long and short term sickness
Jay	71.2 for RN on Days	The shortfall is as a result of sickness and vacancies. Flexing of staff has taken place in addition to using bank.
Bek, Talbot & Ramsey	73.1% for HCA on Days and Nights	The shortfall is due to a reduction in the number of beds as a result of the transforming of care agenda.
Thistle	73.9% for RN on Days	Historically the ward have articulated that the low fill rate was due to a staff suspension and training.
Primrose Lodge	75% for RN on Days	Shortfall is due to sickness, community staff have been utilised where this has occurred.
Wingfield	76.2% for RN on Days	The low fill rate was due to sickness.
Langley	76.4% for RN on Days	This was due to sickness, the ward have articulated the use of the community team to cover the shortfall.
Bedale	76.4% for RN on Days	The ward has articulated that the shortfall was in relation to vacancies and a long term sickness.
Harrier/Hawk	76.8% for RN on Days	Vacancies and maternity have been highlighted previously as reasons for the shortfall.
Linnet	76.9% for RN on Days	The short fall is due to sickness and vacancies. Where possible the ward do flex their workforce and consider the use of bank.
Picktree	78.1% for RN on Days	This is due to a number of vacancies which have not been recruited to due to the potential reconfiguration of the ward. Bank have been used where possible.
Newberry Centre	78.3% for RN on Days	The shortfall was due to sickness.
Peppermill Court	79.0% for HCA on Days	The unit has since closed therefore the low fill rate is as a result of not having a full 6 months worth of data
Bilsdale	79.2% for RN on Days	Long term sickness and vacancies were sighted as reasons for the shortfall.

4.0 Bank, Agency and Overtime

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

Locality	Ward	Bank Usage %
Durham & Darlington	Cedar	**46.5%**
Forensics	Kestrel / Kite	**40.4%**
Forensics	Robin	**43.1%**
Forensics	Langley	**41.7%**

Forensics	Linnet Ward	51.3%
Forensics	Mallard	43.1%
Forensics	Merlin	53.5%
Teesside	Westerdale South	67.3%

- This equates to 8 wards in 3 separate localities.

4.2 There are 55 wards who reported as Amber and 16 wards reported as Green.

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

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

Locality	Ward	Total Hours	Agency Usage %
York & Selby	Worsley Court	7,887.00	32.7%
York & Selby	Cherry Tree House	2,447.00	9.9%
York & Selby	Peppermill Court	462.00	9.8%
North Yorkshire	Rowan Ward	805.25	4.5%
North Yorkshire	Springwood	619.50	3.3%
North Yorkshire	Cedar (NY)	390.45	1.9%
York & Selby	Meadowfields	379.50	1.9%
York & Selby	Recovery Unit Acomb	99.00	1.0%
York & Selby	Oak Rise	10.45	0.1%
Teesside	Westerdale South	12.00	0.0%

- This equates to 10 wards, the majority of which are from within the York and Selby and North Yorkshire localities.

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

Locality	Ward	Overtime Usage %
North Yorkshire	The Orchards (NY)	13.0%
Teesside	Baysdale	9.3%
Forensics	Thistle	9.1%
Teesside	Bankfields Court Unit 2	7.9%
Forensics	Clover / Ivy	6.8%
North Yorkshire	Springwood	6.6%
North Yorkshire	Rowan Lea	6.6%
Teesside	Bedale Ward	6.5%
North Yorkshire	Westwood Centre	6.5%
North Yorkshire	Cedar (NY)	6.0%
Durham & Darlington	Bek, Talbot and Ramsey	5.7%
Forensics	Mandarin	5.6%
Teesside	Stockdale	5.5%
North Yorkshire	Ward 14	5.3%
North Yorkshire	Rowan Ward	5.2%

Teesside	Aysgarth	5.1%
Forensics	Newtondale	5.0%
Forensics	Northdale Centre	4.7%
Teesside	Wingfield	4.6%
Durham & Darlington	Tunstall Ward	4.6%
Teesside	Westerdale North	4.4%
North Yorkshire	Ayckbourn Danby Ward	4.2%

- 22 wards were rated as Red for overtime worked and cover all localities within the Trust.
- Forensic Services are using overtime the most whilst North Yorkshire and York and Selby are using overtime the least
- There are 11 wards who were rated as Amber and 40 wards who were rated as Green for overtime worked

5.0 Quality Indicators

5.1 In turning to the triangulation of staffing data with other safety indicators at appendix 5 an overview can be found of all quality indicators. Firstly there were 25 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
1	Elm Ward	17.9%	94.7%	100.0%	108.6%	112.8%
4	Farnham Ward	9.7%	102.3%	101.2%	106.7%	105.9%
2	Maple	23.7%	97.4%	97.4%	98.4%	107.1%
1	Hamsterley	18.0%	92.5%	100.0%	129.9%	98.9%
1	Oak Ward	7.6%	82.1%	99.5%	93.5%	100.8%
1	Picktree	36.6%	78.1%	100.1%	129.4%	103.6%
1	Harrier / Hawk	15.9%	76.8%	99.9%	110.7%	103.6%
1	Robin	43.1%	50.1%	57.9%	108.3%	120.9%
1	Oakwood	11.7%	84.9%	97.9%	129.1%	100.1%
1	Sandpiper Ward	35.4%	93.4%	86.6%	111.2%	139.5%
1	Fulmar Ward	14.1%	100.7%	102.9%	93.0%	102.3%
1	Ayckbourn Unit					
1	Cedar (NY)	15.9%	91.5%	94.4%	109.2%	103.9%
1	The Evergreen Centre	14.7%	92.6%	103.1%	118.8%	103.9%
1	Ward 14	1.2%	88.4%	104.8%	113.3%	104.6%
1	Bedale Ward	28.6%	76.4%	104.1%	171.9%	112.9%
1	Lincoln Ward	7.2%	105.7%	94.8%	97.5%	104.2%
1	Overdale	15.9%	80.4%	94.5%	131.6%	107.9%
1	Westerdale North	10.8%	103.0%	101.4%	129.3%	105.0%
1	Westerdale South	67.3%	92.1%	98.6%	298.0%	216.9%
1	Wingfield	15.4%	76.2%	100.4%	102.8%	101.2%

- Within the reporting period Elm, Farnham, Hamsterly, Fulmar, Cedar (NY), The Evergreen Centre, Lincoln and Westerdale North all had SUI's within the reporting period. When compared to the staffing fill rates and bank usage these are either reporting as 'green' or 'blue'.
- Oak, Harrier/Hawk, Oakwood, Ward 14, Overdale and Wingfield wards all had SUI's and are reporting as 'green' for bank usage. They did have 1 fill rate

indicator showing as 'red' whilst all the others are reporting as either 'green' or 'blue'.

- Maple Ward had an SUI and are showing as 'amber' for their bank usage. They reported as 'green' across all fill rate indicators
- Picktree, Sandpiper and Bedale all had SUI's and reported as 'amber' for bank usage and had 1 fill rate indicator shown as 'Red' all other fill rate indicators are reporting as either 'green' or blue'.
- Westerdale South had an SUI and are reporting as 'red' for bank usage,. All fill rate indicators are reporting as either 'green' or 'blue'.
- Robin had an SUI and are reporting as 'red' for bank usage. They had 2 fill rate indicators that are reporting as 'red' whilst all the 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.

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

No. L4 Incidents	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
2	Elm Ward	17.9%	94.7%	100.0%	108.6%	112.8%
3	Farnham Ward	9.7%	102.3%	101.2%	106.7%	105.9%
1	Hamsterley	18.0%	92.5%	100.0%	129.9%	98.9%
1	Picktree	36.6%	78.1%	100.1%	129.4%	103.6%
1	Oakwood	11.7%	84.9%	97.9%	129.1%	100.1%
1	Fulmar Ward	14.1%	100.7%	102.9%	93.0%	102.3%
1	Ayckbourn Unit					
1	The Evergreen Centre	14.7%	92.6%	103.1%	118.8%	103.9%
1	Westerdale North	10.8%	103.0%	101.4%	129.3%	105.0%
1	Westerdale South	67.3%	92.1%	98.6%	298.0%	216.9%
1	Wingfield	15.4%	76.2%	100.4%	102.8%	101.2%

- From the 14 level 4 incidents this equated to 11 wards across 4 localities.
- Durham and Darlington had the highest number of level 4 incidents in the reporting period with 7 incidents in total.
- 4 wards (Elm Ward, Farnham, Fulmar, The Evergreen Centre) who had level 4 incidents reported as 'green' for bank usage and 'green' across all 4 of the staffing fill rate indicators.
- Hamsterley and Westerdale North had level 4 incidents occurring during the period and reported as 'green' for bank usage. In terms of the fill rate indicators they had 1 indicator that reported as 'blue' whilst the others reported as 'green'.
- Picktree had a level 4 incident and are reporting as 'amber' for bank usage. They are also reporting as 'red' for RN days and 'blue' for HCA days.
- Westerdale South had a level 4 incident and are reporting as 'red' for bank usage whilst the fill rate indicators are reporting as either 'green' or 'blue'.

5.3 There were 49 level 3 self-harm incidents occurred within the reporting period. These are summarised below utilising the bank and staffing fil rates as comparative data:

No. L3 (self-harm) Incidents	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
2	Elm Ward	17.9%	94.7%	100.0%	108.6%	112.8%
1	Maple	23.7%	97.4%	97.4%	98.4%	107.1%
4	Tunstall Ward	4.7%	94.9%	97.3%	109.1%	101.3%
1	Willow Ward	14.3%	90.2%	100.0%	147.3%	102.8%
1	Oak Ward	7.6%	82.1%	99.5%	93.5%	100.8%
6	Clover / Ivy	30.6%	100.3%	103.5%	111.1%	159.1%
1	Sandpiper Ward	35.4%	93.4%	86.6%	111.2%	139.5%
2	Swift Ward	24.0%	87.5%	100.3%	105.0%	117.0%
3	Fulmar Ward	14.1%	100.7%	102.9%	93.0%	102.3%
3	Cedar (NY)	15.9%	91.5%	94.4%	109.2%	103.9%
1	Ward 15	18.5%	83.3%	99.5%	123.3%	106.3%
7	Newberry Centre	9.7%	78.3%	105.3%	121.2%	108.9%
3	The Evergreen Centre	14.7%	92.6%	103.1%	118.8%	103.9%
1	Westwood Centre	32.1%	99.2%	90.5%	130.9%	163.0%
2	Bedale Ward	28.6%	76.4%	104.1%	171.9%	112.9%
7	Bransdale	37.3%	**81.7%**	**104.1%**	**130.5%**	101.4%
1	Lincoln Ward	7.2%	**105.7%**	**94.8%**	**97.5%**	104.2%
3	Overdale	15.9%	**80.4%**	**94.5%**	**131.6%**	107.9%

- From the 49 level 3 self harm incidents this equated to 18 wards across 4 localities.
- North Yorkshire had the highest number of level 3 incidents in the reporting period with 15 incidents in total.
- Bransdale had the highest number of level 3 incidents across the reporting period with 7.
- Elm, Tunstall, Fulmar, Cedar (NY), The Evergreen Centre and Lincoln Wards all had Level 3 self-harm incidents during the reporting period. In addition they are reporting as ‘green’ for bank usage and ‘green’ across all 4 fill rate indicators.
- Oak Ward, Ward 15, Overdale and Newberry Centre all had level 3 incidents during the reporting period. They are also reporting as ‘green’ for bank usage and have 1 fill rate indicator that is reporting as ‘red’. All other fill rate indicators are reporting as either ‘green’ or ‘blue’.
- Willow Ward had 1 level 3 incident in the reporting period and are showing as ‘green’ for bank usage. In terms of the fill rate indicators they are all reporting as either ‘green’ or ‘blue’.
- Maple Ward had 1 level 3 self harm incident and are reporting as ‘amber’ for bank usage and ‘green’ across all 4 fill rate indicators.
- Clover/Ivy and Westwood Centre all had level 3 incidents and are reporting as ‘amber’ for bank and fill rates of either ‘green’ or ‘blue’.
- Sandpiper, Swift, Bedale and Bransdale all had level 3 incidents and ‘amber’ bank usage. In terms of the fill rate indicators 1 of them is reporting as ‘red’ whilst the others are reporting as either ‘green’ or ‘blue’.

5.4 It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. Within the reporting period there were 66 incidents raised citing issues with staffing.

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

Locality	No. of Incidents
North Yorkshire	14
Durham & Darlington	13
Teesside	10
Forensics	19
York and Selby	10

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

- The majority were raised highlighting that there were inadequate staffing within the ward for a particular shift
- Due to staffing, wards would be unable to provide a response should this be required during the course of the shift.
- 2 incidents were completed highlighting that there was no qualified present during the shift. This related to Forensic Services during the month of December 2015 and February 2016
- Other reasons were highlighted and include:
  - Staff being late for a shift
  - Staff not being able to take breaks
  - Unable to carry out reviews and essential patient activity without additional staff
  - Issues with medication, obtaining a doctor and prescribing

5.7 It is recommended that further monitoring of this occurs within the monthly safe staffing reports. Further discussion is required regarding staffing escalation processes in order that a standard approach can be adopted across the Trust and a timely response to ensure patient safety is not compromised. This is currently being tested within Tees locality.

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

No. of Complaints	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
2	Elm Ward	17.9%	94.7%	100.0%	108.6%	112.8%
1	Maple	23.7%	97.4%	97.4%	98.4%	107.1%
1	Tunstall Ward	4.7%	94.9%	97.3%	109.1%	101.3%
1	Kestrel / Kite	40.4%	81.4%	98.1%	105.4%	115.8%
1	Langley	41.7%	76.4%	101.8%	125.9%	186.9%
1	Northdale Centre	17.7%	82.2%	92.8%	93.8%	97.1%
1	Mallard	43.1%	86.7%	110.0%	118.9%	167.7%
2	Newtondale	18.0%	90.0%	86.9%	95.9%	100.7%
1	Sandpiper Ward	35.4%	93.4%	86.6%	111.2%	139.5%
1	Kirkdale	21.0%	81.8%	92.2%	101.6%	96.1%
4	Ayckbourn Unit					
1	Cedar (NY)	15.9%	91.5%	94.4%	109.2%	103.9%
1	Rowan Lea	9.8%	89.3%	108.0%	108.3%	102.3%

1	Rowan Ward	20.6%	95.9%	111.8%	116.7%	102.2%
1	Bedale Ward	28.6%	76.4%	104.1%	171.9%	112.9%
3	Bilsdale	27.4%	79.2%	103.5%	133.0%	99.3%
2	Bransdale	37.3%	81.7%	104.1%	130.5%	101.4%
2	Overdale	15.9%	80.4%	94.5%	131.6%	107.9%
1	Meadowfields	16.8%	68.3%	108.6%	93.9%	108.2%
1	Worsley Court	5.5%	92.6%	102.7%	122.2%	197.0%
2	AMH IP BPH Ward 2 Male					

- From the 31 complaints this equated to 21 wards across all localities.
- Forensic Services and Teesside had the highest number of complaints in the reporting period with 8 incidents occurring within each locality.
- Bransdale had the highest number of level 3 incidents across the reporting period with 7.
- Elm, Tunstall and Cedar (NY) all had complaints raised in the reporting period and are showing 'green' across bank and all fill rate indicators.
- Worsley Court had a complaint and reported as 'green' for bank usage and either 'green' or 'blue' across the fill rate indicators.
- Northdale, Rowan Lea, Overdale and Meadowfields all had complaints and reported as 'green' for bank. They also had 1 fill rate indicator reporting as 'red'.
- Newtondale Ward had 2 complaints in the reporting period and reported as 'green' for bank. In addition they had 2 fill rate indicators that reported as 'red' whilst the others reported as 'green'.
- Maple and Rowan Wards had complaints and reported as 'amber' for bank usage and were 'green' across all 4 fill rate indicators.
- Sandpiper, Kirkdale, Bedale, Bilsdale and Bransdale all had complaints and reported as 'amber' for bank and had 1 fill rate indicator reporting as 'red' whilst all the others were either 'green' or 'blue'.
- Kestrel/Kite, Langley and Mallard had complaints and reported as 'red' for bank and had 1 fill rate indicator reporting as 'red' whilst all the other indicators were either 'green' or 'blue'.

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

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

Ward	**Locality**	**Incidents of Restraint**				**Bank Usage**
		Incidents	**PRO used**	**Other**	**Restraint Total**	
Westwood Centre	North Yorkshire	400	16	743	759	32.1%
The Evergreen Centre	North Yorkshire	300	0	473	473	14.7%
Springwood	North Yorkshire	191	1	216	217	15.3%
Sandpiper Ward	Forensic Services	133	5	317	322	35.4%
Bankfields Court	Teesside	124	2	180	182	13.8%
Swift Ward	Forensic Services	93	7	156	163	24.0%
Bedale	Teesside	88	3	138	141	28.6%
Merlin	Forensic Services	62	2	102	104	53.5%
Cedar	Durham & Darlington	55	7	88	95	46.5%
Cedar (NY)	North Yorkshire	50	4	82	86	15.9%

- Westwood had 400 incidents of restraints during the reporting period with 16 episodes of Prone restraint. In addition they also reported as 'amber' for bank usage.
- The Evergreen Centre had the second highest number of incidents resulting in restraint with 473 classified as other types of restraints. They reported as 'green' for bank usage.
- All other wards although they did have incidents that resulted in the use of restraint their totals were way below that of the Westwood Centre and The Evergreen Centre. A recent report to QuAC by the Westwood Centre highlighted the challenges faced within these units and the approaches being taken to address these.
- Merlin and Cedar although they had fewer incidents which resulted in the use of restraint they did have a 'red' bank fill rate.

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

Ward Name	Registered Average %		Unregistered Average %	
	Day	Night	Day	Night
Cedar	**104.0%**	**102.8%**	**143.4%**	**128.6%**
Merlin	**96.6%**	**93.1%**	**147.9%**	**194.7%**
Sandpiper Ward	**93.4%**	**86.6%**	**111.2%**	**139.5%**
Swift Ward	**87.5%**	**100.3%**	**105.0%**	**117.0%**
Cedar (NY)	**91.5%**	**94.4%**	**109.2%**	**103.9%**
The Evergreen Centre	**92.6%**	**103.1%**	**118.8%**	**103.9%**
Westwood Centre	**99.2%**	**90.5%**	**130.9%**	**163.0%**
Springwood	**96.3%**	**105.1%**	**102.7%**	**134.8%**
Bedale Ward	**76.4%**	**104.1%**	**171.9%**	**112.9%**
Bankfields Court	**90.7%**	**98.9%**	**113.1%**	**99.2%**

5.12 With regards to the use of Prone restraint this will continue to be monitored within the Force reduction project and monthly within the Safe Staffing reports, however, it is worth highlighting that during the reporting period there were 75 episodes of Prone used. This is a significant reduction (89 episodes) when compared to the previous 6 month report.

6.0 9 Safe Nursing Indicators

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

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

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

6.3 Falls that have resulted in significant harm for all inpatient services have been examined. Within the reporting period there have been a total of 529 incidents across 60 wards.

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

Speciality	Ward / Team	Number of incidents
MHSOP	Springwood	50
MHSOP	Westerdale South	49
MHSOP	Westerdale North	38
MHSOP	Picktree	36
MHSOP	Rowan Ward	35
MHSOP	Rowan Lea	30
MHSOP	Ceddesfeld	30

From the table the following is of relevance:

- It is not surprising that the majority of the falls incidents have occurred within the older people's service due to other health problems that older people may encounter such as reduced vision, mobility and balance problems.
- In turning to the triangulation of data with the safe nursing indicators:
  - Picktree and Rowan Lea all had one metric that was categorised as being 'red' within the staffing fill rate 6 month average. All the other indicators reported as 'green' or 'blue'
  - Springwood, Westerdale North and South, Rowan Ward and Ceddesfeld all had staffing that were classified as either 'green' or 'blue'
  - Westerdale South had bank usage equating to 67.3% shown as 'red'
  - Springwood, Westerdale North, Picktree, Rowan Ward and Ceddesfeld had bank usage reporting as 'amber'
  - Agency workers were utilised within Rowan, Springwood and Westerdale South
  - Overtime occurred within all wards during the reporting period
  - All wards are showing as 'red' for compliance with mandatory training.

6.5 Data in relation to pressure ulcers was obtained. There were 6 incidents reported across 5 wards as follows:

Speciality	Ward / Team	Number of incidents
AMH	Stockdale	1
MHSOP	Rowan Ward	2
MHSOP	Springwood	1
MHSOP	Rowan Lea	1
MHSOP	Oak Ward	1

From the table the following is of relevance:

- As expected, the majority of the incidents of 'pressure ulcers' occurred within the older people's service.
- In turning to the triangulation of staffing data:

- Oak Ward and Rowan Lea all had one metric within the staffing fill rate that was classified as 'red'.
- Stockdale, Rowan Ward and Springwood all had fill rate indicators showing as either 'green' or 'blue'.
- Rowan Ward, Springwood and Stockdale had an 'amber' rating for bank usage.
- Agency workers were utilised within Rowan Ward and Springwood
- Overtime was worked across all of the wards listed.
- All wards are showing as 'red' for compliance with mandatory training.

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

6.6 There were 381 incidents of medication errors reported within the reporting period across 65 wards. The top 6 wards are shown as follows:

Ward / Team	Number of incidents
Elm Ward	35
Newtondale Ward	25
Swift Ward	24
Brambling Ward	24
Birch	17
Merlin	17

From the table the following is of relevance:

- Birch, Swift and Newtondale wards who are showing as 'red' for one or more of the fill rate indicators
- Elm, Newtondale, Brambling and Merlin are showing either as 'green' or 'blue' across all metrics within the fill rate indicators
- Merlin Ward had bank usage equating to 53.5% shown as 'red'
- From the wards listed agency working was not undertaken.
- Overtime working occurred within all of the wards listed.
- With the exception of Merlin all wards listed within the table are showing as 'red' for mandatory training.

6.7 In terms of shifts worked without a break there were 7664 shifts worked within the reporting period where breaks were not given. The top 6 wards were as follows:

WARD	No of eligible shifts	No. of eligible shifts without breaks 1st Dec 15 - 31st May 16	% of shifts without break	Days without breaks	Nights without break
Oak Rise (Acomb)	2267	2094	92.37	1511	583
Aysgarth	1244	1226	98.55	868	358
Bankfields Court Unit 2	1218	810	66.50	787	23
Newberry Centre	2431	621	25.55	354	267
Westwood Centre	2973	275	9.25	154	121
Baysdale	1237	231	18.67	230	1

From the table the following is of relevance:

- It is important to highlight that staff are not ordinarily allocated breaks within Oak Rise, Aysgarth and Bankfields Court Unit 2 as a result of therapeutic engagement.
- The majority of the shifts where breaks were not given occurred on day shifts
- It is not possible to highlight the reasons as to why breaks are not given due to this not being reported within the HealthRoster system. It is therefore not possible to separate whether this is due to clinical need or customary practice.
- This exercise also highlighted examples whereby staff were receiving both time owing and overtime payments for breaks not taken in some areas.
- The only ward highlighted within the above table whereby they had a 'red' fill rate indicator within the reporting period related to the Newberry Centre.
- All other wards had either a 'green' or 'blue' fill rate indicators across all metrics within the staffing fill rates
- All wards were categorised as either 'amber' or 'green' for bank usage
- There was only Oak Rise listed in the above table that had used agency workers within the reporting period
- Overtime was utilised across all of the wards listed within the table during the reporting period.
- All wards with the exception of Bankfields Court Unit 2 were all 'red' for mandatory training.

Budgeted and Actual Staffing Establishments in WTE

Appendix 2

Locality	WARD	Speciality	Bed Numbers	Shifts LD or SD	Establishment at 1/12/15				Establishment at 31/05/16				Comparison 1/12/16 to 31/5/16 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	10	LD	8.50	10.00	14.30	12.60	8.50	11.30	14.30	13.20	0.00	1.30	0.00	0.60
	Birch Ward	Adults	15	LD	8.60	8.40	15.90	13.70	8.60	7.30	15.90	14.30	0.00	-1.10	0.00	0.60
	Earlston House	Adults	15	LD	8.60	8.50	11.40	10.10	0.00	0.00	0.00	0.00	-8.60	-8.50	-11.40	-10.10
	Primrose Lodge	Adults	15	LD	8.60	7.60	11.40	10.00	8.60	9.80	11.40	13.00	0.00	2.20	0.00	3.00
	Willow Ward	Adults	15	LD	8.60	9.10	11.40	11.10	8.60	8.70	12.40	14.90	0.00	-0.40	1.00	3.80
	Maple Ward	Adults	17	LD	8.60	8.90	11.40	10.60	8.60	10.40	11.40	10.60	0.00	1.50	0.00	0.00
	Elm Ward	Adults	20	LD	8.60	8.10	11.40	12.10	8.60	9.50	11.40	10.30	0.00	1.40	0.00	-1.80
	Farnham Ward	Adults	20	LD	8.60	8.60	11.40	11.70	8.60	9.60	11.40	10.50	0.00	1.00	0.00	-1.20
	Tunstall Ward	Adults	20	LD	8.60	9.00	11.40	12.70	8.60	8.00	11.40	11.60	0.00	-1.00	0.00	-1.10
	Holly Unit	CYPS	4	LD & SD	4.80	4.60	5.20	5.10	4.80	4.60	5.20	5.60	0.00	0.00	0.00	0.50
	Bek, Talbot Wards	LD	16	LD	11.20	10.40	44.10	33.10	11.20	8.40	44.10	23.80	0.00	-2.00	0.00	-9.30
	Ceddesfeld Ward	MHSOP	10	LD	8.60	9.00	5.40	11.70	8.60	8.40	5.40	11.70	0.00	-0.60	0.00	0.00
	Hamsterley Ward	MHSOP	10	LD	8.60	9.00	7.00	9.70	8.60	8.00	7.00	9.70	0.00	-1.00	0.00	0.00
	Picktree Ward.	MHSOP	10	LD	8.60	8.40	8.30	8.40	8.60	5.40	8.30	9.10	0.00	-3.00	0.00	0.70
	Oak Ward	MHSOP	12	LD	8.60	8.80	11.40	11.10	8.60	9.40	11.40	11.20	0.00	0.60	0.00	0.10
	Roseberry Wards	MHSOP	15	LD	8.60	7.40	11.40	13.00	8.60	8.30	12.40	12.40	0.00	0.90	1.00	-0.60
Forensics	Clover/Ivy	Forensics LD	12	LD	8.10	9.00	20.30	20.40	8.10	9.00	20.20	18.60	0.00	0.00	-0.10	-1.80
	Thistle Ward	Forensics LD	5	LD	10.70	7.00	14.80	11.60	10.70	6.00	14.80	12.50	0.00	-1.00	0.00	0.90
	Northdale Centre	Forensics LD	6	LD	8.10	8.00	26.90	20.90	8.10	5.00	27.80	24.90	0.00	-3.00	0.90	4.00
	Oakwood	Forensics LD	8	LD	8.10	7.80	6.60	8.00	8.10	7.70	6.60	8.00	0.00	-0.10	0.00	0.00
	Eagle/Osprey	Forensics LD	10	LD	8.10	9.70	17.50	19.60	8.10	9.70	17.50	19.30	0.00	0.00	0.00	-0.30
	Harrier/Hawk	Forensics LD	10	LD	8.10	7.20	20.20	19.60	8.10	7.90	20.20	16.00	0.00	0.70	0.00	-3.60

	Langley Ward	Forensics LD	10	LD	8.10	6.80	9.30	10.00	8.10	7.70	9.30	9.00	0.00	0.90	0.00	-1.00
	Robin (formally K,H & Robin)	Forensics LD	14	LD	13.50	4.00	17.60	15.70	5.40	6.00	9.50	9.60	-8.10	2.00	-8.10	-6.10
	Kestrel/Kite	Forensics LD	16	LD	8.10	7.80	22.00	19.90	8.10	5.80	22.00	18.40	0.00	-2.00	0.00	-1.50
	Brambling Ward	Forensics MH	13	LD	8.10	5.60	13.20	8.30	8.10	8.00	13.20	12.20	0.00	2.40	0.00	3.90
	Jay Ward	Forensics MH	5	LD	8.10	5.70	13.40	13.10	8.10	6.40	13.40	13.00	0.00	0.70	0.00	-0.10
	Sandpiper Ward	Forensics MH	8	LD	10.70	11.00	17.10	14.50	10.70	9.00	17.10	16.50	0.00	-2.00	0.00	2.00
	Merlin	Forensics MH	10	LD	10.70	8.50	15.30	13.70	10.70	8.50	15.30	14.60	0.00	0.00	0.00	0.90
	Swift Ward	Forensics MH	10	LD	8.10	7.40	15.30	17.90	8.10	8.00	15.30	14.10	0.00	0.60	0.00	-3.80
	Fulmar Ward.	Forensics MH	12	LD	8.10	8.80	15.30	14.80	8.10	8.20	15.30	15.00	0.00	-0.60	0.00	0.20
	Lark	Forensics MH	15	LD	8.10	8.00	13.20	14.00	8.10	7.40	13.20	11.00	0.00	-0.60	0.00	-3.00
	Kirkdale Ward	Forensics MH	16	LD	8.10	6.90	15.30	13.60	8.10	7.90	15.30	13.90	0.00	1.00	0.00	0.30
	Mallard Ward	Forensics MH	16	LD	8.10	7.60	15.30	15.40	8.10	7.60	15.30	16.40	0.00	0.00	0.00	1.00
	Mandarin	Forensics MH	16	LD	8.10	8.00	13.20	13.50	8.10	9.00	13.20	12.40	0.00	1.00	0.00	-1.10
	Nightingale Ward	Forensics MH	16	LD	8.10	8.00	13.20	12.70	8.10	7.00	13.20	12.70	0.00	-1.00	0.00	0.00
	Linnet Ward	Forensics MH	17	LD	8.10	6.90	13.20	13.80	8.10	4.90	13.20	13.80	0.00	-2.00	0.00	0.00
	Newtondale Ward	Forensics MH	20	LD	10.70	10.90	17.90	16.20	10.70	8.00	17.90	16.70	0.00	-2.90	0.00	0.50
North Yorkshire	Abdale House (The Orchards)	Adults	9	LD	10.70	9.20	5.60	5.50	10.70	9.70	5.60	5.50	0.00	0.50	0.00	0.00
	Ayckbourn Unit Danby Ward	Adults	13	SD	9.10	9.00	10.70	9.00	9.10	7.00	10.70	10.00	0.00	-2.00	0.00	1.00
	Ayckbourn Unit Esk Ward	Adults	13	LD	9.10	9.00	10.70	10.60	9.10	8.40	10.70	11.60	0.00	-0.60	0.00	1.00
	Ward 15 Friarage	Adults	14	LD	9.10	7.00	10.70	11.30	9.10	8.00	10.70	11.60	0.00	1.00	0.00	0.30
	Cedar Ward (NY)	Adults	18	LD	9.10	8.60	15.20	18.20	9.10	10.00	15.20	13.60	0.00	1.40	0.00	-4.60
	Newberry Centre	CYPS	14	SD	11.70	11.70	15.20	17.30	12.70	15.40	15.20	16.80	1.00	3.70	0.00	-0.50
	The Evergreen Centre	CYPS	12	LD	13.50	12.40	18.30	18.70	13.50	14.00	18.30	19.60	0.00	1.60	0.00	0.90
	Westwood Centre	CYPS	12	LD	14.70	12.60	18.20	19.50	14.70	13.80	16.50	16.00	0.00	1.20	-1.70	-3.50
	Ward 14	MHSOP	9	LD & SD	9.10	9.40	10.00	10.40	9.10	8.40	10.00	10.40	0.00	-1.00	0.00	0.00
	Rowan Ward	MHSOP	12	LD	9.10	9.30	10.70	9.30	9.10	9.30	10.70	9.60	0.00	0.00	0.00	0.30
	Springwood Community Unit	MHSOP	14	LD	9.10	8.70	12.50	11.40	9.10	8.00	12.50	11.40	0.00	-0.70	0.00	0.00
	Rowan Lea	MHSOP	20	SD&LD	9.10	8.20	17.90	16.00	9.10	7.40	17.90	18.40	0.00	-0.80	0.00	2.40

Teesside	Bedale Ward	Adults	10	LD	8.20	7.00	13.70	13.60	8.20	8.00	13.70	13.70	0.00	1.00	0.00	0.10
	Bilsdale Ward	Adults	14	LD	8.20	8.80	11.00	10.20	8.20	9.00	11.00	10.20	0.00	0.20	0.00	0.00
	Bransdale Ward	Adults	14	LD	8.20	7.10	11.00	9.80	8.20	6.80	10.00	9.80	0.00	-0.30	-1.00	0.00
	Park House	Adults	14	LD	7.80	6.90	11.00	10.00	0.00	0.00	0.00	0.00	7.80	-6.90	-11.00	-10.00
	Overdale Ward	Adults	18	LD	8.20	6.60	11.00	12.00	8.20	8.60	11.00	12.00	0.00	2.00	0.00	0.00
	Stockdale Ward	Adults	18	LD	8.20	9.80	11.00	12.30	8.20	7.60	11.00	11.50	0.00	-2.20	0.00	-0.80
	Lincoln Ward	Adults	20	LD & SD	9.40	11.00	11.90	13.30	9.40	10.30	11.90	13.30	0.00	-0.70	0.00	0.00
	Lustrum Vale	Adults	20	LD & SD	10.30	8.10	11.00	10.20	10.30	11.00	11.00	13.00	0.00	2.90	0.00	2.80
	Baysdale	CYPS	6	SD	6.70	7.10	12.70	11.10	6.70	7.10	12.70	12.50	0.00	0.00	0.00	1.40
	Aysgarth	LD	6	SD	6.00	5.40	11.50	10.10	6.00	5.40	11.50	9.40	0.00	0.00	0.00	-0.70
	Bankfields Court Unit 2	LD	5	SD	6.80	6.00	9.50	7.00	6.80	7.00	9.50	8.70	0.00	1.00	0.00	1.70
	Bankfields Court	LD	12	SD&LD	14.30	17.50	57.30	48.00	14.30	17.20	58.30	50.80	0.00	-0.30	1.00	2.80
	Wingfield Ward	MHSOP	9	LD & SD	8.10	7.80	10.00	9.50	8.10	7.80	10.00	11.40	0.00	0.00	0.00	1.90
	Westerdale South	MHSOP	14	SD&LD	8.20	10.00	11.00	12.90	8.20	8.50	11.00	12.00	0.00	-1.50	0.00	-0.90
	Westerdale North	MHSOP	18	SD&LD	8.20	8.20	11.00	11.60	8.20	8.20	11.00	11.40	0.00	0.00	0.00	-0.20
York & Selby	Acomb Recovery Unit	Adults			9.50	11.30	10.00	15.20	0.00	0.00	0.00	0.00	-9.50	-11.30	-10.00	-15.20
	Oak Rise	LD		SD	9.90	10.30	10.20	10.20	9.90	12.30	10.20	20.60	0.00	2.00	0.00	10.40
	Whitehorse View	LD			9.20	6.60	14.40	14.00	0.00	0.00	0.00	0.00	-9.20	-6.60	-14.40	-14.00
	Cherrytree House	MHSOP		SD	7.20	7.50	19.00	18.00	12.20	10.20	15.00	19.50	-5.00	2.70	-4.00	1.50
	Peppermill Court	MHSOP		SD	10.70	9.50	24.00	23.40	0.00	0.00	0.00	0.00	-10.70	-9.50	-24.00	-23.40
	Worsley Court	MHSOP		LD	7.40	8.00	14.20	13.20	9.30	8.00	15.00	18.30	-1.90	0.00	0.80	5.10
	Meadowfields	MHSOP		LD & SD	88.00	7.80	16.10	15.30	9.30	9.40	15.00	23.80	78.70	1.60	-1.10	8.50

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

Ward Name	Locality	Speciality	Bed Numbers	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	10	253.49	1.2%	0	0.0%	10214.3	46.5%	912.0	4.2%	1344.0	6.1%	412.5	1.9%
Earlston House	Durham & Darlington	AMH	15	70.17	0.7%	0	0.0%	1123.0	10.5%	206.3	1.9%	541.5	5.1%	176.3	1.6%
Elm Ward	Durham & Darlington	AMH	20	550.96	3.3%	0	0.0%	3011.2	17.9%	732.0	4.4%	750.0	4.5%	558.8	3.3%
Farnham Ward	Durham & Darlington	AMH	20	401.67	2.5%	0	0.0%	1579.3	9.7%	222.8	1.4%	945.0	5.8%	142.5	0.9%
Maple	Durham & Darlington	AMH	17	369.00	2.3%	0	0.0%	3847.7	23.7%	302.3	1.9%	1347.8	8.3%	243.8	1.5%
Primrose Lodge	Durham & Darlington	AMH	15	24.00	0.2%	0	0.0%	1709.7	11.1%	267.0	1.7%	893.0	5.8%	450.0	2.9%
Tunstall Ward	Durham & Darlington	AMH	20	744.08	4.6%	0	0.0%	767.7	4.7%	341.3	2.1%	1648.5	10.2%	198.8	1.2%
Willow Ward	Durham & Darlington	AMH	15	194.17	1.2%	0	0.0%	2384.7	14.3%	395.3	2.4%	2185.3	13.1%	277.5	1.7%
Holly	Durham & Darlington	CYPS	4	164.50	2.1%	0	0.0%	333.4	4.2%	157.5	2.0%	809.2	10.2%	37.5	0.5%
Birch Ward	Durham & Darlington	ED	15	206.33	1.2%	0	0.0%	4170.0	23.5%	123.8	0.7%	2337.2	13.2%	828.8	4.7%
Bek, Talbot Wards	Durham & Darlington	LD	16	1,473.66	5.7%	0	0.0%	1394.1	5.4%	1149.8	4.4%	1023.5	3.9%	4522.5	17.4%
Ceddesfeld	Durham & Darlington	MHSOP	10	199.01	1.2%	0	0.0%	1846.0	11.1%	520.5	3.1%	214.3	1.3%	225.0	1.3%
Hamsterley	Durham & Darlington	MHSOP	10	266.08	1.7%	0	0.0%	2826.7	18.0%	307.5	2.0%	1131.0	7.2%	236.3	1.5%
Oak Ward	Durham & Darlington	MHSOP	12	469.00	3.1%	0	0.0%	1142.5	7.6%	72.0	0.5%	589.5	3.9%	48.8	0.3%
Picktree	Durham & Darlington	MHSOP	10	238.51	1.5%	0	0.0%	5758.1	36.6%	232.5	1.5%	2266.2	14.4%	341.3	2.2%
Roseberry Wards	Durham & Darlington	MHSOP	15	169.58	1.0%	0	0.0%	2850.2	17.2%	609.8	3.7%	1172.0	7.1%	56.3	0.3%
Clover / Ivy	Forensics	Forensic LD	12	1,756.41	6.8%	0	0.0%	7931.9	30.6%	1567.5	6.1%	1080.0	4.2%	1271.3	4.9%
Eagle / Osprey	Forensics	Forensic LD	10	595.14	3.0%	0	0.0%	2807.1	14.3%	2688.5	13.7%	1773.3	9.0%	892.5	4.5%
Harrier / Hawk	Forensics	Forensic LD	10	815.17	3.6%	0	0.0%	3572.3	15.9%	873.8	3.9%	907.5	4.0%	930.0	4.1%
Kestrel / Kite	Forensics	Forensic LD	16	384.88	1.6%	0	0.0%	9739.5	40.4%	1121.3	4.7%	558.8	2.3%	1447.5	6.0%
Kingfisher / Heron	Forensics	Forensic LD	4	51.92	1.6%	0	0.0%	776.8	24.6%	446.3	14.1%	176.3	5.6%	656.3	20.8%
Robin	Forensics	Forensic LD	6	233.25	1.8%	0	0.0%	5444.3	43.1%	1143.8	9.1%	588.8	4.7%	757.5	6.0%
Langley	Forensics	Forensic LD	10	622.25	3.8%	0	0.0%	6805.8	41.7%	387.5	2.4%	2239.8	13.7%	247.5	1.5%
Northdale Centre	Forensics	Forensic LD	12	1,206.29	4.7%	0	0.0%	4524.5	17.7%	570.5	2.2%	1237.0	4.8%	1320.0	5.2%
Oakwood	Forensics	Forensic LD	8	432.17	3.8%	0	0.0%	1340.5	11.7%	742.5	6.5%	1086.3	9.5%	56.3	0.5%
Thistle Ward	Forensics	Forensic LD	5	1,630.84	9.1%	0	0.0%	4847.7	26.9%	393.8	2.2%	300.4	1.7%	1882.5	10.5%
Brambling	Forensics	Forensic MH	13	497.05	2.8%	0	0.0%	5541.8	31.4%	558.0	3.2%	527.0	3.0%	1593.8	9.0%
Jay Ward	Forensics	Forensic MH	5	535.65	3.2%	0	0.0%	4693.3	27.9%	645.0	3.8%	728.2	4.3%	2122.5	12.6%
Lark	Forensics	Forensic MH	15	349.25	2.1%	0	0.0%	4802.0	28.6%	1000.8	6.0%	548.0	3.3%	1687.5	10.1%

Linnet Ward	Forensics	Forensic MH	17	572.50	2.9%	0	0.0%	9996.1	51.3%	2467.5	12.7%	872.0	4.5%	2186.3	11.2%
Mallard	Forensics	Forensic MH	16	524.25	2.3%	0	0.0%	9724.0	43.1%	1237.5	5.5%	450.0	2.0%	1095.0	4.9%
Mandarin	Forensics	Forensic MH	16	919.84	5.6%	0	0.0%	3938.3	24.0%	1721.0	10.5%	1831.5	11.2%	2388.8	14.6%
Merlin	Forensics	Forensic MH	10	740.75	2.7%	0	0.0%	14718.5	53.5%	442.5	1.6%	427.5	1.6%	2085.0	7.6%
Newtondale	Forensics	Forensic MH	20	1,061.40	5.0%	0	0.0%	3848.8	18.0%	1248.8	5.8%	325.5	1.5%	1991.3	9.3%
Nightingale	Forensics	Forensic MH	16	526.50	3.1%	0	0.0%	3607.8	21.4%	431.3	2.6%	1153.0	6.8%	1901.3	11.3%
Sandpiper Ward	Forensics	Forensic MH	8	898.00	3.7%	0	0.0%	8687.5	35.4%	682.5	2.8%	723.3	2.9%	1203.8	4.9%
Swift Ward	Forensics	Forensic MH	10	496.40	2.6%	0	0.0%	4644.8	24.0%	1418.5	7.3%	1029.3	5.3%	1087.5	5.6%
Fulmar Ward	Forensics	Locked Rehab	12	440.13	2.4%	0	0.0%	2604.8	14.1%	1113.8	6.0%	263.3	1.4%	813.8	4.4%
Kirkdale	Forensics	Locked Rehab	16	320.50	1.8%	0	0.0%	3688.0	21.0%	1249.2	7.1%	1008.8	5.7%	1938.8	11.0%
The Orchards (NY)	North Yorkshire	AMH	10	1,740.50	13.0%	0	0.0%	891.5	6.7%	266.3	2.0%	246.0	1.8%	1398.8	10.5%
Ayckbourn Danby Ward	North Yorkshire	AMH	13	659.00	4.2%	0	0.0%	3869.3	24.9%	600.0	3.9%	1174.7	7.6%	1796.3	11.6%
Ayckbourn Esk Ward	North Yorkshire	AMH	13	452.00	2.8%	0	0.0%	1135.0	7.0%	607.8	3.8%	848.0	5.3%	971.3	6.0%
Cedar (NY)	North Yorkshire	AMH	18	1,214.81	6.0%	390.45	1.9%	3201.0	15.9%	1821.0	9.0%	2020.5	10.0%	2808.8	13.9%
Ward 15	North Yorkshire	AMH	14	370.00	2.3%	0	0.0%	2912.9	18.5%	552.1	3.5%	484.1	3.1%	1121.3	7.1%
Newberry Centre	North Yorkshire	CYPS	14	286.15	1.4%	0	0.0%	1996.4	9.7%	251.3	1.2%	388.5	1.9%	791.3	3.8%
The Evergreen Centre	North Yorkshire	CYPS	16	837.25	3.0%	0	0.0%	4062.7	14.7%	1140.8	4.1%	742.5	2.7%	765.0	2.8%
Westwood Centre	North Yorkshire	CYPS	12	1,848.28	6.5%	0	0.0%	9187.0	32.1%	696.8	2.4%	1134.0	4.0%	1860.0	6.5%
Rowan Lea	North Yorkshire	MHSOP	20	1,486.76	6.6%	0	0.0%	2225.6	9.8%	560.8	2.5%	961.3	4.2%	1451.3	6.4%
Rowan Ward	North Yorkshire	MHSOP	12	932.50	5.2%	805.25	4.5%	3664.9	20.6%	401.3	2.3%	377.3	2.1%	1008.8	5.7%
Springwood	North Yorkshire	MHSOP	14	1,237.35	6.6%	619.5	3.3%	2887.0	15.3%	552.0	2.9%	637.9	3.4%	1856.3	9.8%
Ward 14	North Yorkshire	MHSOP	9	796.25	5.3%	0	0.0%	179.3	1.2%	30.0	0.2%	190.8	1.3%	217.5	1.4%
Bedale Ward	Teesside	AMH	10	1,326.68	6.5%	0	0.0%	5818.4	28.6%	738.0	3.6%	640.5	3.1%	1436.3	7.0%
Bilsdale	Teesside	AMH	14	454.76	2.9%	0	0.0%	4280.0	27.4%	1575.5	10.1%	2177.0	13.9%	1575.0	10.1%
Bransdale	Teesside	AMH	14	279.25	1.7%	0	0.0%	5961.1	37.3%	695.0	4.4%	1455.0	9.1%	1387.5	8.7%
Lincoln Ward	Teesside	AMH	20	388.00	2.1%	0	0.0%	1348.0	7.2%	948.0	5.1%	866.5	4.7%	1425.0	7.7%
Overdale	Teesside	AMH	18	376.03	2.2%	0	0.0%	2694.2	15.9%	379.3	2.2%	359.0	2.1%	532.5	3.1%
Park House	Teesside	AMH	14	20.50	0.2%	0	0.0%	2528.3	25.6%	11.5	0.1%	101.0	1.0%	0.0	0.0%
Stockdale	Teesside	AMH	18	902.38	5.5%	0	0.0%	4681.0	28.4%	1469.5	8.9%	1562.0	9.5%	836.3	5.1%
Baysdale	Teesside	CYPS	6	1,438.99	9.3%	0	0.0%	1051.4	6.8%	180.8	1.2%	599.9	3.9%	596.3	3.9%
Aysgarth	Teesside	LD	6	696.80	5.1%	0	0.0%	3632.0	26.6%	633.0	4.6%	1544.0	11.3%	401.3	2.9%
Bankfields Court	Teesside	LD	19	1,416.43	2.8%	0	0.0%	6931.4	13.8%	2163.0	4.3%	3712.8	7.4%	3896.3	7.8%
Bankfields Court Unit 2	Teesside	LD	5	1,059.74	7.9%	0	0.0%	3391.1	25.3%	839.7	6.3%	409.7	3.1%	532.5	4.0%
Lustrum Vale	Teesside	MHSOP	20	59.00	0.4%	0	0.0%	3842.5	22.9%	784.0	4.7%	1028.5	6.1%	843.8	5.0%
Westerdale North	Teesside	MHSOP	18	740.85	4.4%	0	0.0%	1827.2	10.8%	393.5	2.3%	1438.5	8.5%	303.8	1.8%
Westerdale South	Teesside	MHSOP	14	612.10	2.2%	12	0.0%	18841.9	67.3%	217.8	0.8%	538.7	1.9%	127.5	0.5%
Wingfield	Teesside	MHSOP	10	636.33	4.6%	0	0.0%	2130.0	15.4%	320.5	2.3%	998.0	7.2%	855.0	6.2%

Oak Rise	York & Selby	LD	8	414.50	2.2%	10.45	0.1%	2643.0	13.9%	239.0	1.3%	923.5	4.9%	22.5	0.1%
White Horse View	York & Selby	LD	8	174.42	1.4%	0	0.0%	230.0	1.8%	195.0	1.5%	640.0	5.1%	378.8	3.0%
Recovery Unit Acomb	York & Selby	Adults	16	399.45	3.9%	99	1.0%	715.0	7.0%	325.5	3.2%	528.0	5.2%	247.5	2.4%
Meadowfields	York & Selby	MHSOP	14	144.25	0.7%	379.5	1.9%	3288.1	16.8%	918.0	4.7%	2717.7	13.9%	187.5	1.0%
Peppermill Court	York & Selby	MHSOP	18	25.00	0.5%	462	9.8%	168.0	3.6%	709.5	15.0%	581.0	12.3%	307.5	6.5%
Worsley Court	York & Selby	MHSOP	14	31.00	0.1%	7887	32.7%	1336.0	5.5%	904.5	3.7%	1651.0	6.8%	618.8	2.6%
Cherry Tree House	York & Selby	MHSOP	18	346.70	1.4%	2447	9.9%	4451.0	18.0%	508.0	2.1%	1862.0	7.5%	555.0	2.2%

	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

Average fill rate covering the period of 1st Decemer 2015 to 31st May 2016

Appendix 4

Ward Name	Locality	Speciality	Bed Numbers	6 Months - 1st December 2015 - 31st May 2016			
				Registered Average %		Unregistered Average %	
				Day	Night	Day	Night
Cedar	Durham & Darlington	AMH	10	**104.0%**	**102.8%**	**143.4%**	**128.6%**
Earlston House	Durham & Darlington	AMH	15	**92.3%**	**99.2%**	**97.4%**	**99.4%**
Elm Ward	Durham & Darlington	AMH	20	**94.7%**	**100.0%**	**108.6%**	**112.8%**
Farnham Ward	Durham & Darlington	AMH	20	**102.3%**	**101.2%**	**106.7%**	**105.9%**
Maple	Durham & Darlington	AMH	17	**97.4%**	**97.4%**	**98.4%**	**107.1%**
Primrose Lodge	Durham & Darlington	AMH	15	**75.0%**	**100.0%**	**109.2%**	**101.9%**
Tunstall Ward	Durham & Darlington	AMH	20	**94.9%**	**97.3%**	**109.1%**	**101.3%**
Willow Ward	Durham & Darlington	AMH	15	**90.2%**	**100.0%**	**147.3%**	**102.8%**
Holly	Durham & Darlington	CYPS	4	**136.8%**	**104.0%**	**120.2%**	**118.6%**
Birch Ward	Durham & Darlington	ED	15	**89.5%**	**101.1%**	**101.5%**	**116.7%**
Bek, Talbot Wards	Durham & Darlington	LD	16	**93.6%**	**99.5%**	**73.1%**	**73.1%**
Ceddesfeld	Durham & Darlington	MHSOP	10	**95.3%**	**100.1%**	**125.6%**	**98.9%**
Hamsterley	Durham & Darlington	MHSOP	10	**92.5%**	**100.0%**	**129.9%**	**98.9%**
Oak Ward	Durham & Darlington	MHSOP	12	**82.1%**	**99.5%**	**93.5%**	**100.8%**
Picktree	Durham & Darlington	MHSOP	10	**78.1%**	**100.1%**	**129.4%**	**103.6%**
Roseberry Wards	Durham & Darlington	MHSOP	15	**93.2%**	**100.0%**	**96.9%**	**100.0%**
Clover / Ivy	Forensics	Forensic LD	12	**100.3%**	**103.5%**	**111.1%**	**159.1%**
Eagle / Osprey	Forensics	Forensic LD	10	**95.4%**	**98.1%**	**96.8%**	**102.9%**
Harrier / Hawk	Forensics	Forensic LD	10	**76.8%**	**99.9%**	**110.7%**	**103.6%**

Kestrel / Kite	Forensics	Forensic LD	16	81.4%	98.1%	105.4%	115.8%
Kingfisher / Heron	Forensics	Forensic LD	4	41.0%	61.7%	67.8%	83.3%
Robin	Forensics	Forensic LD	6	50.1%	57.9%	108.3%	120.9%
Langley	Forensics	Forensic LD	10	76.4%	101.8%	125.9%	186.9%
Northdale Centre	Forensics	Forensic LD	12	82.2%	92.8%	93.8%	97.1%
Oakwood	Forensics	Forensic LD	8	84.9%	97.9%	129.1%	100.1%
Thistle Ward	Forensics	Forensic LD	5	73.9%	94.8%	117.1%	100.2%
Brambling	Forensics	Forensic MH	13	92.5%	102.0%	106.0%	111.1%
Jay Ward	Forensics	Forensic MH	5	71.2%	99.5%	115.0%	104.4%
Lark	Forensics	Forensic MH	15	87.3%	98.7%	107.7%	101.8%
Linnet Ward	Forensics	Forensic MH	17	76.9%	99.5%	136.8%	130.8%
Mallard	Forensics	Forensic MH	16	86.7%	110.0%	118.9%	167.7%
Mandarin	Forensics	Forensic MH	16	95.7%	101.0%	91.3%	99.0%
Merlin	Forensics	Forensic MH	10	96.6%	93.1%	147.9%	194.7%
Newtondale	Forensics	Forensic MH	20	90.0%	86.9%	95.9%	100.7%
Nightingale	Forensics	Forensic MH	16	93.7%	100.7%	99.0%	101.8%
Sandpiper Ward	Forensics	Forensic MH	8	93.4%	86.6%	111.2%	139.5%
Swift Ward	Forensics	Forensic MH	10	87.5%	100.3%	105.0%	117.0%
Fulmar Ward	Forensics	Locked Rehab	12	100.7%	102.9%	93.0%	102.3%
Kirkdale	Forensics	Locked Rehab	16	81.8%	92.2%	101.6%	96.1%
The Orchards (NY)	North Yorkshire	AMH	10	91.4%	61.6%	92.3%	171.2%
Ayckbourn Danby Ward	North Yorkshire	AMH	13	93.2%	100.1%	108.3%	102.8%
Ayckbourn Esk Ward	North Yorkshire	AMH	13	99.0%	100.3%	97.9%	98.5%
Cedar (NY)	North Yorkshire	AMH	18	91.5%	94.4%	109.2%	103.9%
Ward 15	North Yorkshire	AMH	14	83.3%	99.5%	123.3%	106.3%
Newberry Centre	North Yorkshire	CYPS	14	78.3%	105.3%	121.2%	108.9%
The Evergreen Centre	North Yorkshire	CYPS	16	92.6%	103.1%	118.8%	103.9%
Westwood Centre	North Yorkshire	CYPS	12	99.2%	90.5%	130.9%	163.0%
Rowan Lea	North Yorkshire	MHSOP	20	89.3%	108.0%	108.3%	102.3%
Rowan Ward	North Yorkshire	MHSOP	12	95.9%	111.8%	116.7%	102.2%
Springwood	North Yorkshire	MHSOP	14	96.3%	105.1%	102.7%	134.8%
Ward 14	North Yorkshire	MHSOP	9	88.4%	104.8%	113.3%	104.6%
Bedale Ward	Teesside	AMH	10	76.4%	104.1%	171.9%	112.9%
Bilsdale	Teesside	AMH	14	79.2%	103.5%	133.0%	99.3%
Bransdale	Teesside	AMH	14	81.7%	104.1%	130.5%	101.4%
Lincoln Ward	Teesside	AMH	20	105.7%	94.8%	97.5%	104.2%
Overdale	Teesside	AMH	18	80.4%	94.5%	131.6%	107.9%

Park House	Teesside	AMH	14	**96.1%**	**100.4%**	**107.7%**	**100.4%**
Stockdale	Teesside	AMH	18	**90.3%**	**105.7%**	**113.5%**	**102.4%**
Baysdale	Teesside	CYPS	6	**128.3%**	**103.7%**	**100.0%**	**100.3%**
Aysgarth	Teesside	LD	6	**109.1%**	**101.2%**	**142.7%**	**100.8%**
Bankfields Court	Teesside	LD	19	**90.7%**	**98.9%**	**113.1%**	**99.2%**
Bankfields Court Unit 2	Teesside	LD	5	**117.8%**	**100.2%**	**105.1%**	**108.9%**
Lustrum Vale	Teesside	MHSOP	20	**83.3%**	**100.0%**	**127.3%**	**100.3%**
Westerdale North	Teesside	MHSOP	18	**103.0%**	**101.4%**	**129.3%**	**105.0%**
Westerdale South	Teesside	MHSOP	14	**92.1%**	**98.6%**	**298.0%**	**216.9%**
Wingfield	Teesside	MHSOP	10	**76.2%**	**100.4%**	**102.8%**	**101.2%**
Oak Rise	York & Selby	LD	8	**117.4%**	**102.2%**	**100.9%**	**100.7%**
White Horse View	York & Selby	LD	8	**65.0%**	**96.6%**	**79.8%**	**101.3%**
Recovery Unit Acomb	York & Selby	Adults	16	**70.0%**	**52.5%**	**74.0%**	**87.7%**
Meadowfields	York & Selby	MHSOP	14	**68.3%**	**108.6%**	**93.9%**	**108.2%**
Peppermill Court	York & Selby	MHSOP	18	**84.0%**	**96.8%**	**79.0%**	**109.3%**
Worsley Court	York & Selby	MHSOP	14	**92.6%**	**102.7%**	**122.2%**	**197.0%**
Cherry Tree House	York & Selby	MHSOP	18	**88.9%**	**99.6%**	**130.3%**	**143.3%**

Quality Indicators - 6 Month Total

Appendix 5

Ward Name	Locality	Speciality	Bed Numbers	Bank Usage vs Actual Hours		Quality Indicators					Incidents of Restraints				Registered Average %		Unregistered Average %	
				Hours	% against Actual Hours	Number of SUIs	Number of Level 4 Incidents	Number of Level 3 Incidents (Self-Harm)	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	10214.3	46.5%					8	55	7	88	95	104.0%	102.8%	143.4%	128.6%
Earlston House	Durham & Darlington	AMH	15	1123.0	10.5%										92.3%	99.2%	97.4%	99.4%
Elm Ward	Durham & Darlington	AMH	20	3011.2	17.9%	1	2	2	2	7	11	1	13	14	94.7%	100.0%	108.6%	112.8%
Farnham Ward	Durham & Darlington	AMH	20	1579.3	9.7%	4	3			3	21	1	30	31	102.3%	101.2%	106.7%	105.9%
Maple	Durham & Darlington	AMH	17	3847.7	23.7%	2		1	1	10	17		27	27	97.4%	97.4%	98.4%	107.1%
Primrose Lodge	Durham & Darlington	AMH	15	1709.7	11.1%										75.0%	100.0%	109.2%	101.9%
Tunstall Ward	Durham & Darlington	AMH	20	767.7	4.7%			4	1	9	3		4	4	94.9%	97.3%	109.1%	101.3%
Willow Ward	Durham & Darlington	AMH	15	2384.7	14.3%			1		2	9	2	10	12	90.2%	100.0%	147.3%	102.8%
Holly	Durham & Darlington	CYPS	4	333.4	4.2%					1					136.8%	104.0%	120.2%	118.6%
Birch Ward	Durham & Darlington	ED	15	4170.0	23.5%										89.5%	101.1%	101.5%	116.7%
Bek, Talbot Wards	Durham & Darlington	LD	16	1394.1	5.4%						37	8	48	56	93.6%	99.5%	73.1%	73.1%
Ceddesfeld	Durham & Darlington	MHSOP	10	1846.0	11.1%						27		37	37	95.3%	100.1%	125.6%	98.9%
Hamsterley	Durham & Darlington	MHSOP	10	2826.7	18.0%	1	1			1	8		10	10	92.5%	100.0%	129.9%	98.9%
Oak Ward	Durham & Darlington	MHSOP	12	1142.5	7.6%	1		1							82.1%	99.5%	93.5%	100.8%
Picktree	Durham & Darlington	MHSOP	10	5758.1	36.6%	1	1				37	1	84	85	78.1%	100.1%	129.4%	103.6%
Roseberry Wards	Durham &	MHSOP	15	2850.2	17.2%					1	4		3	3	93.2%	100.0%	96.9%	100.0%

	Darlington																	
Clover / Ivy	Forensics	Forensic LD	12	7931.9	30.6%			6		9	25	2	44	46	100.3%	103.5%	111.1%	159.1%
Eagle / Osprey	Forensics	Forensic LD	10	2807.1	14.3%						1		2	2	95.4%	98.1%	96.8%	102.9%
Harrier / Hawk	Forensics	Forensic LD	10	3572.3	15.9%	1				4	6		7	7	76.8%	99.9%	110.7%	103.6%
Kestrel / Kite	Forensics	Forensic LD	16	9739.5	40.4%				1	13	12		28	28	81.4%	98.1%	105.4%	115.8%
Kingfisher / Heron	Forensics	Forensic LD	4	776.8	24.6%					2	1		2	2	41.0%	61.7%	67.8%	83.3%
Robin	Forensics	Forensic LD	6	5444.3	43.1%	1					1		1	1	50.1%	57.9%	108.3%	120.9%
Langley	Forensics	Forensic LD	10	6805.8	41.7%				1	4	3		3	3	76.4%	101.8%	125.9%	186.9%
Northdale Centre	Forensics	Forensic LD	12	4524.5	17.7%				1	2	15	2	29	31	82.2%	92.8%	93.8%	97.1%
Oakwood	Forensics	Forensic LD	8	1340.5	11.7%	1	1								84.9%	97.9%	129.1%	100.1%
Thistle Ward	Forensics	Forensic LD	5	4847.7	26.9%					5	16		23	23	73.9%	94.8%	117.1%	100.2%
Brambling	Forensics	Forensic MH	13	5541.8	31.4%					1	47		81	81	92.5%	102.0%	106.0%	111.1%
Jay Ward	Forensics	Forensic MH	5	4693.3	27.9%					1	5		6	6	71.2%	99.5%	115.0%	104.4%
Lark	Forensics	Forensic MH	15	4802.0	28.6%					8					87.3%	98.7%	107.7%	101.8%
Linnet Ward	Forensics	Forensic MH	17	9996.1	51.3%					6	25		34	34	76.9%	99.5%	136.8%	130.8%
Mallard	Forensics	Forensic MH	16	9724.0	43.1%				1	6	4		5	5	86.7%	110.0%	118.9%	167.7%
Mandarin	Forensics	Forensic MH	16	3938.3	24.0%					13	4		4	4	95.7%	101.0%	91.3%	99.0%
Merlin	Forensics	Forensic MH	10	14718.5	53.5%					3	62	2	102	104	96.6%	93.1%	147.9%	194.7%
Newtondale	Forensics	Forensic MH	20	3848.8	18.0%				2	5	1		1	1	90.0%	86.9%	95.9%	100.7%
Nightingale	Forensics	Forensic MH	16	3607.8	21.4%					4	1		2	2	93.7%	100.7%	99.0%	101.8%
Sandpiper Ward	Forensics	Forensic MH	8	8687.5	35.4%	1		1	1	6	133	5	317	322	93.4%	86.6%	111.2%	139.5%
Swift Ward	Forensics	Forensic MH	10	4644.8	24.0%			2		2	93	7	156	163	87.5%	100.3%	105.0%	117.0%
Fulmar Ward	Forensics	Locked Rehab	12	2604.8	14.1%	1	1	3		2	24	2	38	40	100.7%	102.9%	93.0%	102.3%
Kirkdale	Forensics	Locked Rehab	16	3688.0	21.0%				1	1	2		2	2	81.8%	92.2%	101.6%	96.1%
The Orchards (NY)	North Yorkshire	AMH	10	891.5	6.7%										91.4%	61.6%	92.3%	171.2%
Ayckbourn Danby Ward	North Yorkshire	AMH	13	3869.3	24.9%					1	4		6	6	93.2%	100.1%	108.3%	102.8%

Ayckbourn Esk Ward	North Yorkshire	AMH	13	1135.0	7.0%					1	4		7	7	99.0%	100.3%	97.9%	98.5%
Ayckbourn Unit	North Yorkshire	AMH				1	1		4	10	34	2	59	61				
Cedar (NY)	North Yorkshire	AMH	18	3201.0	15.9%	1		3	1	6	50	4	82	86	91.5%	94.4%	109.2%	103.9%
Ward 15	North Yorkshire	AMH	14	2912.9	18.5%			1		1	17		25	25	83.3%	99.5%	123.3%	106.3%
Newberry Centre	North Yorkshire	CYPS	14	1996.4	9.7%			7		1	35		49	49	78.3%	105.3%	121.2%	108.9%
The Evergreen Centre	North Yorkshire	CYPS	16	4062.7	14.7%	1	1	3		3	300		473	473	92.6%	103.1%	118.8%	103.9%
Westwood Centre	North Yorkshire	CYPS	12	9187.0	32.1%			1		1	400	16	743	759	99.2%	90.5%	130.9%	163.0%
Rowan Lea	North Yorkshire	MHSOP	20	2225.6	9.8%				1		45		78	78	89.3%	108.0%	108.3%	102.3%
Rowan Ward	North Yorkshire	MHSOP	12	3664.9	20.6%				1	1	12		14	14	95.9%	111.8%	116.7%	102.2%
Springwood	North Yorkshire	MHSOP	14	2887.0	15.3%						191	1	216	217	96.3%	105.1%	102.7%	134.8%
Ward 14	North Yorkshire	MHSOP	9	179.3	1.2%	1				1	22	1	40	41	88.4%	104.8%	113.3%	104.6%
Bedale Ward	Teesside	AMH	10	5818.4	28.6%	1		2	1		88	3	138	141	76.4%	104.1%	171.9%	112.9%
Bilsdale	Teesside	AMH	14	4280.0	27.4%				3	7	7		14	14	79.2%	103.5%	133.0%	99.3%
Bransdale	Teesside	AMH	14	5961.1	37.3%			7	2	6	14	1	23	24	81.7%	104.1%	130.5%	101.4%
Lincoln Ward	Teesside	AMH	20	1348.0	7.2%	1		1		1	7		9	9	105.7%	94.8%	97.5%	104.2%
Overdale	Teesside	AMH	18	2694.2	15.9%	1		3	2	3	35	2	55	57	80.4%	94.5%	131.6%	107.9%
Park House	Teesside	AMH	14	2528.3	25.6%						1		1	1	96.1%	100.4%	107.7%	100.4%
Stockdale	Teesside	AMH	18	4681.0	28.4%					3	41	2	63	65	90.3%	105.7%	113.5%	102.4%
Baysdale	Teesside	CYPS	6	1051.4	6.8%					1	3		3	3	128.3%	103.7%	100.0%	100.3%
Aysgarth	Teesside	LD	6	3632.0	26.6%						2		5	5	109.1%	101.2%	142.7%	100.8%
Bankfields Court	Teesside	LD	19	6931.4	13.8%					1	124	2	180	182	90.7%	98.9%	113.1%	99.2%
Bankfields Court Unit 2	Teesside	LD	5	3391.1	25.3%						3		3	3	117.8%	100.2%	105.1%	108.9%
Lustrum Vale	Teesside	MHSOP	20	3842.5	22.9%					3	3		3	3	83.3%	100.0%	127.3%	100.3%
Westerdale North	Teesside	MHSOP	18	1827.2	10.8%	1	1			5	20		28	28	103.0%	101.4%	129.3%	105.0%
Westerdale South	Teesside	MHSOP	14	18841.9	67.3%	1	1			1	15		22	22	92.1%	98.6%	298.0%	216.9%
Wingfield	Teesside	MHSOP	10	2130.0	15.4%	1	1				2		3	3	76.2%	100.4%	102.8%	101.2%
Oak Rise	York & Selby	LD	8	2643.0	13.9%					1	1		1	1	117.4%	102.2%	100.9%	100.7%
White Horse View	York & Selby	LD	8	230.0	1.8%										65.0%	96.6%	79.8%	101.3%
Recovery Unit Acomb	York & Selby	Adults	16	715.0	7.0%					1					70.0%	52.5%	74.0%	87.7%
Meadowfields	York & Selby	MHSOP	14	3288.1	16.8%				1	1	6		6	6	68.3%	108.6%	93.9%	108.2%
Peppermill Court	York & Selby	MHSOP	18	168.0	3.6%										84.0%	96.8%	79.0%	109.3%
Worsley Court	York & Selby	MHSOP	14	1336.0	5.5%				1	3	12	1	14	15	92.6%	102.7%	122.2%	197.0%
Cherry Tree House	York & Selby	MHSOP	18	4451.0	18.0%					1	3		3	3	88.9%	99.6%	130.3%	143.3%
AMH IP BPH Ward 2 Male									2	1								

MHSOP IP BPH Ward 6 EAU									1									

Locality	Ward Name	Safe Nursing Indicators											
		Falls resulting in significant harm	Pressure Ulcers	Medication Errors	Missed Breaks (No. of Shifts)	Staffing Fill Rate - Day - Registered Nurses	Staffing Fill Rate - Night - Registered Nurses	Staffing Fill Rate - Day - Unregistered Nurses	Staffing Fill Rate - Night - Unregistered Nurses	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours	Mandatory Training (May-16)
Durham & Darlington	Cedar	1		7	1	104.0%	102.8%	143.4%	128.6%	46.5%	0.0%	1.2%	78.57%
Durham & Darlington	Earlston House					92.3%	99.2%	97.4%	99.4%	10.5%	0.0%	0.7%	No data
Durham & Darlington	Elm Ward	1		35	2	94.7%	100.0%	108.6%	112.8%	17.9%	0.0%	3.3%	90.80%
Durham & Darlington	Farnham Ward	4		3		102.3%	101.2%	106.7%	105.9%	9.7%	0.0%	2.5%	90.90%
Durham & Darlington	Maple	4		6	45	97.4%	97.4%	98.4%	107.1%	23.7%	0.0%	2.3%	82.60%
Durham & Darlington	Primrose Lodge	1		2		75.0%	100.0%	109.2%	101.9%	11.1%	0.0%	0.2%	84.10%
Durham & Darlington	Tunstall Ward	1		3	46	94.9%	97.3%	109.1%	101.3%	4.7%	0.0%	4.6%	82.30%
Durham & Darlington	Willow Ward			1		90.2%	100.0%	147.3%	102.8%	14.3%	0.0%	1.2%	90.70%
Durham & Darlington	Holly	3		1	12	136.8%	104.0%	120.2%	118.6%	4.2%	0.0%	2.1%	87.90%
Durham & Darlington	Birch Ward			17	1	89.5%	101.1%	101.5%	116.7%	23.5%	0.0%	1.2%	92.70%
Durham & Darlington	Bek, Talbot and Ramsey			1	3	93.6%	99.5%	73.1%	73.1%	5.4%	0.0%	5.7%	92.10%
Durham & Darlington	Ceddesfeld	30		4	2	95.3%	100.1%	125.6%	98.9%	11.1%	0.0%	1.2%	84.60%
Durham & Darlington	Hamsterley	25		2		92.5%	100.0%	129.9%	98.9%	18.0%	0.0%	1.7%	87.50%
Durham & Darlington	Oak Ward	18	1	4	9	82.1%	99.5%	93.5%	100.8%	7.6%	0.0%	3.1%	81.90%
Durham & Darlington	Picktree	36		5	25	78.1%	100.1%	129.4%	103.6%	36.6%	0.0%	1.5%	88.30%
Durham & Darlington	Roseberry Wards	17		3	34	93.2%	100.0%	96.9%	100.0%	17.2%	0.0%	1.0%	90.20%
Forensics	Clover / Ivy	8			40	100.3%	103.5%	111.1%	159.1%	30.6%	0.0%	6.8%	91.60%
Forensics	Eagle / Osprey			10	19	95.4%	98.1%	96.8%	102.9%	14.3%	0.0%	3.0%	97.50%
Forensics	Harrier / Hawk	4		5	21	76.8%	99.9%	110.7%	103.6%	15.9%	0.0%	3.6%	96.40%
Forensics	Kestrel / Kite	2		2	16	81.4%	98.1%	105.4%	115.8%	40.4%	0.0%	1.6%	87.30%
Forensics	Kingfisher / Heron / Robin	2		3	25	41.0%	61.7%	67.8%	83.3%	24.6%	0.0%	1.6%	90.60%
Forensics	Langley	4		4	81	76.4%	101.8%	125.9%	186.9%	41.7%	0.0%	3.8%	84.20%

Forensics	Northdale Centre	3		7	47	82.2%	92.8%	93.8%	97.1%	17.7%	0.0%	4.7%	94.60%
Forensics	Oakwood			5	20	84.9%	97.9%	129.1%	100.1%	11.7%	0.0%	3.8%	93.70%
Forensics	Thistle Ward	1		2	52	73.9%	94.8%	117.1%	100.2%	26.9%	0.0%	9.1%	92.10%
Forensics	Brambling	3		24	38	92.5%	102.0%	106.0%	111.1%	31.4%	0.0%	2.8%	90.20%
Forensics	Jay Ward	1			38	71.2%	99.5%	115.0%	104.4%	27.9%	0.0%	3.2%	91.10%
Forensics	Lark	1		2	33	87.3%	98.7%	107.7%	101.8%	28.6%	0.0%	2.1%	92.10%
Forensics	Linnet Ward	1		9	62	76.9%	99.5%	136.8%	130.8%	51.3%	0.0%	2.9%	92.10%
Forensics	Mallard	25		5	69	86.7%	110.0%	118.9%	167.7%	43.1%	0.0%	2.3%	96.00%
Forensics	Mandarin	1			25	95.7%	101.0%	91.3%	99.0%	24.0%	0.0%	5.6%	28.57%
Forensics	Merlin	1		17	58	96.6%	93.1%	147.9%	194.7%	53.5%	0.0%	2.7%	96.40%
Forensics	Newtondale			25	41	90.0%	86.9%	95.9%	100.7%	18.0%	0.0%	5.0%	86.70%
Forensics	Nightingale			7	57	93.7%	100.7%	99.0%	101.8%	21.4%	0.0%	3.1%	91.50%
Forensics	Sandpiper Ward	6		6	51	93.4%	86.6%	111.2%	139.5%	35.4%	0.0%	3.7%	85.10%
Forensics	Swift Ward	2		24	121	87.5%	100.3%	105.0%	117.0%	24.0%	0.0%	2.6%	82.10%
Forensics	Fulmar Ward	2		3	91	100.7%	102.9%	93.0%	102.3%	14.1%	0.0%	2.4%	95.00%
Forensics	Kirkdale	1		6	23	81.8%	92.2%	101.6%	96.1%	21.0%	0.0%	1.8%	91.60%
North Yorkshire	Abdale House				10	91.4%	61.6%	92.3%	171.2%	6.7%	0.0%	13.0%	80.90%
North Yorkshire	Ayckbourn Danby Ward	2		13	29	93.2%	100.1%	108.3%	102.8%	24.9%	0.0%	4.2%	85.60%
North Yorkshire	Ayckbourn Esk Ward				7	99.0%	100.3%	97.9%	98.5%	7.0%	0.0%	2.8%	
North Yorkshire	Cedar (NY)			14	171	91.5%	94.4%	109.2%	103.9%	15.9%	1.9%	6.0%	87.00%
North Yorkshire	Ward 15	2		1	84	83.3%	99.5%	123.3%	106.3%	18.5%	0.0%	2.3%	87.00%
North Yorkshire	Newberry Centre			1	621	78.3%	105.3%	121.2%	108.9%	9.7%	0.0%	1.4%	91.60%
North Yorkshire	The Evergreen Centre			1	94	92.6%	103.1%	118.8%	103.9%	14.7%	0.0%	3.0%	89.50%
North Yorkshire	Westwood Centre	2		6	275	99.2%	90.5%	130.9%	163.0%	32.1%	0.0%	6.5%	87.90%
North Yorkshire	Rowan Lea	30	1	4	106	89.3%	108.0%	108.3%	102.3%	9.8%	0.0%	6.6%	83.40%
North Yorkshire	Rowan Ward	35	2	5	2	95.9%	111.8%	116.7%	102.2%	20.6%	4.5%	5.2%	92.30%
North Yorkshire	Springwood	50	1	2	2	96.3%	105.1%	102.7%	134.8%	15.3%	3.3%	6.6%	89.00%

North Yorkshire	Ward 14	8		4	48	88.4%	104.8%	113.3%	104.6%	1.2%	0.0%	5.3%	86.20%
Teesside	Bedale Ward	2		6	60	76.4%	104.1%	171.9%	112.9%	28.6%	0.0%	6.5%	91.60%
Teesside	Bilsdale	4		1	23	79.2%	103.5%	133.0%	99.3%	27.4%	0.0%	2.9%	90.00%
Teesside	Bransdale	17		4	30	81.7%	104.1%	130.5%	101.4%	37.3%	0.0%	1.7%	76.40%
Teesside	Lincoln Ward	4		2	72	105.7%	94.8%	97.5%	104.2%	7.2%	0.0%	2.1%	94.80%
Teesside	Overdale	3		5	20	80.4%	94.5%	131.6%	107.9%	15.9%	0.0%	2.2%	82.10%
Teesside	Park House	4		3		96.1%	100.4%	107.7%	100.4%	25.6%	0.0%	0.2%	
Teesside	Stockdale	1	1	5	57	90.3%	105.7%	113.5%	102.4%	28.4%	0.0%	5.5%	83.80%
Teesside	Baysdale	4		6	231	128.3%	103.7%	100.0%	100.3%	6.8%	0.0%	9.3%	79.10%
Teesside	Aysgarth	1		2	1226	109.1%	101.2%	142.7%	100.8%	26.6%	0.0%	5.1%	93.20%
Teesside	Bankfields Court	7		4	81	90.7%	98.9%	113.1%	99.2%	13.8%	0.0%	2.8%	87.70%
Teesside	Bankfields Court Unit 2	10		2	810	117.8%	100.2%	105.1%	108.9%	25.3%	0.0%	7.9%	98.90%
Teesside	Lustrum Vale	1		9	17	83.3%	100.0%	127.3%	100.3%	22.9%	0.0%	0.4%	91.00%
Teesside	Westerdale North	38		12	44	103.0%	101.4%	129.3%	105.0%	10.8%	0.0%	4.4%	94.00%
Teesside	Westerdale South	49			61	92.1%	98.6%	298.0%	216.9%	67.3%	0.0%	2.2%	84.20%
Teesside	Wingfield	10		2	66	76.2%	100.4%	102.8%	101.2%	15.4%	0.0%	4.6%	87.10%
York and Selby	Oak Rise (Acomb)	2			2094	117.4%	102.2%	100.9%	100.7%	13.9%	0.1%	3.9%	72.50%
York and Selby	Whitehorse View					65.0%	96.6%	79.8%	101.3%	1.8%	0.0%	1.4%	71.40%
York and Selby	Meadowfields	4		1	104	68.3%	108.6%	93.9%	108.2%	16.8%	1.9%	0.7%	62.80%
York and Selby	Peppermill Court				2	84.0%	96.8%	79.0%	109.3%	3.6%	9.8%	0.5%	
York and Selby	Cherrytree House	15		5	9	88.9%	99.6%	130.3%	143.3%	18.0%	9.9%	1.4%	66.00%
York and Selby	Worsley Court	15		1	0	92.6%	102.7%	122.2%	197.0%	5.5%	32.7%	0.1%	50.90%
	Total	529	6	381	7664								

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21ST June 2016**
TITLE:	**Recruitment, Development and Retention of Nurses**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information and Assurance**

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

Executive Summary:

This report provides Directors with information about the Trust's approach to the recruitment, development and retention of nursing staff. The report highlights areas of good practice, recruitment fill rates, actions being taken and related topics for future consideration.

Recommendations:

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

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**21ST June 2016**
TITLE:	**Recruitment, Development and Retention of Nurses**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Board of Directors with information about the Trust's approach to improving the recruitment, development and retention of nurses.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 During 2015 there was a marked increase in the number of reports about difficulties being experienced by TEWV operational services when seeking to recruit nurses. These reported difficulties have continued into 2016 and mirror reports of an NHS-wide shortage of nurses. The monthly safe staffing reports that are presented to the Board of Directors and feedback given at the Quality Assurance Committee make regular reference to shortages of nurses.

3. KEY ISSUES:

3.1 Ensuring that there is a good supply of nurses entails a range of successful activities that go beyond those associated with recruitment only. Being able to accurately plan future workforce numbers and providing staff development opportunities that benefit the employer and individual employee is important. Enhancing the level of staff engagement, operating a successful nurse bank and improving the health and wellbeing of our staff are amongst other activities that also contribute to the provision of safe staffing. Taking a long term approach to managing the issue of recruitment and retention is more likely to yield benefits that can be sustained.

3.2 During 2015/16 the TEWV nurse labour turnover rate was 8.80% (174 nurses). In 2014/15 the TEWV nurse labour turnover rate was 9.31% (184 leavers). During a time when nurse recruitment difficulties have increased the number of nurses leaving TEWV has decreased. These figures exclude the York and Selby locality.

3.3 The rate of sickness absence amongst TEWV nurses in 2015/16 was 5.04% compared to a rate of 5.24% in 2014/15. The impact upon the supply of nurses due to sickness absence reduced during the same time that nurse recruitment difficulties increased.

3.4 The level of staff engagement amongst TEWV nurses increased from 3.95 (out of 5) in the 2014 annual staff opinion survey to 4.05 in the 2015 staff opinion survey and is a little above the Trust average score. The staff

engagement score is a combination of staff survey scores about recommending the Trust as a place to work or receive treatment, staff motivation at work and the ability of staff to contribute towards improvements at work. The level of staff engagement amongst TEWV nurses improved during the same time that nurse recruitment difficulties increased.

3.5 It is important to acknowledge the current pre and post registration nurse training activities within TEWV. At present TEWV provides practice placement experience for pre-registration nursing students primarily from the mental health and learning disability programmes and alternative fields of practice experience in respect of the adult and child programmes. The main provider universities working with TEWV are Teesside, York and the Open University. The scale of student practice placement activity within TEWV is significant with a total of 584 student placements during the first three months of 2016. Student evaluation about their placements in TEWV has been positive with approximately 95% of evaluations being positive. It is believed that proving nursing students with positive experiences when on placement is an important part of being able to recruit newly registered nurses.

3.6 Preceptorship is a structured period of transition for a newly qualified nurse, midwife or allied health professional when they commence employment with the NHS. There are some 88 nurses currently participating in preceptorship within TEWV. A recurring theme of preceptorship evaluation is that new nurses believe that they would benefit from spending more time working with their TEWV preceptor.

3.7 In recent years nurse workforce forecasts/projections made by TEWV have proved to be within one or two percentage points of the actual workforce numbers subsequently employed. Within the north east NHS mental health and learning disability nurse workforce projections made by providers have tended to be conservative in recent years. TEWV nurse workforce projections are based upon an understanding of the workforce implications of service plans that are produced within TEWV on an annual basis along with forecasting by Health Education North East. Forecasting workforce numbers with accuracy some five years ahead has proved difficult though adopting a bolder approach to making nurse workforce projections may be worthwhile particularly given the potential impact upon retirement decisions of the increase in the NHS normal pension age. Further changes to workforce planning processes and outcomes may arise from the development of Local Workforce Action Boards as part of Health Education England's plans in response to the Five Year Forward View including Sustainability and Transformation Plans.

3.8 Return to Practice programmes are available for nurses who have taken a break from the nursing profession and who wish to re-join the professional register and return to the nursing workforce. The number of individuals choosing a Return to Practice programme in mental health has been very small with one Return to Practice student in the Yorkshire and Humber area and three students in the North East. Engaging with this group of people is proving difficult for the NHS as a whole and a lack of flexible working

opportunities is cited by some as being amongst the key reasons why Return to Practice programmes have not been more successful to date and this information may help to guide future efforts to improve the take up of Return to Practice programmes.

3.9 Overall use of agency nurses within TEWV is low compared to many similar NHS organisations though recently reliance upon agency nurses has increased in Forensic Services. The TEWV central nurse bank includes some 280 registered mental health nurses though 56 of these nurses are bank only with the remainder also having contracts of employment with TEWV. Fill rates in respect of registered nurse requests are appreciably lower than the overall bank worker fill rate which is often around the 90% level. Only a little over 10% of the TEWV registered nurse workforce are members of the central nurse bank and efforts are underway to increase this percentage. In addition all part-time registered nurses in TEWV are to be asked whether they wish to increase their contracted hours as part of efforts to increase the total number of nurse hours that are available.

3.10 Recent consultation within TEWV about extending working lives has revealed that there is support for taking a more structured approach to retire and return. At present each retire and return request is considered by an employee's manager and this inevitably limits the likelihood of a suitable retire and return opportunity being available. The establishment of a TEWV-wide retire and return registration service will enable consideration to be given to a wider range of potentially suitable return to work posts including those that are suitable for nursing staff. Detailed proposals are yet to be drafted and a final decision about this matter will be made in the autumn.

3.11 The Executive Management Team has approved a number of changes to recruitment practice with the aim of improving our ability to recruit nurses. Recruitment can commence without formal receipt of notice and there is now no requirement to use fixed term contracts when recruiting nurses. An approach has been agreed whereby 'above the line' nurse candidates are either offered posts or placed on a call off list to be given prior consideration should suitable vacancies arise in the near future. Recruitment campaigns in in North Yorkshire and York and are due to take place in July including the use of social media, leaflet drops and paper based advertising. Student nurses at York University are being offered posts with TEWV on a conditional basis in year 2 of their training programme and additional incentives have also been agreed and are being offered. This year's recruitment of York University nursing students is already looking to be more productive than the reports of last year's recruitment round and up to 20 third year completers are being planned for. There is evidence of good working arrangements being established with York University to better promote opportunities to work within TEWV in both mental health and learning disabilities services.

3.12 The Executive Management Team has agreed that there ought to be clear links established between future TEWV non-medical recruitment needs and activities and recently announced national workforce initiatives and key pieces of local work including the Purposeful and Productive Community Services

work-stream, the Safe Staffing Review and the Extending Working Lives initiative. Pursuing an approach to non-medical recruitment that complements workforce and service development activities will be particularly important at a time of national staff supply shortages. A Task and Finish Group is to make recommendations aligning future non-medical recruitment with service and workforce development activities to the Executive Management Team by October 2016. The recommendations will include the proposed response of TEWV to the introduction of the apprenticeship levy from April 2017, at a cost to TEWV in excess of £1m, and the national introduction of the new Nursing Associate role. There is evidence of good working arrangements and relationships between Human Resources and Organisational Development Directorate, Nursing and Governance Directorate and locality representatives being in place and more such joint working will be essential in the future.

3.13 Appendix 1 provides information about Band 5 and Band 6 nursing posts advertised during 2015/16. Overall 78% of these posts were filled following one advertisement and 90% were filled after up to three advertisements. Variations between locality fill rates are apparent. The majority of nurse recruitment activity, approximately 74%, was in respect of replacing TEWV staff who moved to other posts within TEWV or covering staff on maternity leave or covering staff on long term sick leave rather than replacing people who left TEWV altogether. Typically recruitment to these posts took between three and four months.

3.14 The amount if recruitment activity described in paragraph 3.13 may well increase over the coming years as more TEWV nursing staff reach the Mental Health Officer normal pension age of 55 years. The Extending Working Lives initiative is being pursued, amongst other things, to help manage the associated risks to future workforce supply.

3.15 Overall 60% of Band 5 candidates and 24% of Band 6 candidates appointed during 2015/16 were new to TEWV. There were significant variations in respect of the balance of combined Band 5/Band 6 internal/external appointments between the localities with the Teesside locality recording the highest percentage of internal appointments at 69% and York and Selby recording the lowest percentage of internal appointments at 25%. Better understanding of the recruitment activity flow, whether between pay bands and/or services, whether internal or external, ought to help us to better predict future recruitment activity numbers and patterns.

3.16 Existing recruitment information gathering and reporting arrangements and processes are being reviewed to help make it easier to access and share up to date recruitment information at all levels within TEWV.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** The costs associated with recruitment campaigns have been previously identified and funded by the Executive Management Team.

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

4.4 **Equality and Diversity:** None identified.

4.4 **Other implications:** Further consideration of the resources needed to address recruitment difficulties may be required in the future.

5. RISKS: A failure to address recruitment difficulties could lead to future staff shortages, create quality/safety concerns and incur additional costs.

6. CONCLUSIONS:

6.1 There is evidence available of good employment policy and practice within TEWV that provides a sound basis for the successful recruitment and retention of nursing staff. The need to better align future recruitment information, policy and practice with service and workforce development activities is apparent.

6.2 There is clear scope to increase fill rates particularly at first advertisement.

6.3 There are no grounds for believing that current recruitment activities within TEWV are being adversely affected by efforts to address future recruitment and retention issues.

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: 'Workforce planning in the NHS' Kings Fund April 2015.
'Reshaping the workforce to deliver the care patients need' Nuffield Trust May 2016.
NHS Employers 'A strategic approach to workforce supply' July 2015
National Staff Survey results 2014 & 2015 NHS Staff Surveys
Electronic Staff Record reports
Health Education North East workforce projections
NHS Jobs based recruitment report

Appendix 1

Recruitment data for Registered Mental Health or LD Nursing Band 5 and Band 6 posts – 2015/16

The total number of Registered Mental Health or LD Nursing posts that were advertised by TEWV during 2015/16

Please note that recruiting managers would not usually keep advertising so some of the figure of 77 below are likely to have been re-advertised in a modified way or following a gap and would then not be identifiable as a re-advertisement from a previously unfilled vacancy.

	No of posts advertised	Filled from single advert	Filled from second advert	Filled from third advert	Total filled by 1-3 adverts	Not filled by 1-3 adverts
Durham & Darlington	219	161	20	1	182	37
Forensic Services	90	70	6	5	81	9
North Yorkshire	148	118	15	0	133	15
Tees	184	158	20	1	179	5
York & Selby	38	23	4	0	27	11
Corporate	1	1	0	0	1	0
Totals	680	531	65	7	603	77

The overall percentage of posts that were filled by internal/external candidates and by locality

	External	Internal
Durham & Darlington	39%	61%
Forensic Services	48%	52%
North Yorkshire	50%	50%
Tees	31%	69%
York & Selby	75%	25%
Corporate	50%	50%
Totals	42%	58%

The percentage of appointments made by pay band where internal/external candidates were successful and by locality.

	Band 5		Band 6	
	External	Internal	External	Internal
Durham & Darlington	52%	48%	26%	74%
Forensic Services	74%	26%	17%	83%
North Yorkshire	65%	35%	32%	68%
Tees	55%	45%	9%	91%
York & Selby	78%	22%	74%	26%
Corporate			50%	50%
Totals	60%	40%	24%	76%

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21 June 2016**
TITLE:	**Finance Report for Period 1 April 2016 to 31 May 2016**
REPORT OF:	**Drew Kendall, Acting Director of Finance**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 May 2016 is a surplus of £2,496k, representing 4.6% of the Trust's turnover. The Trust is ahead of plan by £257k largely due to vacancies within Corporate Services.

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

The Financial Sustainability Risk Rating for the Trust is assessed as 4 for the period ending 31 May 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:	**21 June 2016**
TITLE:	**Finance Report for Period 1 April 2016 to 31 May 2016**

1. INTRODUCTION & PURPOSE

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

2. BACKGROUND INFORMATION

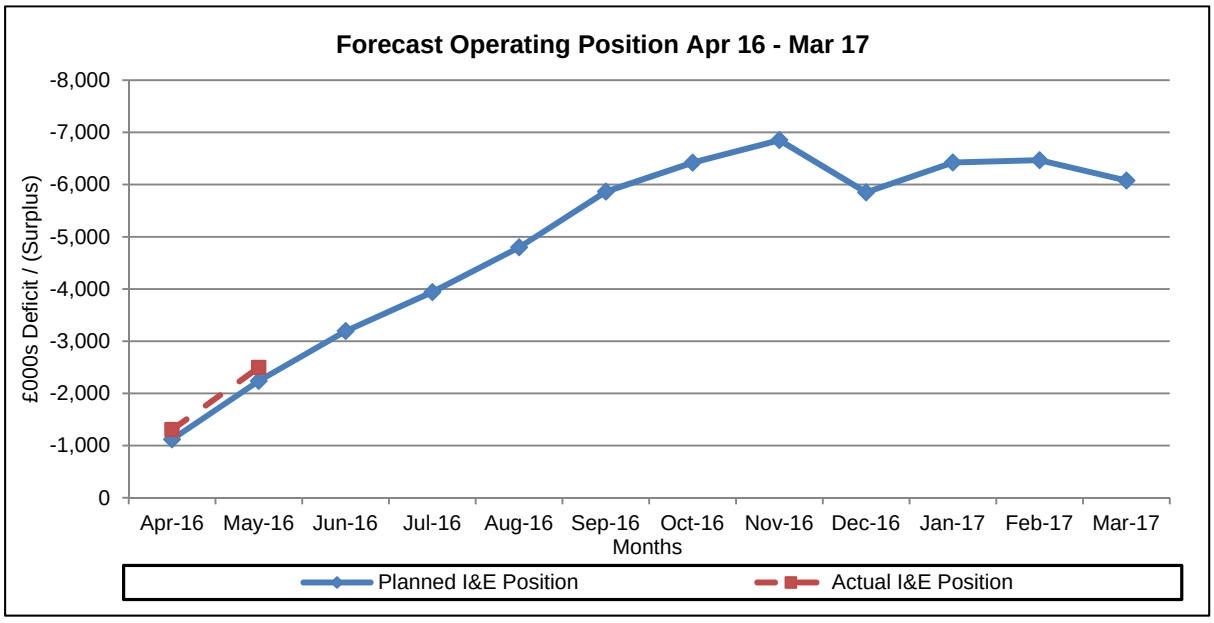
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

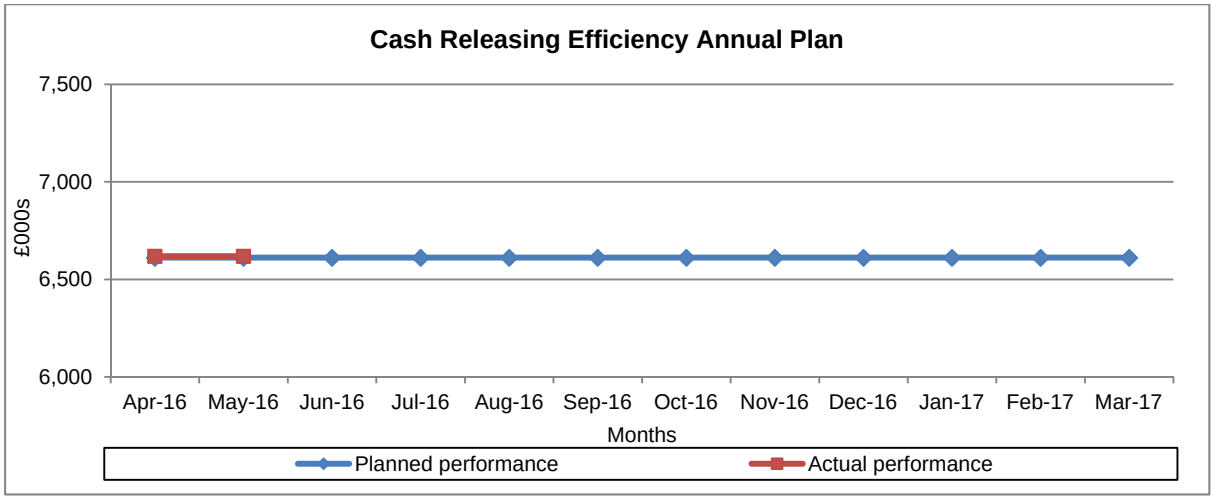
The comprehensive income outturn for the period ending 31 May 2016 is a surplus of £2,496k, representing 4.6% of the Trust's turnover. The Trust is ahead of plan by £257k largely due to vacancies within Corporate Services.

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

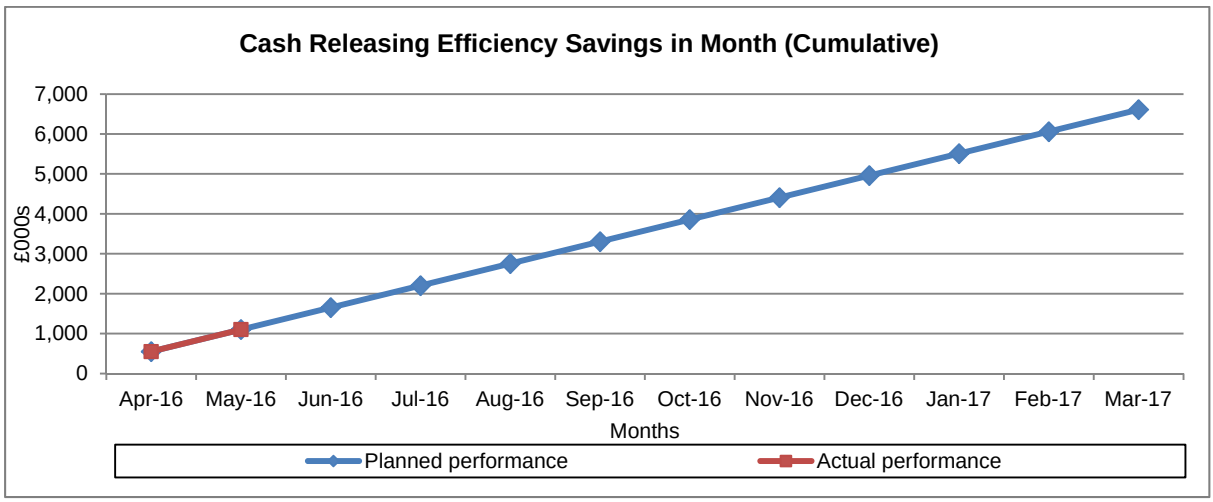


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 May 2016 is £6,618k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

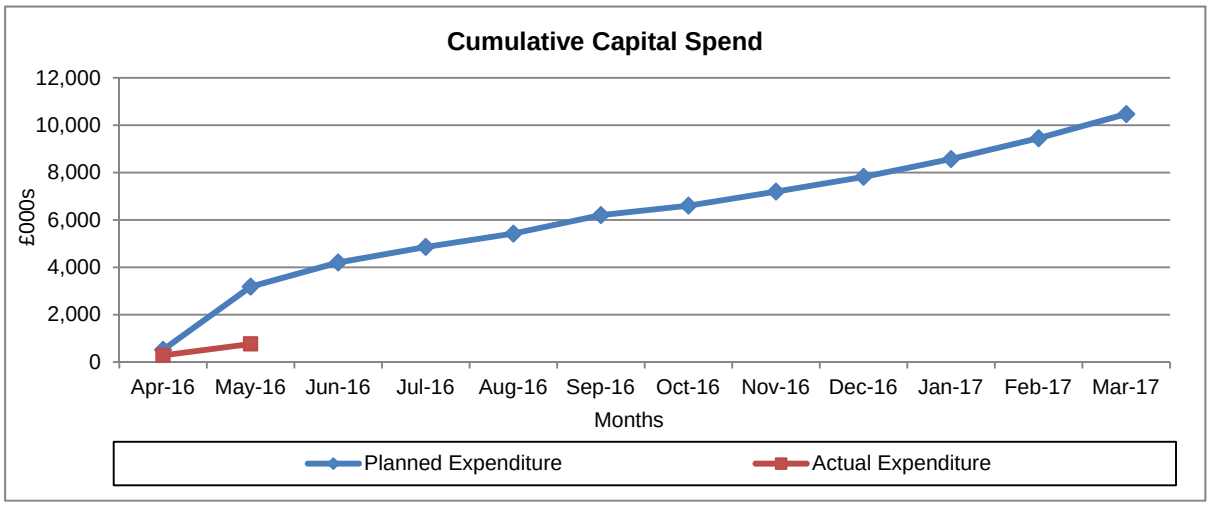


The monthly profile for CRES identified by Localities is shown below.



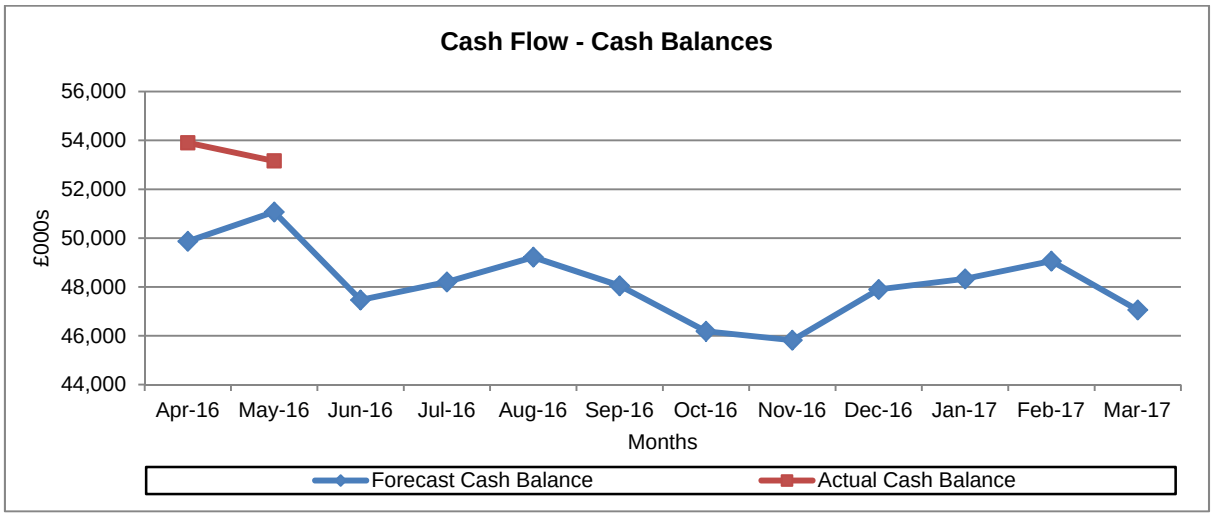
3.3 Capital Programme

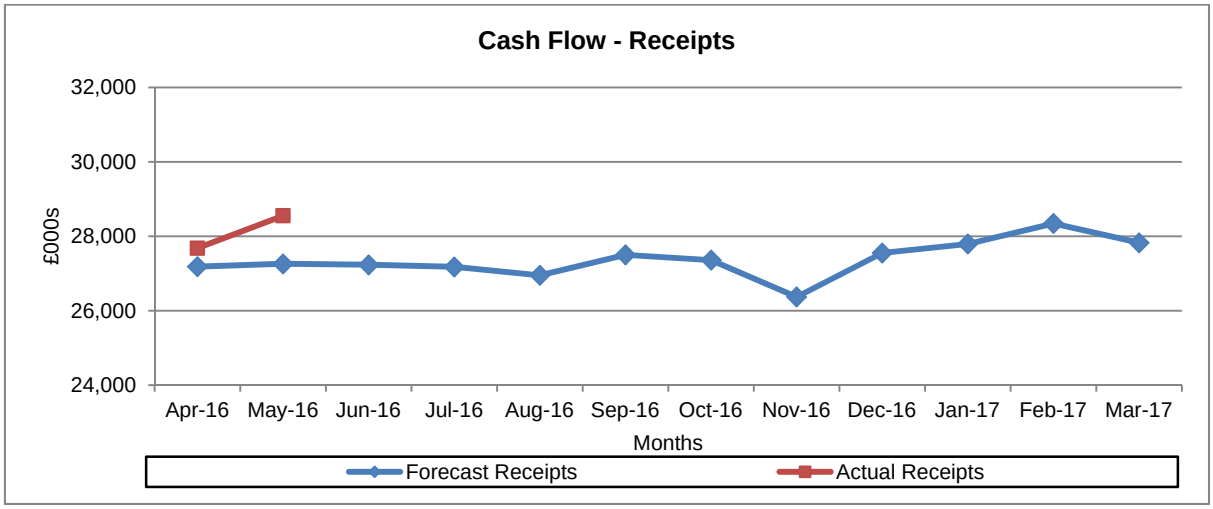
Capital expenditure to 31 May 2016 is £763k and is behind plan largely due to the Trust's decision to defer a scheme with planned year to date capital expenditure of £2,124k.

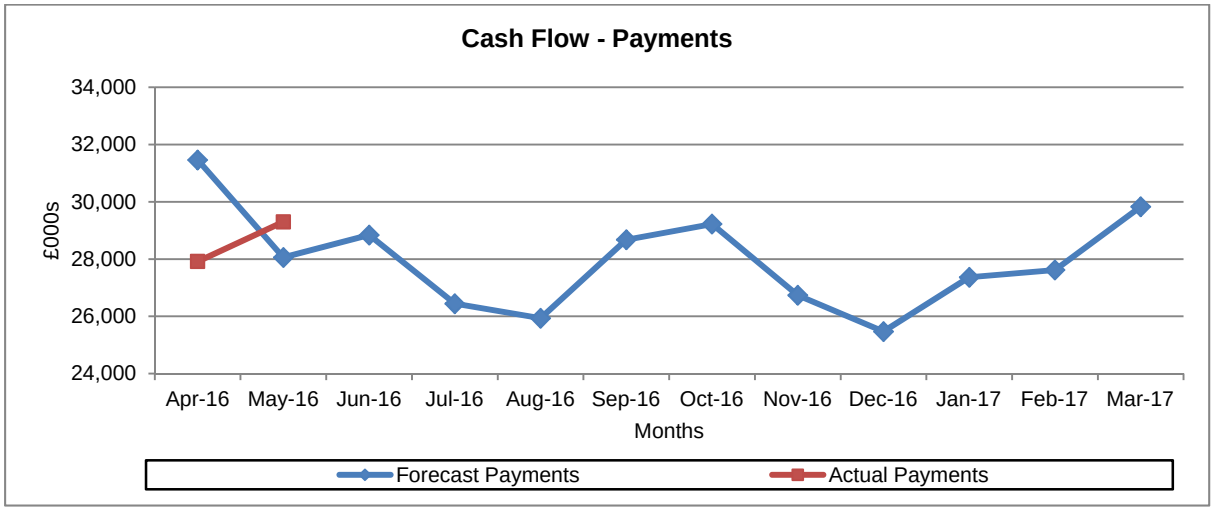


3.4 Cash Flow

Total cash at 31 May 2016 is £53,158k and is ahead of plan due to variances against the planned working capital cycle and planned delays in the capital programme.

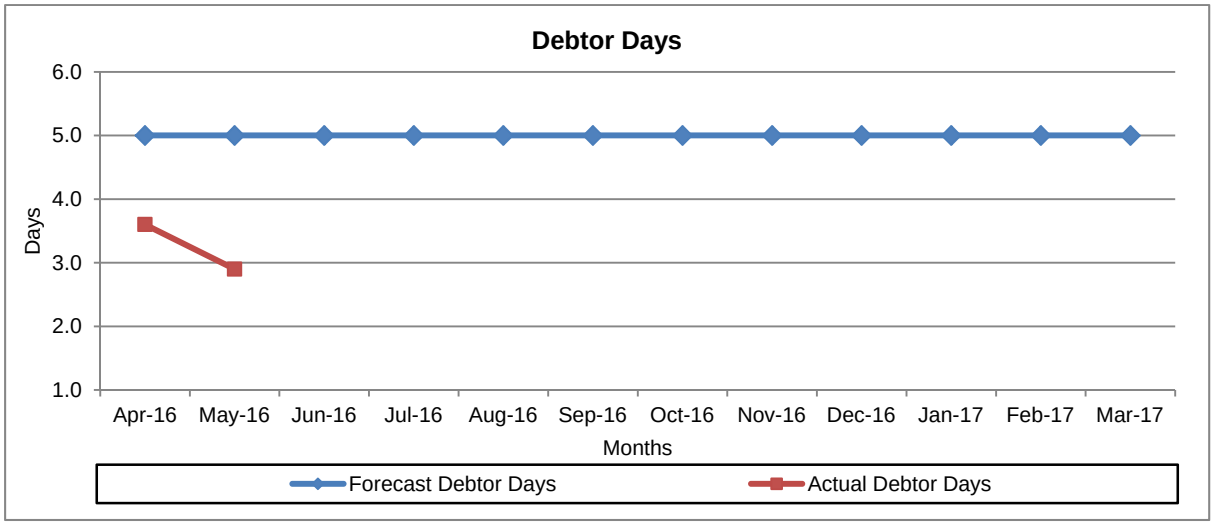






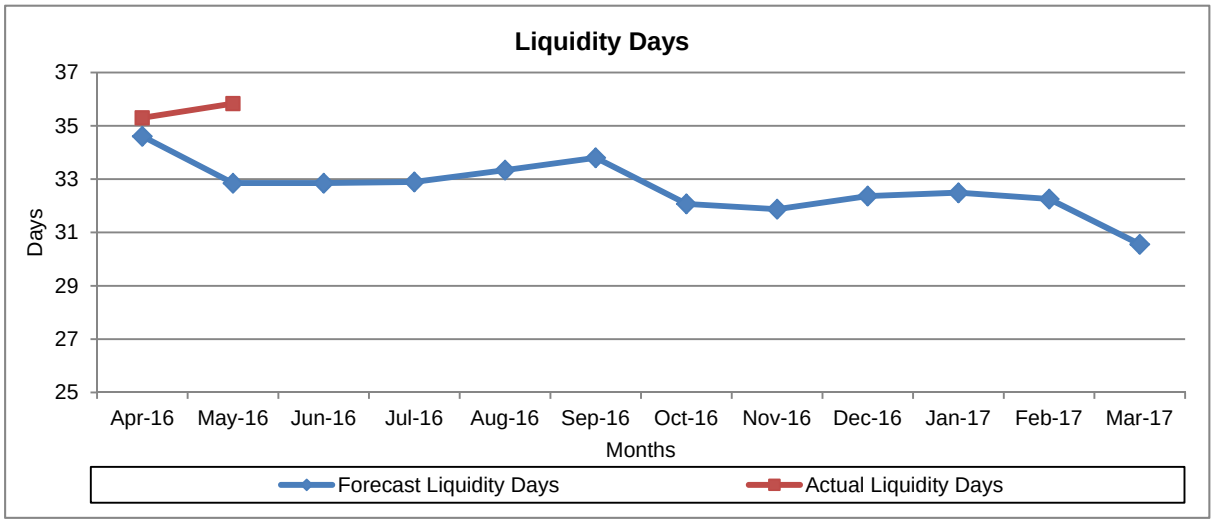
The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.
Working Capital ratios for period to 31 May 2016 are:

- Debtor Days of 2.9 days
- Liquidity of 36.0 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS–26.38% (Due to delays caused by bank account changes)
  Non NHS 30 Days–97.38%



The Trust has a debtors' target of 5.0 days, and actual performance of 2.9 days for May, which is ahead of plan.

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



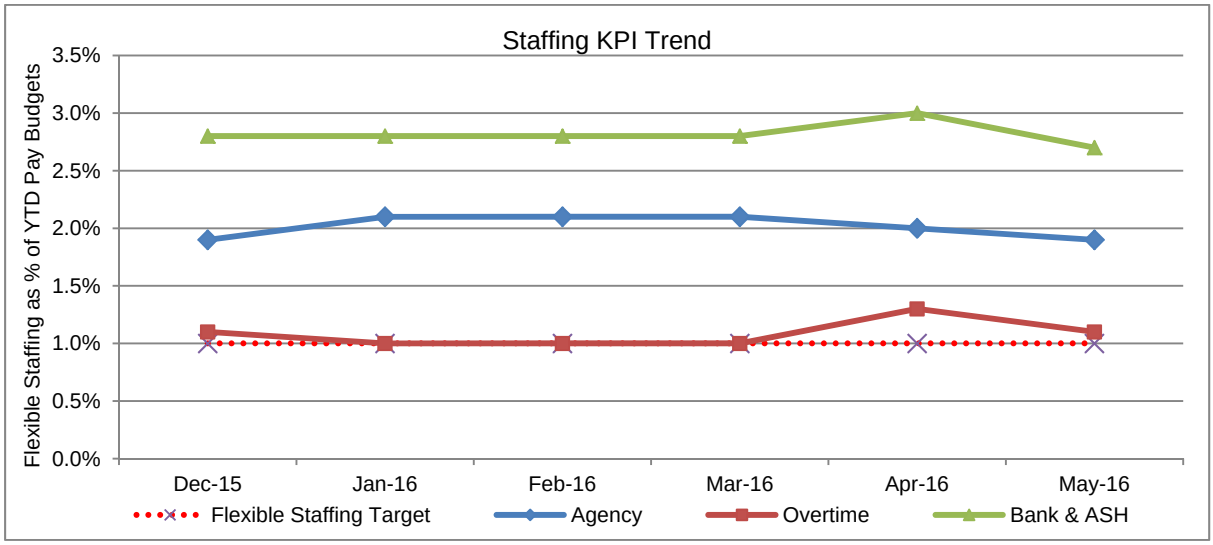
3.5 Financial Drivers

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

Tolerance	Jan	Feb	Mar	Apr	May
Agency (1%)	2.1%	2.1%	2.1%	2.0%	1.9%
Overtime (1%)	1.0%	1.0%	1.0%	1.3%	1.1%
Bank & ASH (flexed against establishment)	2.8%	2.8%	2.8%	3.0%	2.7%
Establishment (90%-95%)	94.2%	93.1%	92.7%	94.5%	93.9%
Total	**100.1%**	**99.0%**	**98.6%**	**100.8%**	**99.6%**

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 & additional standard hours (ASH). For May 2016 the tolerance for Bank and ASH is 4.1% of pay budgets.

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



Additional staffing expenditure is 5.7% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (55%), enhanced observations (16%) and sickness (13%).

3.6 Risk Ratings and Indicators

3.6.1 The Financial Sustainability Risk Rating is assessed as 4 at 31 May 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 1.35x (can cover debt payments due 1.35 times), which is in line with plan and rated as a 2.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 36.0 days, this is in line with plan and is rated as a 4.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has a I&E margin of 4.6% and is rated as a 4.

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

The margins on Financial Sustainability Risk Rating are as follows:

- Capital service cover - to increase to a 3 a surplus increase of £996k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £29,873k is required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £1,953k is required.
- Variance from plan – to reduce to a 3 an operating surplus decrease of £246k is required.

Financial Sustainability Risk Rating at 31 May 2016

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

TEWV Performance	Actual Achieved	Actual Rating	YTD Plan Planned	YTD Plan Rating	RAG Rating
Capital service Cover	1.35x	2	1.27x	2	
Liquidity	36.0 days	4	32.8 days	4	
I&E Margin	4.6%	4	4.1%	4	
Variance from plan	0.5%	4	0.0%	4	
Overall Financial Sustainability Risk Rating		**4.00**		**4.00**	

3.6.7 7.6% of total receivables (£226k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as negotiations are ongoing to resolve.

3.6.8 1.9% of total payables invoices (£255k) 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 May 2016 is £53,158k and represents 65.8 days of annualised operating expenses.

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

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 May 2016 is a surplus of £2,496k, representing 4.6% of the Trust's turnover. The Trust is ahead of plan by £257k largely due to vacancies within Corporate Services.

6.2 Total CRES identified at 31 May 2016 is £6,618k and is in line with plan. The Trust continues to progress schemes to deliver CRES for future years.

6.3 The Financial Sustainability Risk Rating for the Trust is a 4 for the period ending 31 May 2016 which is in line with plan.

7. RECOMMENDATIONS:

7.1 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.

Drew Kendall
Acting Director of Finance

Item 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**21st June 2016**
TITLE:	**Board Dashboard as at 31st May 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 May 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 May 2016, 7 (39%) of the indicators are not achieving the expected levels and are red, which is a significant improvement on the April figure of 12 (67%). Of those red indicators, 4 are showing an improving trend. There are a further 3 indicators which whilst not completely achieving the target levels are within the amber tolerance levels.

Whilst not included in the Trust Dashboard the Corporate Performance Department continue to monitor the indicators within Monitor's Risk Assessment Framework and as at the end May all the targets for these indicators were being achieved.

The key issues/risks continue to be:

- Bed Occupancy – (KPI3)
- Access – Waiting Times (KPI 7)
- Out of Locality Admissions (KPI 9)
- %age registered healthcare professional jobs advertised 2 or more times(KPI 15)
- Appraisal (KPI 16)

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:	**21st June 2016**
TITLE:	**Board Dashboard as at 31st May 2016**

1. INTRODUCTION & PURPOSE:

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

- The Trust Dashboard in Appendix A now includes the performance of the York and Selby locality.

- As at the end of May 2016, 7 (39%) of the indicators are not achieving the expected levels and are red, which is a significant improvement on the April figure of 12 (67%). Of those red indicators 4 are showing an improving trend. There are a further 3 indicators which whilst not completely achieving the target levels are within the amber tolerance levels.

- In agreeing the key indicators to be included in the Trust Dashboard a significant number of new indicators were identified. Unfortunately it has not been possible to include previous year's performance against these indicators within this report however work is ongoing to ensure this is include within future reports. In addition there are 3 indicators identified for inclusion for which the definition/construction of the indicator is still being developed. These are:

    - Caseload Turnover
    - 2 patient outcome indicators currently in development

- The Data Quality Scorecard is included in Appendix B.

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

2.2 The key risks are as follows:

- Bed Occupancy (KPI 3) – The actual performance is worse than the target by 12.27 percentage points with all localities showing levels of over 90%. Teesside and North Yorkshire in particular had very high levels of bed occupancy in May linked to the number of adults from York and Selby occupying beds in these localities. Work is ongoing to open 24 Adult Mental Health beds at Peppermill in York and when complete it is

expected that the overall levels of occupancy will reduce to a level nearer to the target.

- External Waiting Times (KPI 7) – the Trust has not achieved the 90% target it set itself for the number of people seen within 4 weeks in May however there has been an improvement since April. In addition the figure reported in May 2016 is higher than that reported in both May 2015 and May 2014 and is the highest level of performance since October 2015. The main area of concern continues to be Children and Young Peoples services, and in particular in Durham and Darlington. The service has a detailed action plan which it is continuing to implement and there has been an improvement made with the number of people still waiting over 4 weeks at the end May being 308 compared to 451 as at the end April 2016. Overall across all localities there has been an improvement of 175 when comparing the number of people who are waiting more than 4 weeks in Children and Young Peoples Services at the end May 2016 to that at the end April 2016.

- Out of Locality Admissions (OoL) (KPI 9). The Trust has continued not to achieve the target in May with a deterioration compared to April 2016. . Teesside and North Yorkshire are significantly worse than target linked to the pressure on inpatient beds referred to in KPI 3 above.

- %age of registered healthcare professional jobs advertised 2 or more times (KPI 15) - the actual performance is significantly worse than the target set. There were 17 jobs re-advertised in May of which the majority (15) were non-medical registered healthcare posts. Of these 15, 5 related to fixed term posts which may have been a contributory factor in them not being filled. It has now been agreed not to use fixed term contracts for nursing posts and the recruitment team will challenge any such posts that come through for recruitment.

- Appraisal (KPI 16) – The Trust is not achieving the target of 95% as at the end May but the position has improved from April. Work is ongoing to develop more detailed reports via the IIC which will help managers proactively managed the compliance levels of both appraisal and mandatory and statutory training.

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

	May 2016				April 2016 To May 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,339.00	8,583.00			14,441.00	17,133.00		86,407.00
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	97.27%			85.00%	96.91%		85.00%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	23.00	20.00			46.00	51.00		277.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.58%			15.00%	7.58%		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	25.67			21.00	25.67		237.00

Quality

	May 2016				April 2016 To May 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%	85.25%			90.00%	84.03%		90.00%
8) Percentage of appointments cancelled by the Trust	0.67%	0.91%			0.67%	0.96%		0.67%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	22.06%			15.00%	20.25%		15.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	93.38%			91.44%	91.68%		91.44%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.48			1.00	1.43		12.00

Trust Dashboard Summary for TRUST

Workforce

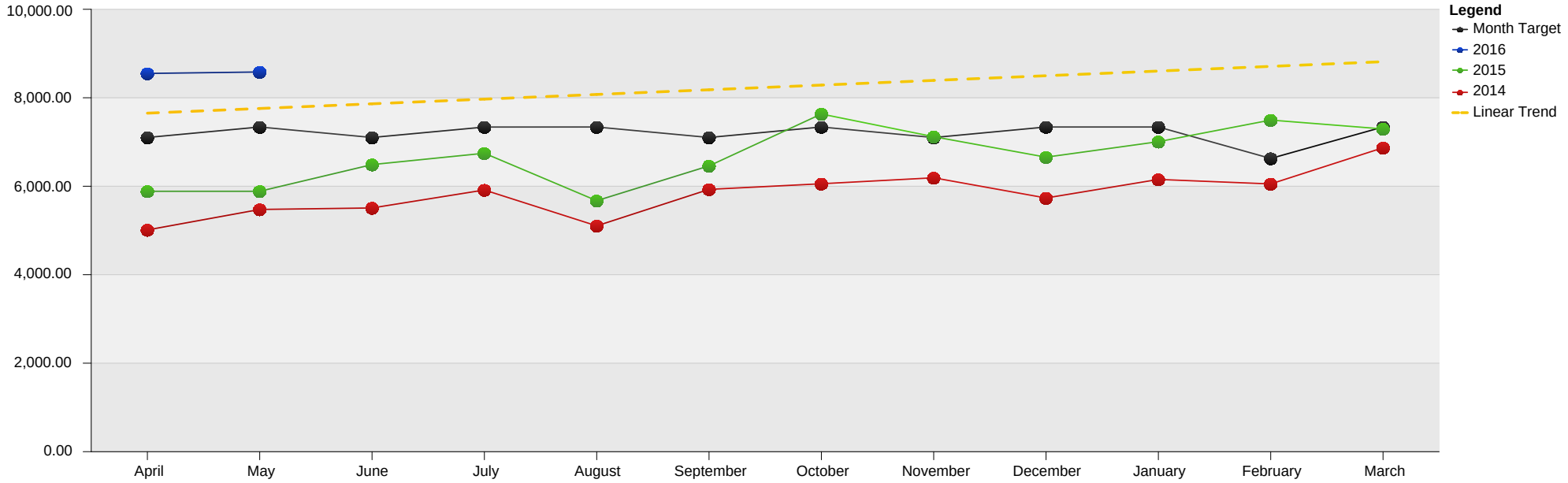
	May 2016				April 2016 To May 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 90%-95%)	95.00%	93.89%			95.00%	93.89%		95.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	5.00%	20.73%			5.00%	20.14%		5.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	83.72%			95.00%	83.72%		95.00%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.09%			95.00%	88.09%		95.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.76%			4.50%	4.81%		4.50%

Money

	May 2016				April 2016 To May 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-1,120,175.00	-1,191,000.00			-2,238,794.00	-2,496,000.00		-6,077,087.00
20) CRES Delivery	550,854.00	551,538.00			1,101,709.00	1,103,076.00		6,610,251.00
21) Cash against plan	51,070,000.00	53,158,000.00			51,070,000.00	53,158,000.00		47,056,000.00

Trust Dashboard Graphs for TRUST

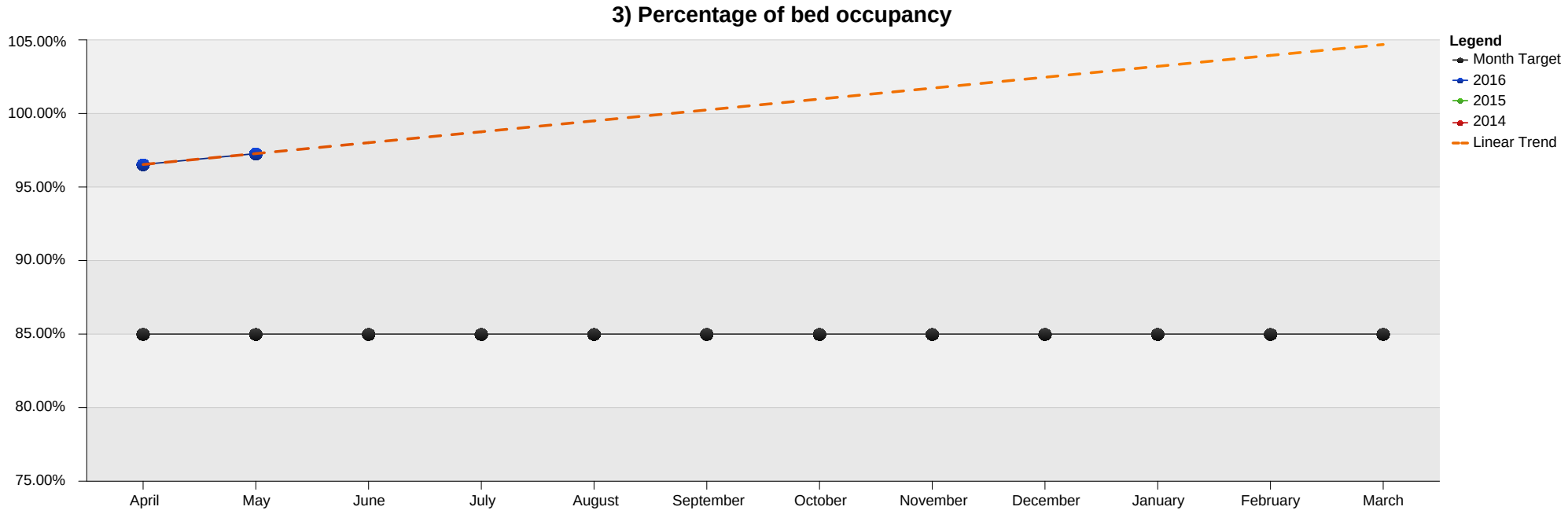
1) Total number of External Referrals into Trust Services



	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	8,583.00	17,133.00	2,030.00	4,070.00	1,982.00	3,907.00	1,983.00	3,854.00	731.00	1,495.00	1,857.00	3,806.00

Narrative
The Trust position for May 2016 is 8583 which is 1244 above the Trust target of 7339. The Trust position for the financial year to date is 17,133, which is 2692 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 6727 which is similar level to April 2016 but an increase of 881 when compared to May 2015.Based on the increasing trend reported it is anticipated that we will exceed the annual target of 86,407 referrals by more than 10%.

Trust Dashboard Graphs for TRUST

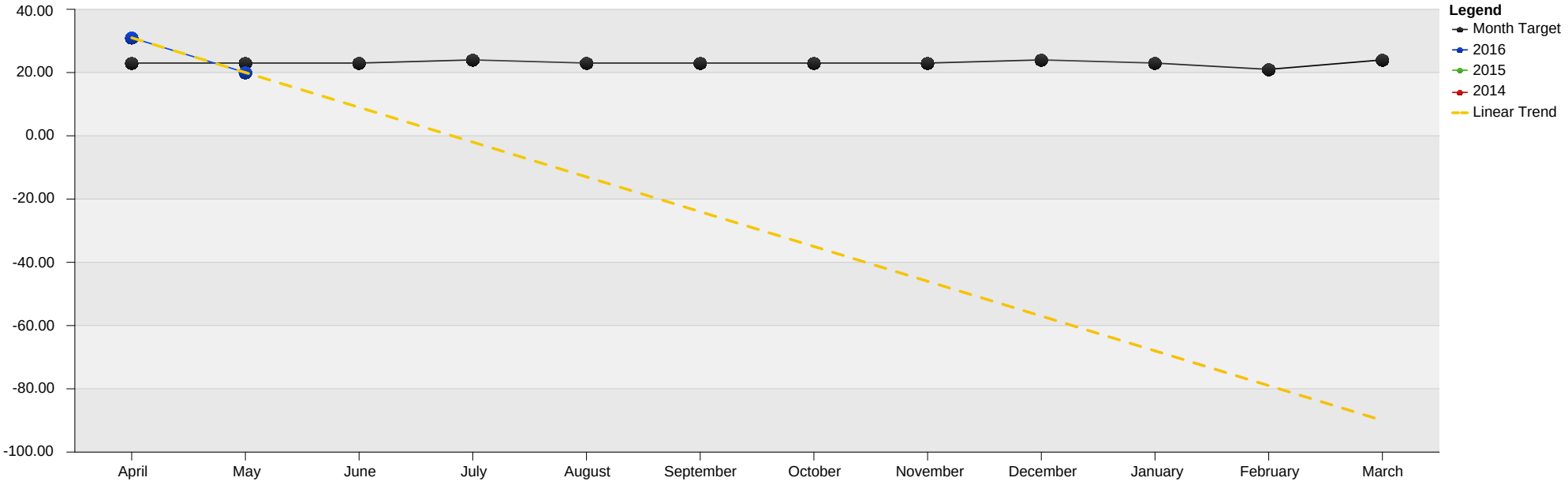


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	97.27%	96.91%	92.80%	92.53%	102.30%	100.44%	97.40%	98.35%	NA	NA	96.21%	96.58%

Narrative
The Trust position for May is 97.27% which is 12.27% over the Trust target of 85%. All localities are over target; however Teesside has the highest bed occupancy at 102.30%, with 6 wards reporting over 100% occupancy. (This is due to the utilisation of beds when patients are on leave.) The Trust position for the financial year to date is 96.91%, which is 11.91% above target.Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available currently in this dashboard.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. It is expected that when the Adult Mental Health beds open at Peppermill in York the levels of occupancy will move closer to the target set.

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

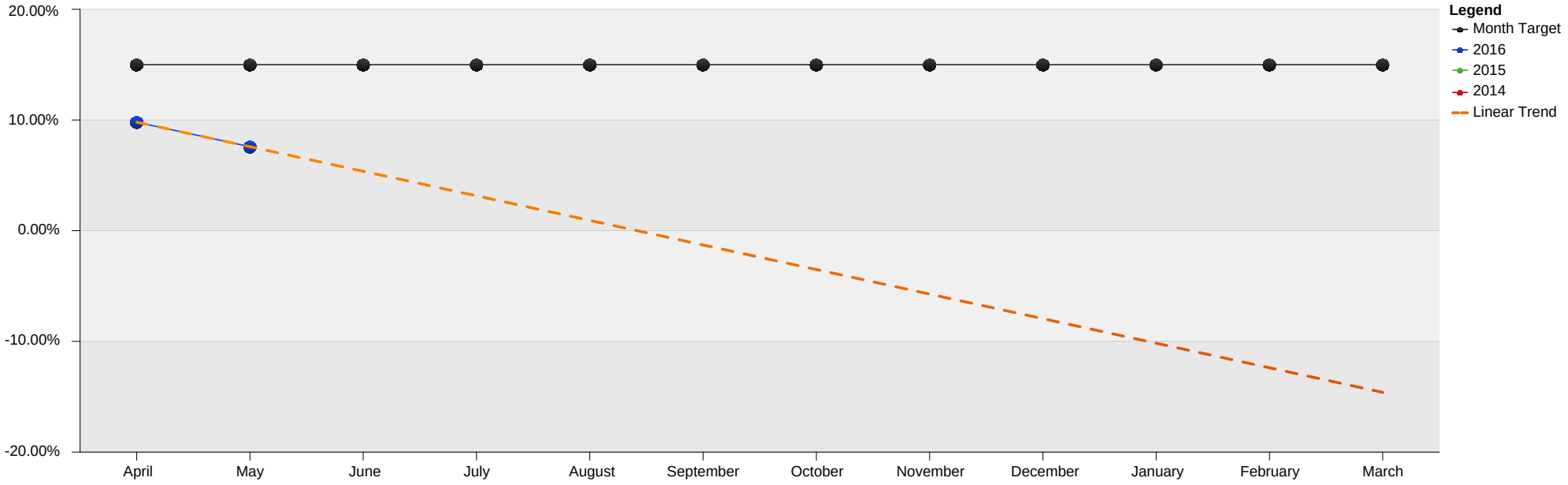


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	20.00	51.00	5.00	14.00	9.00	18.00	6.00	11.00	NA	NA		

Narrative
The Trust position for May 2016 is 20 which is better than the Trust target of 23 and an improvement in Aprils position. The lengths of stay range from 92-271 days. The Trust position for the financial year to date is 51, which is worse than the target of 46.Of the 20 admissions with a LoS greater than 90 days:* 5 (25%) were within Durham & Darlington (5 MHSOP) * 9 (45%) were within Teesside (4 AMH and 5 MHSOP)* 6 (30%) were within North Yorkshire (4 AMH and 2 MHSOP) Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available currently in this dashboard. Based on the improvement in performance reported in May it can be expected that we will achieve the annual target of 277.

Trust Dashboard Graphs for TRUST

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



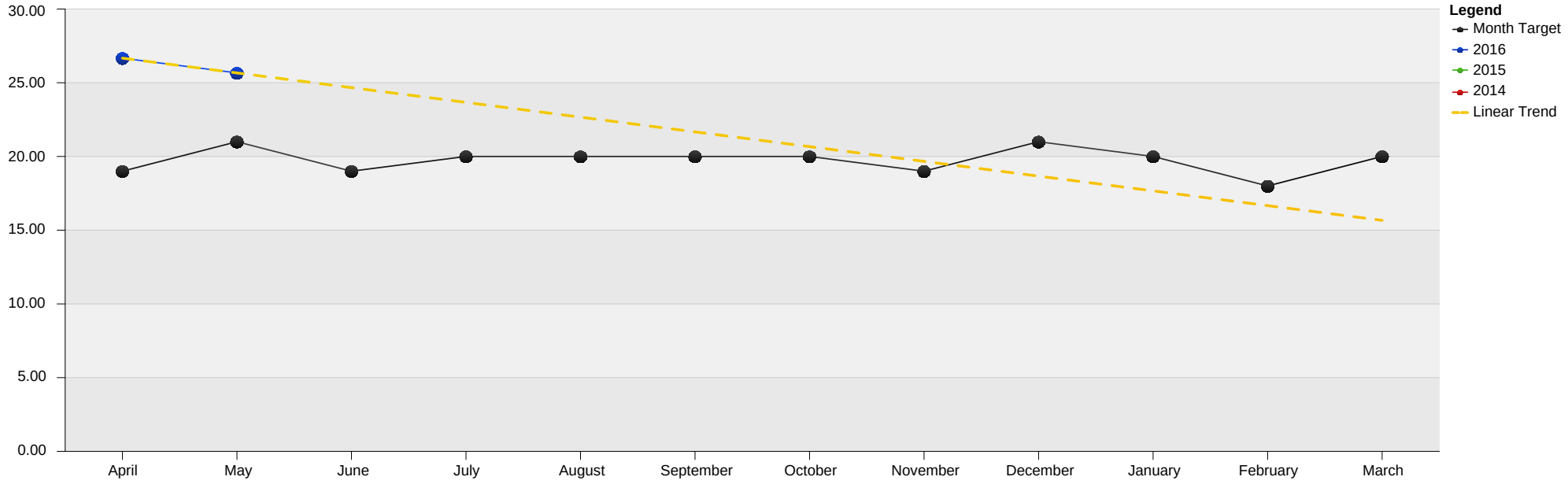
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	7.58%	7.58%	6.11%	6.11%	6.67%	6.67%	8.51%	8.51%	NA	NA	13.33%	13.33%

Narrative

Following discussions at the Quality Assurance Committee, and approval by the Board of Directors, this KPI has been changed to reflect a rolling 3 month position.The Trust position for May 2016 is 7.58%, which relates to 37 patients out of 167 that were readmitted within 30 days. This is 7.42% below the target of 15% and an improvement on the position reported in April 2016. Of the 37 patients:* 10 (27%) were within Durham & Darlington (10 AMH) * 9 (24%) were within Teesside (8 AMH and 1 MHSOP).* 12 (33%) were within North Yorkshire (9 AMH and 3 MHSOP) * 6 (16%) were within York & Selby (6 AMH)The circumstances of the readmissions have been investigated and most were attributable to the severity of the symptoms and personal circumstances of the patients concerned; one was attributable to a data entry error. A discussion is due to take place at OMT to agree a process for validation of these patients on a monthly basis to allow more detailed assurance to be obtained.Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available currently in this dashboard. Based on the improvement in performance reported in May 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)

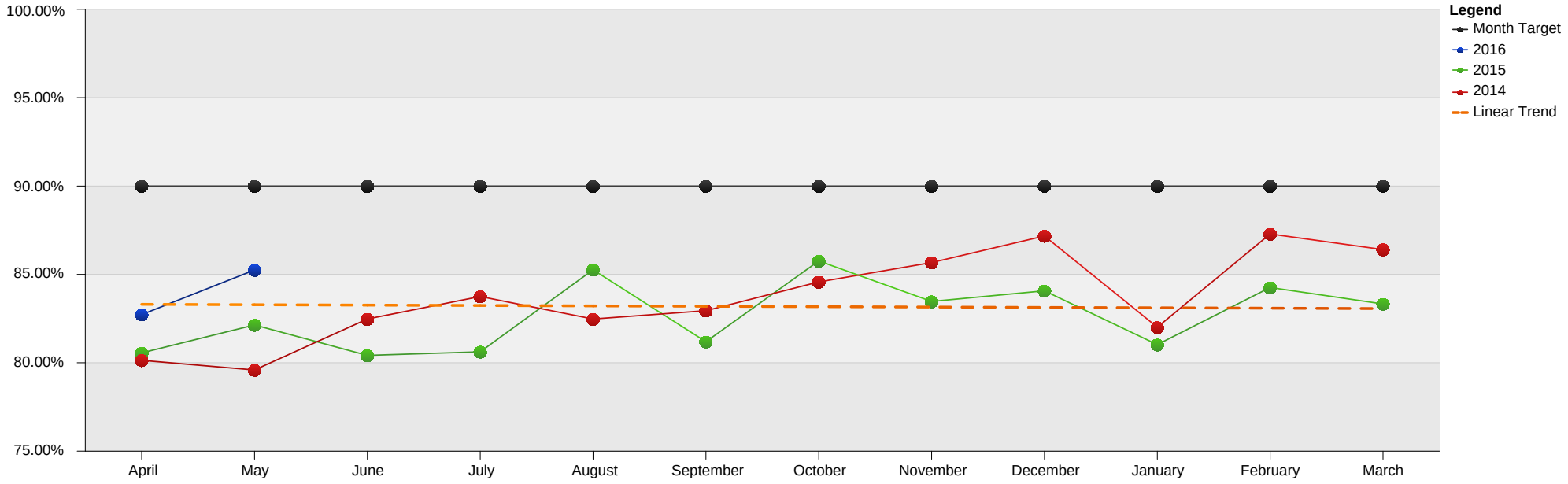


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	25.67	25.67	11.33	11.33	6.67	6.67	5.33	5.33	NA	NA	2.33	2.33

Narrative
Following discussion at the Quality Assurance Committee, and approval by the Board of Directors, this KPI has been changed to reflect a rolling 3 month position.The Trust position for May 2016 is 25.67, which is 4.67 worse than the target of 21 but an improvement on the position reported in April. Of the 24 patients* 11 (45.83%) were within Durham & Darlington (AMH)* 6 (25%) were within Teesside (AMH)* 6 (25%) were within North Yorkshire (5 AMH, 1 MHSOP)* 1 (4%) was within York and Selby (AMH)Data including the York and Selby locality only started to be collected from April 2016; therefore it is not possible to make a comparison with the data for 2015/16. If comparing the remaining 4 localities, the position is 23 which is an improvement of 10 compared to April 2015.

Trust Dashboard Graphs for TRUST

7) Percentage of patients seen within 4 weeks for a first appointment (external referral)



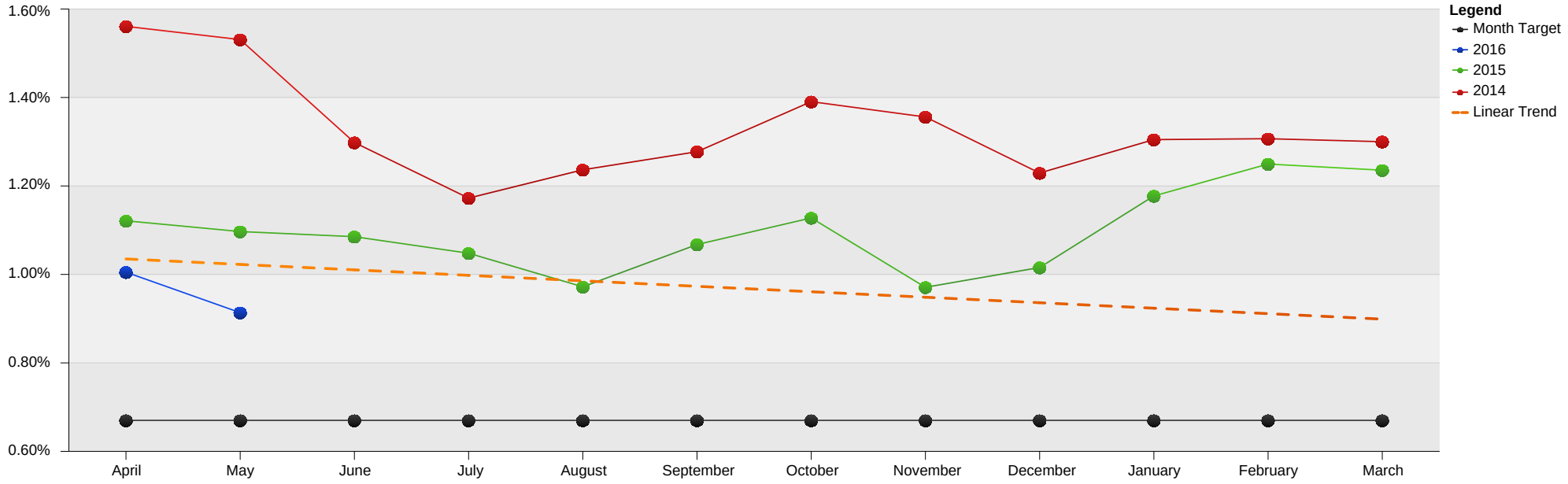
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	85.25%	84.03%	76.61%	76.73%	95.48%	94.00%	75.34%	73.97%	99.59%	99.45%	84.53%	79.33%

Narrative

The position for May 2016 is 85.25%, relating to 689 patients out of 4671 who had waited longer than 4 weeks for first appointment. This is 4.75% worse than target but an improvement on the position reported in April. The Trust position for the financial year to date is 84.03%, which is 5.97% worse than target.Areas of concern are:* Durham & Darlington CYP at 33.10% (194 of 290 patients). Staff vacancies and sickness continue to impact. The action plan is progressing. * North Yorkshire MHSOP at 71.95% (85 of 303 patients), LD at 72.22% (10 of 36 patients) and CYP at 52.78% (51 of 108 patients). Harrogate MHSOP has a number of staff vacancies; flexible working arrangements are being reviewed. A nurse development programme within CYP is being developed to secure students and improve staff retention and succession planning. * York & Selby CAMHS at 67.68% (32 of 99 patients) and LD at 76.47% (4 of 17 patients). Issues following migration to PARIS continue in terms of data quality and these are being addressed. Data including York & Selby only started to be collected from April 16; therefore it is not possible to compare with 2015/16. Comparing the remaining 4 localities, the position is an improvement of 3.17% compared to May 2015.Based on April and May's performance there is a significant risk that we will not achieve the annual target of 90%.

Trust Dashboard Graphs for TRUST

8) Percentage of appointments cancelled by the Trust



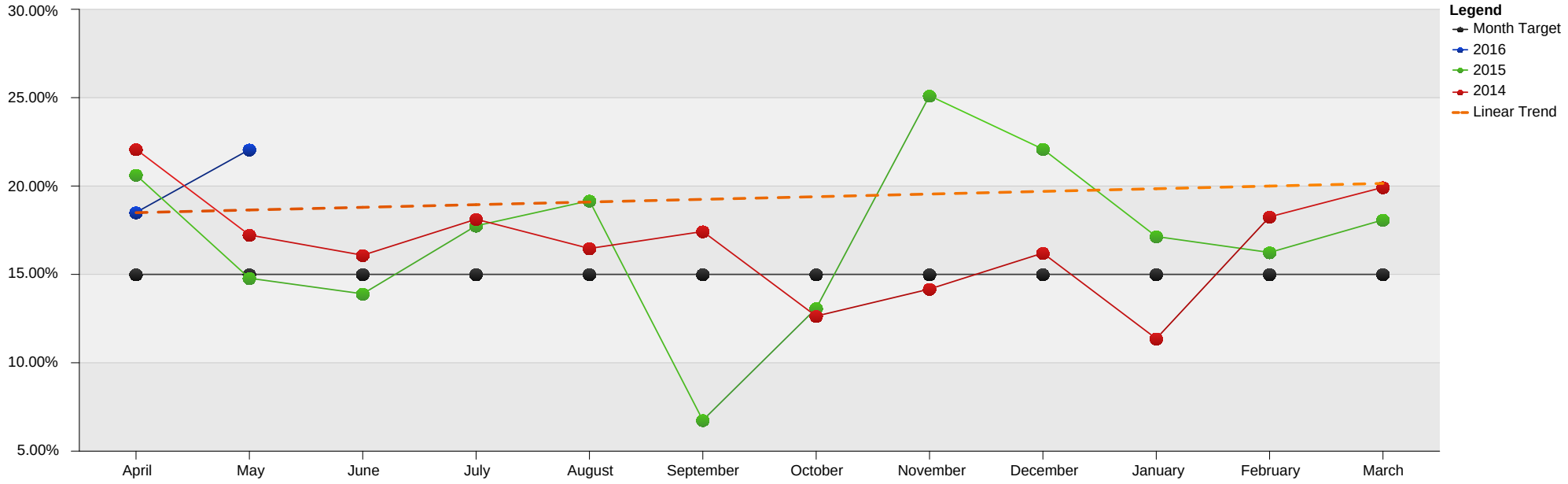
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of appointments cancelled by the Trust	0.91%	0.96%	1.16%	1.23%	0.70%	0.77%	1.18%	1.18%	0.14%	0.17%	0.53%	0.44%

Narrative

Following audit proposals, the construction of this indicator has been updated to cover cancellations due to:* staff unavailability* rescheduling by the service to a later appointment* clinician on callThe Trust position for May 2016 is 0.91%, which relates to 815 appointments out of 89,212 that have been cancelled. This is 0.24% worse than the target but an improvement on the position reported in April. The Trust position for the financial year to date is 0.96%, which is 0.29% worse than the target.Only York and Selby and Forensic are achieving the target.The new codes for cancelled appointments were introduced in May and these are currently being monitored by the Information Service Managers, to assess whether there are any issues being experienced within teams.Based on past performance and May's performance there is a significant risk that we will not achieve the annual target of 0.67%.

Trust Dashboard Graphs for TRUST

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

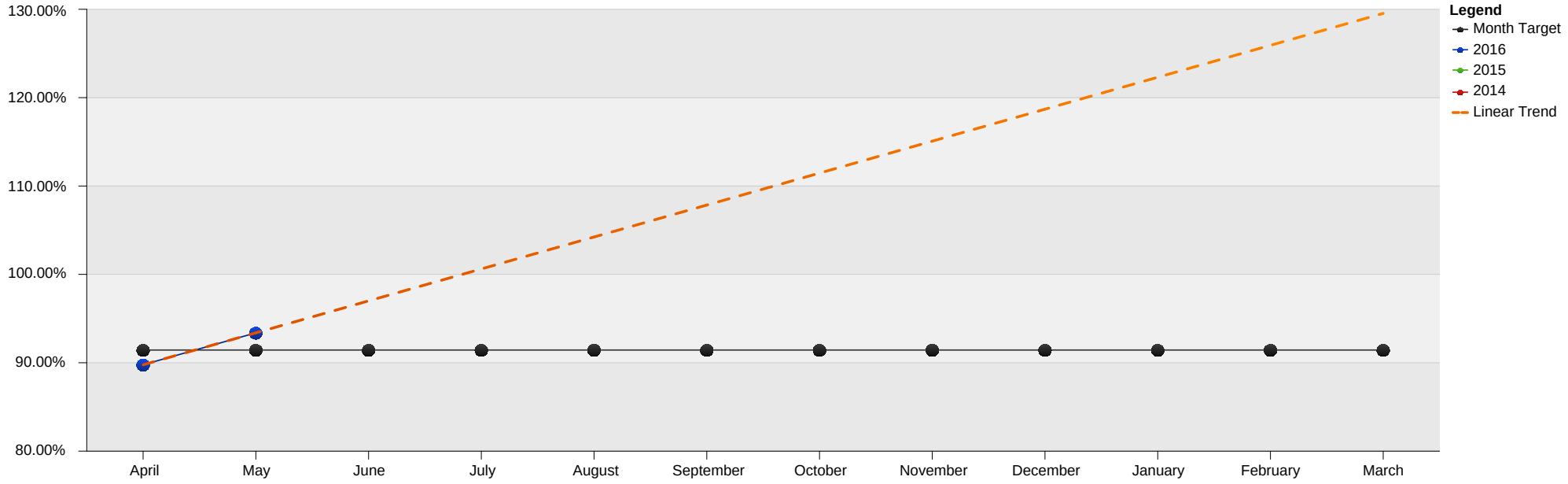


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	22.06%	20.25%	14.10%	19.08%	29.35%	22.22%	29.31%	25.81%	NA	NA	11.36%	10.59%

Narrative
The Trust position for May 2016 is 22.06%, which relates to 60 admissions out of 272 that were admitted to assessment and treatment wards out of locality. This is 7.06% worse than the target of 15% and a deterioration on the position reported in April. The Trust position for the financial year to date is 20.25%, which is 5.25% worse than the target. This increase is linked to the high level of bed occupancy reported in KPI 3.North Yorkshire (29.31%), Durham and Darlington (14.10%) and Tees (29.35%) are not achieving the target whilst York and Selby (11.36%) are achieving. Of the 60 patients (AMH 41, MHSOP 19) admitted to an 'out of locality' bed, 59 were due to no beds being available at their local hospital. The localities continue to investigate ways in which they can reduce OOL admissions.Data including the York and Selby locality only started to be collected from April 2016; therefore it is not possible to make a comparison with the data for 2015/16. If comparing the remaining 4 localities, the position is 24.12% which is deterioration of 9.52% compared to May 2015.Based on past performance and May's performance there is a significant risk that we will not achieve the annual target 15.00%.

Trust Dashboard Graphs for TRUST

10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)



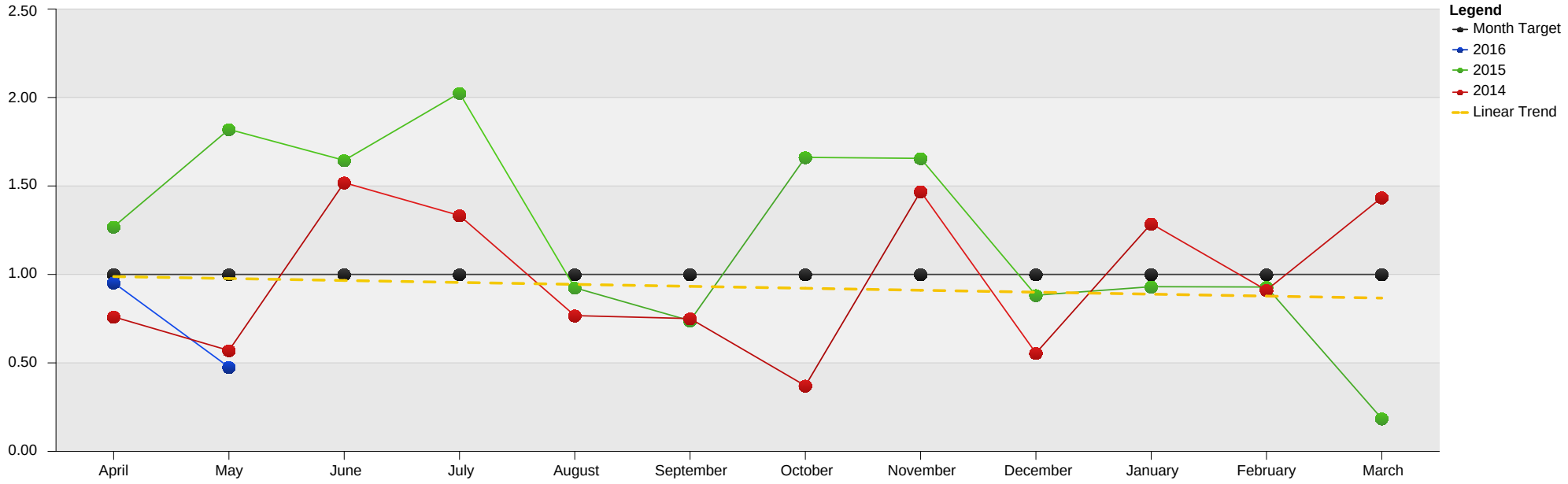
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	93.38%	91.68%	95.05%	93.54%	93.66%	93.46%	90.93%	90.67%	93.44%	77.61%		

Narrative

The Trust position reported in May relates to April performance. The Trust position for April 2016 is 93.38% which is 1.94% better than the target of 91.44% and an improvement on the position reported for March. Only North Yorkshire is not achieving the target at 90.93%. The Trust position for the financial year to date is 91.68%, which is 0.24% better than the target.All teams are monitoring surveys and work closely with Patient Experience to investigate any trends. 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 levels achieved in in May 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

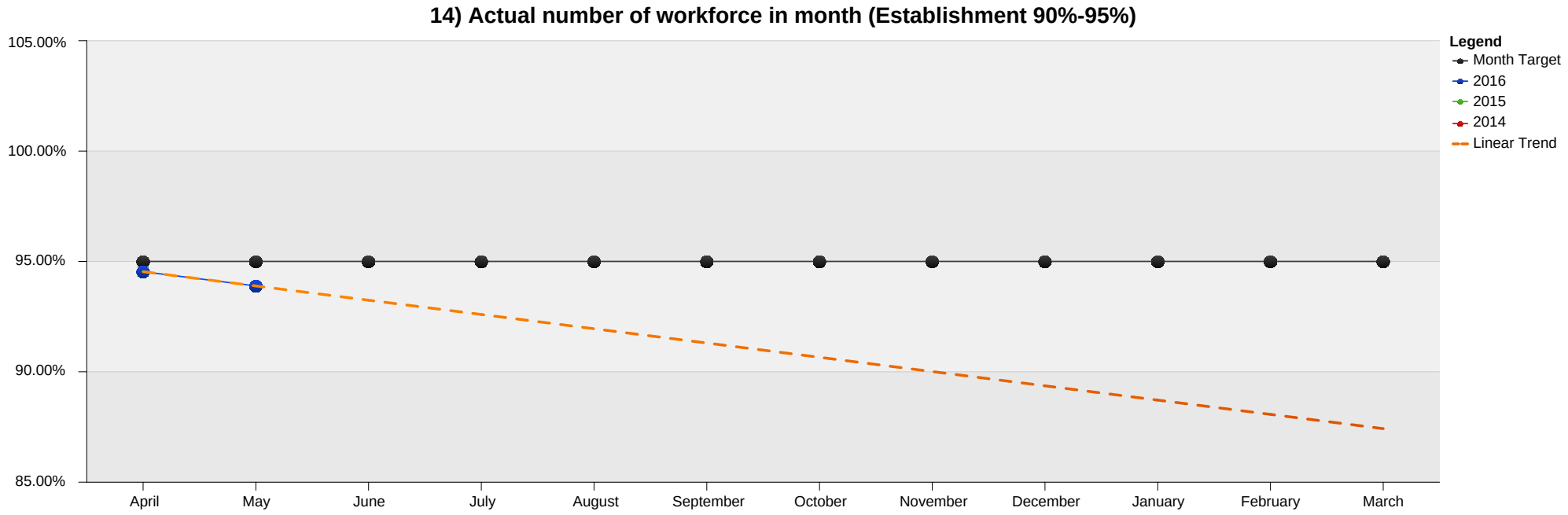


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.48	1.43	0.00	0.41	0.00	1.25	1.67	3.32	0.00	0.00	1.04	2.12

Narrative

The Trust position for May 2016 is 0.48, which is 0.52 better that the target of 1.00. This rate relates to 3 unexpected deaths. The Trust position for the financial year to date is 1.43%, which is 0.57% better than the target.Of the 3 unexpected deaths:* 2 were in North Yorkshire (AMH)* 1 was in York and Selby (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 May 2015 was 10 and therefore the figure of 2 across Durham and Darlington, Teesside, North Yorkshire and Forensics is significantly lower. The Trust has consistently reported below target since December 2015, therefore it can be anticipated that we will achieve the annual target of 12.00.

Trust Dashboard Graphs for TRUST

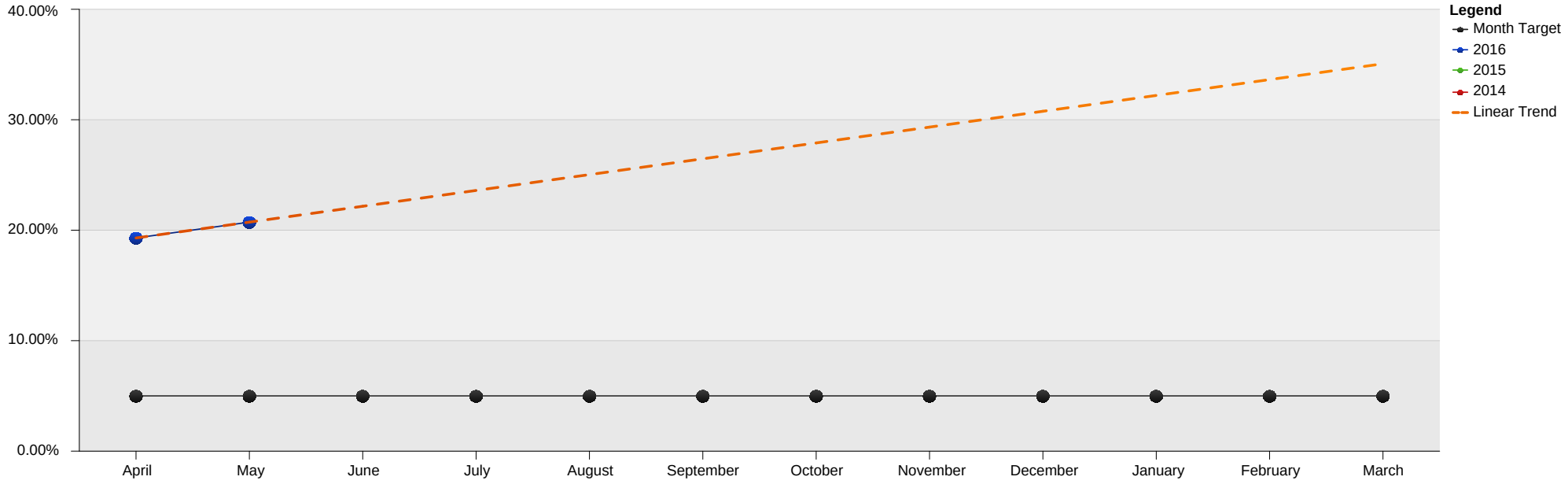


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Actual number of workforce in month (Establishment 90%-95%)	93.89%	93.89%	96.50%	96.50%	96.52%	96.52%	95.47%	95.47%	91.80%	91.80%	90.28%	90.28%

Narrative
The Trust position for May 2016 is 93.89% which is within the expected establishment level of 90-95%, and a reduction on the position reported in April.Data only started to be reported in this dashboard from April 2016; however the position in April 2016 is a slight improvement on the 94% achieved in April 2015.Based on the performance during April and May it can be expected that we will achieve the annual target.

Trust Dashboard Graphs for TRUST

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



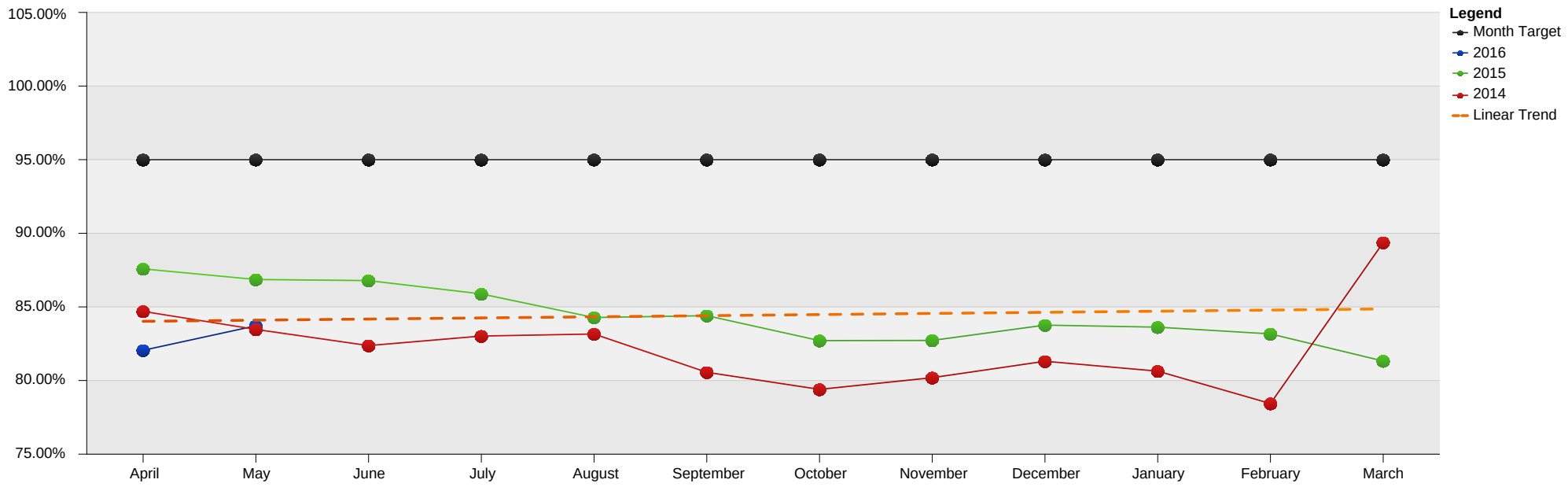
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Percentage of registered healthcare professional jobs that are advertised two or more times	20.73%	20.14%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative

The Trust position for May 2016 is 20.73%, which is 15.73% worse than the target of 5.00% and a deterioration on the position reported in April. The Trust position for the financial year to date is 20.14%, which is 15.14% worse than the target.There were 17 jobs re-advertised in May, 2 were for doctors and the remaining 15 were for other registered healthcare professional jobs. The two doctors posts were in Children & Young People's Services. Of the remaining 15 posts re-advertised 5 were fixed term only, which may be a reason why there was difficulties in filling these posts. The posts were primarily for a range of registered nurse vacancies across a number of specialities throughout the Trust, and a Clinical Psychologist in North Yorkshire. A paper considered by the Executive Management Team has resulted in an agreement not to use fixed terms contracts for vacant nursing posts. The recruitment team will challenge any qualified healthcare vacancy that comes to them as fixed term to promote this commitment.Data only started to be reported in this dashboard from April 2016; therefore no comparative data for 2015/16 is available.Based on April and May's performance there is a significant risk that we will not achieve the annual target of 5.00%.

Trust Dashboard Graphs for TRUST

16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)

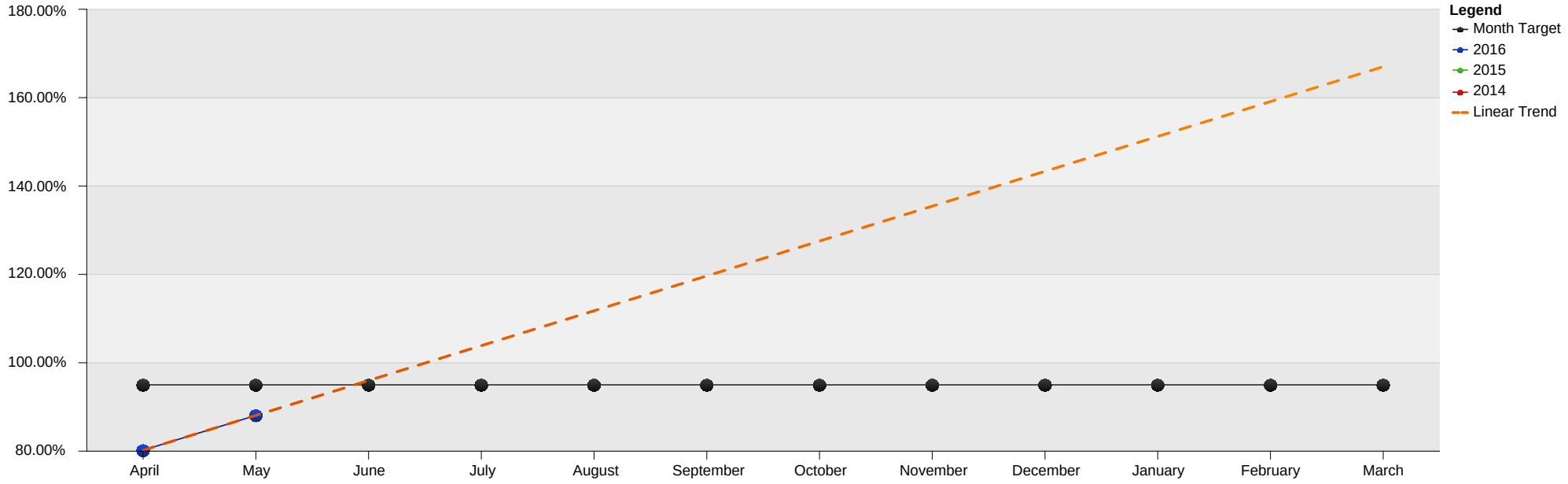


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	83.72%	83.72%	82.10%	82.10%	88.35%	88.35%	77.53%	77.53%	88.54%	88.54%	60.00%	60.00%

Narrative
The Trust position for May 2016 is 83.72% which relates to 837 members of staff out of 5140 that do not have a current appraisal. This is 11.28% worse that the target of 95% but an improvement on the April position.Development work to enhance HR related information available through the IIC is underway. Managers are able to access compliance reports through the IIC to monitor performance against the target of 95% and this is reviewed at the Performance Improvement Group, where Directors of Operations provide details of actions being taken to improve compliance. Based on past performance and May's performance there is a significant risk that we will not achieve the annual target of 95%.

Trust Dashboard Graphs for TRUST

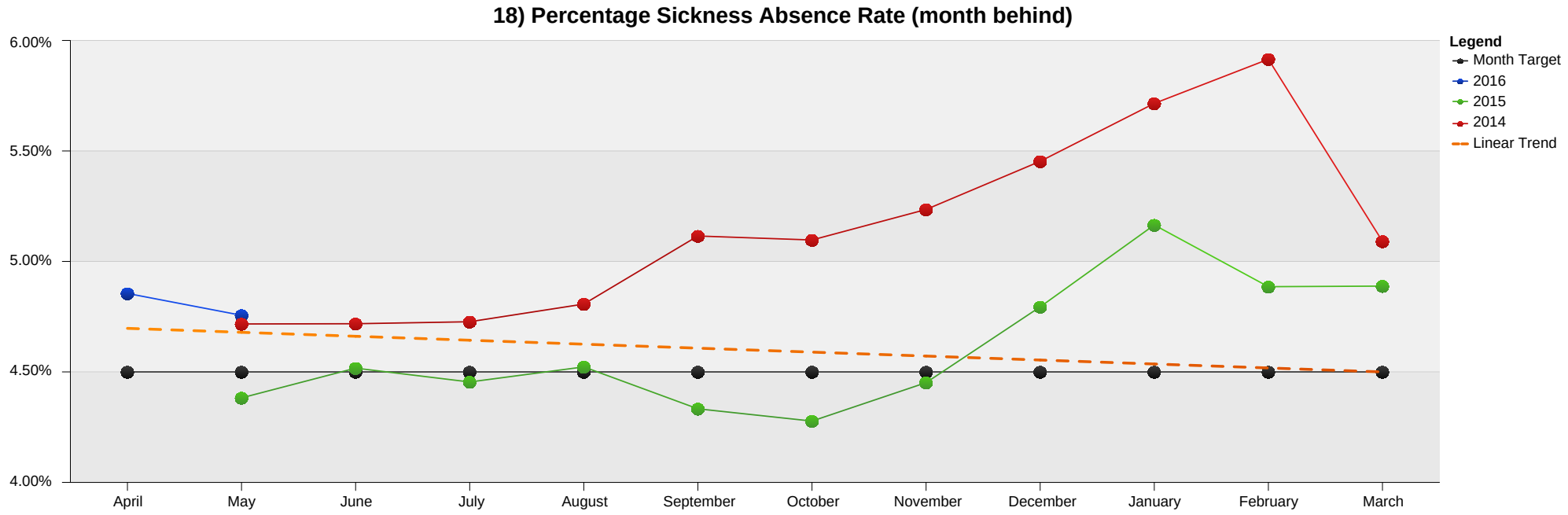
17) Percentage compliance with mandatory and statutory training (snapshot)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with mandatory and statutory training (snapshot)	88.09%	88.09%	89.59%	89.59%	90.63%	90.63%	86.97%	86.97%	91.73%	91.73%	66.02%	66.02%

Narrative
The position for May 2016 is 88.09%. This is 6.91% worse than the target of 95% but is an improvement on the position reported in April. The construction of this indicator has been amended from 1 April to ensure it more accurately reflects the Trust policy on Mandatory and Statutory Training compliance. Therefore it is not possible to include previous years' data for this indicator. The increase is attributable to this amendment Development work is underway to enhance the available HR related information available through IIC and it is envisaged this will include more detailed information reports relating to appraisal and mandatory & statutory training that highlight competencies due to expire, in addition to those that have already expired. It is hoped this will support managers to proactively manage these key performance indicators.Based on the improvement reported in May, it is possible that we will achieve the annual target of 95%.

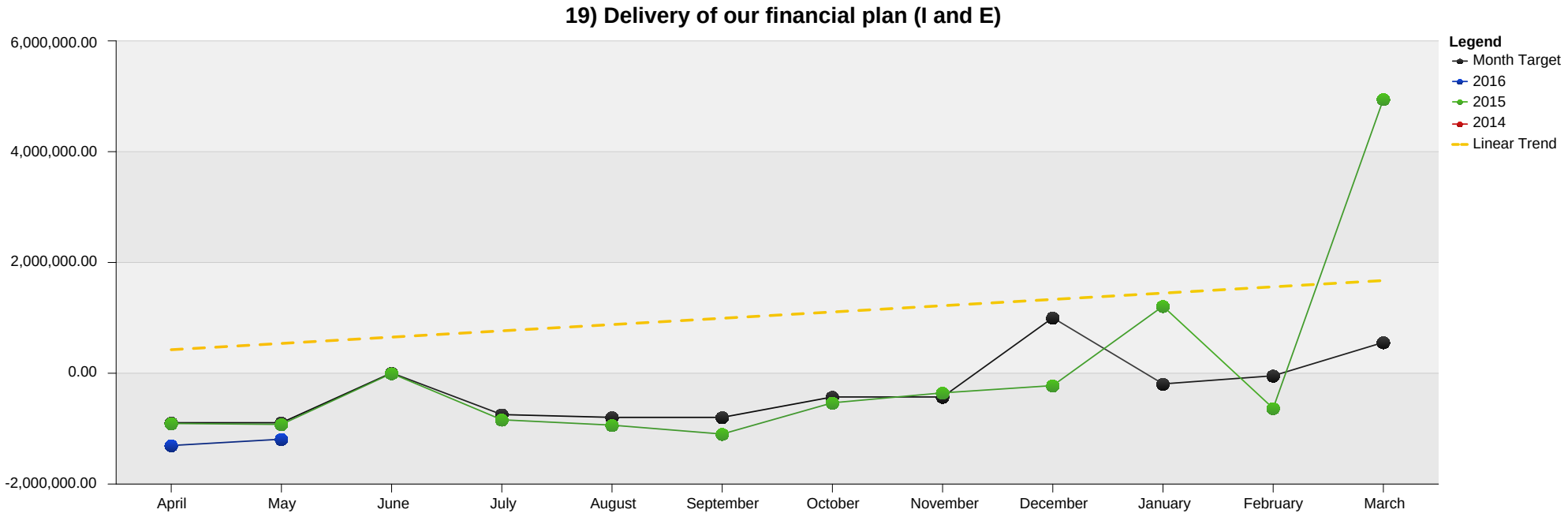
Trust Dashboard Graphs for TRUST



	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)	4.76%	4.81%	5.43%	5.33%	5.47%	5.61%	4.02%	4.24%	5.70%	5.81%	4.21%	4.12%

Narrative
The Trust position reported in May relates to the April sickness level. The Trust position reported in May 2016 is 4.76%, which is 0.26% worse than the Trust target of 4.50% but an improvement on the position reported in April. The Trust position for the financial year to date is 4.81%, which is 0.31% worse than the target.The figure reported is higher than the sickness rate recorded for the same period last year. Short term absence continues to average between 1.3% and 1.4% with long term absence reporting a more fluctuating rate. The long term sickness absence team continues to manage staff on long term sickness, proactively facilitating staff back to work or ultimately to a point leading to ending employment. The number of staff on long term sickness absence being managed by the long term sickness team is between 150 and 200 at any point in time. At the end of March 2016, 44% of staff had no recorded episodes of absence in the preceding 12 months compared to 41% reported at March 2015.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 performance and May's performance there is a significant risk that we will not achieve the annual target of 4.50%.

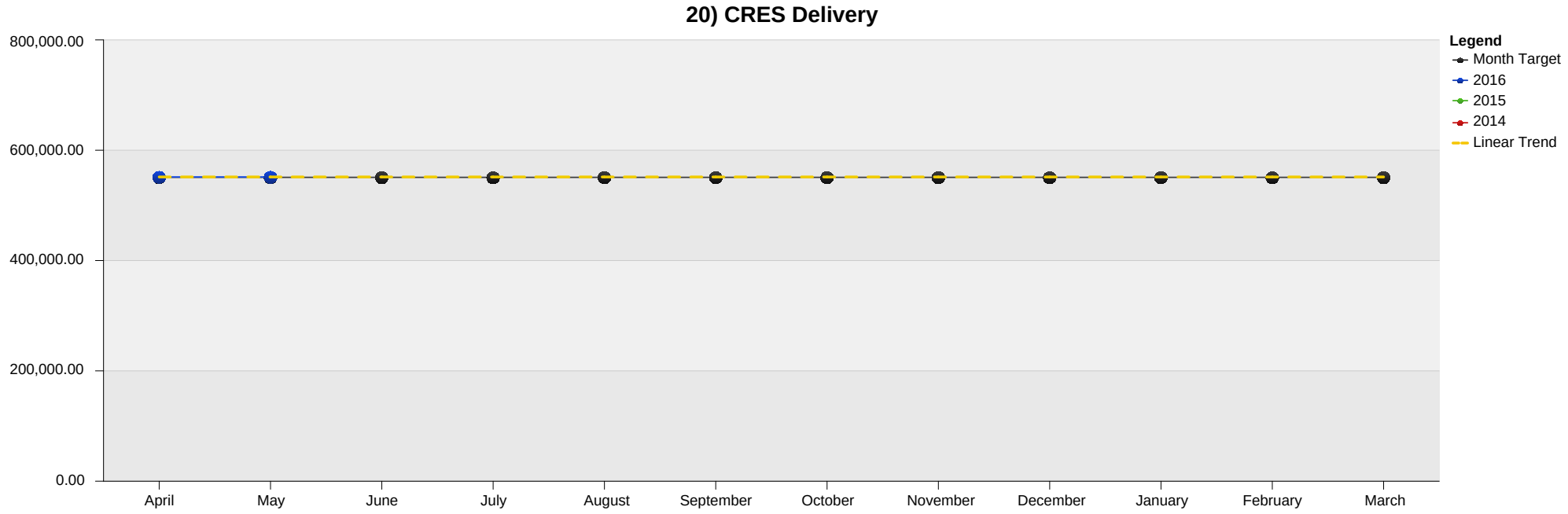
Trust Dashboard Graphs for TRUST



	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)	-1,191,000.00	-2,496,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The comprehensive income outturn for the month of May 2016 was a surplus of £1,191k, The comprehensive income outturn for the period ending 31 May 2016 was a surplus of £2,496k, representing 4.6% of the Trust's turnover and was ahead of plan. The Trust is ahead of plan by £257k largely due to vacancies within EFM and Corporate Services.

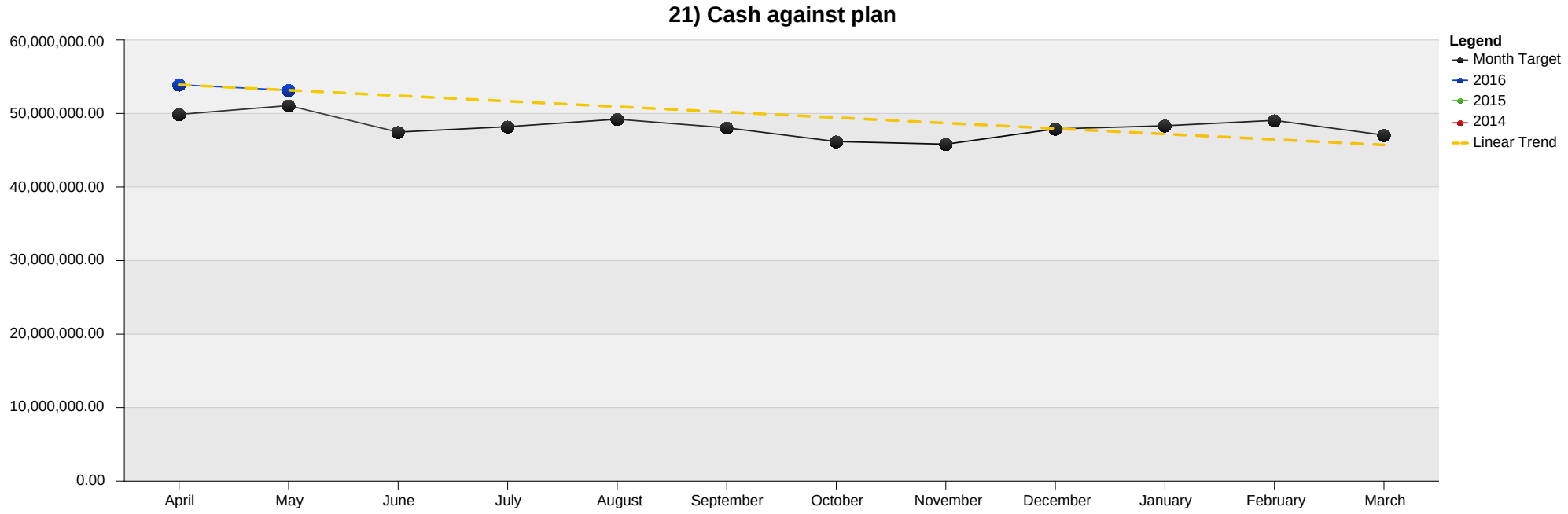
Trust Dashboard Graphs for TRUST



	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	551,538.00	1,103,076.00	196,833.00	393,666.00	94,000.00	188,000.00	32,833.00	65,666.00	26,833.00	53,666.00		

Narrative
The Trust position for May is £551.5k. 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	53,158,000.00	53,158,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The Trust position for May is £53,158k and is ahead of plan due variances against the planned working capital cycle and planned delays in the capital programme.

Trust Dashboard - Locality Breakdown for TRUST

1 - Activity

	May 2016												April 2016 To May 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	7,339.00	8,583.00	1,930.00	2,030.00	1,961.00	1,982.00	1,893.00	1,983.00	600.00	731.00	954.00	1,857.00	14,441.00	17,133.00	3,798.00	4,070.00	3,860.00	3,907.00	3,725.00	3,854.00	1,180.00	1,495.00	1,877.00	3,806.00
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	97.27%	85.00%	92.80%	85.00%	102.30%	85.00%	97.40%	85.00%	NA	85.00%	96.21%	85.00%	96.91%	85.00%	92.53%	85.00%	100.44%	85.00%	98.35%	85.00%	NA	85.00%	96.58%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	23.00	20.00	8.00	5.00	7.00	9.00	7.00	6.00	NA	NA	2.00		46.00	51.00	16.00	14.00	13.00	18.00	13.00	11.00	NA	NA	5.00	
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	7.58%	15.00%	6.11%	15.00%	6.67%	15.00%	8.51%	NA	NA	15.00%	13.33%	15.00%	7.58%	15.00%	6.11%	15.00%	6.67%	15.00%	8.51%	NA	NA	15.00%	13.33%
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	25.67	6.00	11.33	6.00	6.67	7.00	5.33	NA	NA	3.00	2.33	40.00	25.67	11.00	11.33	11.00	6.67	13.00	5.33	NA	NA	5.00	2.33

Trust Dashboard - Locality Breakdown for TRUST

2 - Quality

	May 2016												April 2016 To May 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%	85.25%	90.00%	76.61%	90.00%	95.48%	90.00%	75.34%	90.00%	99.59%	90.00%	84.53%	90.00%	84.03%	90.00%	76.73%	90.00%	94.00%	90.00%	73.97%	90.00%	99.45%	90.00%	79.33%
8) Percentage of appointments cancelled by the Trust	0.67%	0.91%	0.67%	1.16%	0.67%	0.70%	0.67%	1.18%	0.67%	0.14%	0.67%	0.53%	0.67%	0.96%	0.67%	1.23%	0.67%	0.77%	0.67%	1.18%	0.67%	0.17%	0.67%	0.44%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	22.06%	15.00%	14.10%	15.00%	29.35%	15.00%	29.31%	NA	NA	15.00%	11.36%	15.00%	20.25%	15.00%	19.08%	15.00%	22.22%	15.00%	25.81%	NA	NA	15.00%	10.59%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	93.38%	91.44%	95.05%	91.44%	93.66%	91.44%	90.93%	91.44%	93.44%	91.44%		91.44%	91.68%	91.44%	93.54%	91.44%	93.46%	91.44%	90.67%	91.44%	77.61%	91.44%	
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.48	1.00	0.00	1.00	0.00	1.00	1.67	1.00	0.00	1.00	1.04	2.00	1.43	2.00	0.41	2.00	1.25	2.00	3.32	2.00	0.00	2.00	2.12

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	May 2016												April 2016 To May 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 90%-95%)	95.00%	93.89%	95.00%	96.50%	95.00%	96.52%	95.00%	95.47%	95.00%	91.80%	95.00%	90.28%	95.00%	93.89%	95.00%	96.50%	95.00%	96.52%	95.00%	95.47%	95.00%	91.80%	95.00%	90.28%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	5.00%	20.73%	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	20.14%	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	NA	5.00%	NA
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	83.72%	95.00%	82.10%	95.00%	88.35%	95.00%	77.53%	95.00%	88.54%	95.00%	60.00%	95.00%	83.72%	95.00%	82.10%	95.00%	88.35%	95.00%	77.53%	95.00%	88.54%	95.00%	60.00%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	88.09%	95.00%	89.59%	95.00%	90.63%	95.00%	86.97%	95.00%	91.73%	95.00%	66.02%	95.00%	88.09%	95.00%	89.59%	95.00%	90.63%	95.00%	86.97%	95.00%	91.73%	95.00%	66.02%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.76%	4.50%	5.43%	4.50%	5.47%	4.50%	4.02%	4.50%	5.70%	4.50%	4.21%	4.50%	4.81%	4.50%	5.33%	4.50%	5.61%	4.50%	4.24%	4.50%	5.81%	4.50%	4.12%

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	May 2016												April 2016 To May 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)	-1,120,175.00	-1,191,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	-2,238,794.00	-2,496,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
20) CRES Delivery	550,854.00	551,538.00	183,500.00	196,833.00	168,250.00	94,000.00	117,595.00	32,833.00	92,909.00	26,833.00			1,101,709.00	1,103,076.00	367,000.00	393,666.00	336,500.00	188,000.00	235,191.00	65,666.00	185,818.00	53,666.00		
21) Cash against plan	51,070,000.00	53,158,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100,940,000.00	53,158,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Data Quality Scorecarrd 2016/17

Appendix B

		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					
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. Actions to be developed through Data Quality working group to resolve this.
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.
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.

		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					
11	Percentage of appointments cancelled by the Trust	5									1				2		8	**87%**	**53%**		PARIS codes to be updated in May and indicator construction to change – this to be conducted through the KPI process. Audit conducted on this indicator and action plan in place to address concerns.
14	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5							3			5					13	**93%**	**87%**		Issues with appraisal dates being entered to ESR Issues with data being input correctly. York and Selby staff were transferred on 1st October, currently an issue with any appraisals carried out prior to this date. HR are monitoring this closely and identifying issues as they arise.
15	Percentage compliance with mandatory and statutory training – snapshot	5							3			5					13	**93%**	**87%**		Issues with training dates being entered to ESR Issues with data being input correctly. York and Selby staff were transferred on 1st October, currently an issue with any training carried out prior to this date. HR are monitoring this closely and identifying issues as they arise.
16	Percentage Sickness Absence Rate (month behind)	5							3			5					13	**87%**	**87%**		Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR and there are examples whereby managers are failing to end sickness in a timely manner or inaccurately recording information onto the system – this is picked up and monitored through sickness absence audits that the Operational HR team undertake. York and Selby services are in the process of implementing MSS. The current process implemented for capturing sickness activity is via email notification to payroll. There is the potential for activity to be inaccurate due to managers failing to inform payroll of absence or forgetting to inform payroll when an employee returns to work following a period of absence.
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				3			5					10		**67%**		Mostly reliable Reliant on recruiting managers informing the recruitment team that the vacancy has been advertised on two previous occasions. The recording of the information is a manual input into a spreadsheet which has the potential for human error.
19	Are we delivering our financial plan (I and E)		4				5					5					14	**93%**	**93%**		An extract is taken from the system then processed manually to obtain actual performance.
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																					**0**
Hanging																					**0**
Suicides																					**0**
Open																					**0**
Drug related death																					**0**
Drowning																					**0**
Misadventure																					**0**
Awaiting verdict		1	1		2							1	3			1					**9**
Total	**0**	**1**	**1**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**3**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**9**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
6	3										

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

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
1	2	4	0	2

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

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

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient					Number of unexpected deaths where the patient is an inpatient but the					Number of unexpected deaths where the patient was no longer					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death	1																				**1**
Natural causes	1					1															**2**
Hanging	3	1	2								1						1		1		**9**
Suicides	7	3	6										1				1				**18**
Open	1		1																		**2**
Drug related death	1	2																			**3**
Drowning																					**0**
Misadventure	1		1																		**2**
Awaiting verdict	11	8	7	2		2		1			1	2	2			1	4		1		**42**
Total	**26**	**14**	**17**	**2**	**0**	**3**	**0**	**1**	**0**	**0**	**2**	**2**	**3**	**0**	**0**	**1**	**6**	**0**	**2**	**0**	**79**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
7	10	9	10*	5	4	9	9	5	5	5	1

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
32	22	21	4	0

ITEM NO.11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28 June 2016**
TITLE:	**Policies and Procedures 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:

2 policies that have undergone full review and require ratification:

- MHA-0003-001 v1 Time away from hospital and leave of absence under s17 MHA 1983
- CLIN-0021-v8 Resuscitation Policy

1 new document that has been produced and requires ratification:

- CORP-0059-001 v1 Volunteering Procedure

Recommendations:

The Board are asked to ratify the decisions made by EMT on 01 June 2016

DATE:	**28 June 2016**
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 underwent significant amendment and required ratification:

MHA-0003-001 v1 Time away from hospital and leave of absence under s17 MHA 1983
Review date 01 June 2019

This policy has been updated to reflect the new Code of Practice in terms of cross references and terminology. The Standard Process Description that was an appendix has been removed because it was not a Trust wide standard process, and explicit guidance has been added re medical emergencies. Also the policy has been renumbered to reflect that it is part of the Mental Health Act suite of documents (previously CLIN/0025).

CLIN-0021-v8 Resuscitation Policy
Review date 01 June 2019

This policy has been updated to reflect current practice and that the Trust now has a Resuscitation Officer in post.

3.2 The following new document has been produced and required ratification:

CORP-0059-001 v1 Volunteering Procedure
Review date 01 June 2019

This new procedure describes the recruitment and management of the volunteers managed by the Trust's Volunteer Services Department

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meetings on 01 June 2016 have been presented for ratification.

7. RECOMMENDATIONS:

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

Author: Colin Martin
Title: Chief Executive