AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 29TH JANUARY 2019
VENUE: THE DURHAM CENTRE, BELMONT INDUSTRIAL ESTATE, DURHAM, DH1 1TN
AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meetings of the Board of Directors held on **27th November 2018** and **18th December 2018.**		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To receive a briefing on key issues in the County Durham and Darlington Locality.	**Levi Buckley to attend**	**Presentation**
Item 7	To receive and note the report of the Guardian of Safe Working.	**Dr. Whaley to attend**	**Attached**
Item 8	To consider the six monthly "Hard Truths" Nurse Staffing Report.	**EM**	**Attached**
Item 9	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 10	To consider the report on Learning from Deaths.	**EM**	**Attached**
Item 11	To consider any matters of urgency arising from the meeting of the Mental Health Legislation Committee held on 24th January 2018.	**RS/EM**	**Verbal**

Performance (11.15 am)

Item 12	To consider the summary Finance Report as at 31st December 2018.	**PM**	**Attached**
Item 13	To consider the Trust Performance Dashboard as at 31st December 2018.	**SP**	**Attached**

Governance (11.30 am)

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

Items for Information (11.35 am)

Item 15	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 16 To note that the next meeting of the Board of Directors is scheduled to be held at 9.30 am on Tuesday **26th February 2019** in the Boardroom, West Park Hospital, Darlington.

Confidential Motion (11.40 am)

Item 17 **The Chairman to move:**

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

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

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

Any 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.

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
23rd January 2019

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 27TH NOVEMBER 2018 IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Mr. M. Hawthorn, Senior Independent Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mrs. R. Hill, Chief Operating Officer
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mr. A. Williams, Public Governor for Redcar and Cleveland
Dr. J. Whaley, Guardian of Safe Working (minute 18/310 refers)
Mr. P. Bellas, Trust Secretary
Mrs. J. Illingworth, Director of Quality Governance (representing Mrs. Moody)
Mr. D. Kendall, Associate Director of Finance (representing Mr. McGahon)
Mrs. S. Menzies, Communications Manager
Mrs. J. Lightfoot, Care Quality Commission
Mr. N. Ayre, Healthwatch North Yorkshire
Mr. N. Woodcock, Member of the Public

Dr. C. Lanigan and Mrs. R. Weddle, Shadow Board Members

18/304 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr. H. Griffiths, Deputy Chairman, Mr. P. McGahon, Director of Finance and Information, Mrs. E. Moody, Director of Nursing and Governance, and Dr. A. Khouja, Medical Director.

18/305 MINUTES

***Agreed** – that the minutes of the last meeting held on 30th October 2018 be approved as a correct record and signed by the Chairman.*

18/306 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Arising from the report:
(1) The Board noted that the identification of a key performance indicator (KPI) relating to the Equality and Diversity Strategy, for inclusion in the Strategic Direction Scorecard, would be deferred until June 2019 by which time the Strategy would be refreshed.

In the circumstances it was agreed that the action under minute 18/216 (19/7/18) should be closed.

(2) The Chairman asked for the Board to be updated on the outcome of discussions, between the Director of Therapies and the Chaplains, in relation to the suggestion to hold an annual event/ceremony to remember people who had died in the Trust's services (minute 18/241 – 25/9/18 refers).

Action: Mr. Martin

18/307 DECLARATIONS OF INTEREST

There were no declarations of interest.

18/308 CHAIRMAN'S REPORT

The Chairman reported on her participation in the first meeting of the Shadow Board which had been held on 26th November 2018.

Mrs. Bessant advised that the meeting had been very positive and interesting; discussions had been of a high quality; all those involved had contributed well across a range of issues; and the event had reinforced her opinion about the high quality of senior managers in the Trust.

The Board noted that a further two meetings of the Shadow Board were due to be held over the next few months together with a taught session in December 2018.

The Members of the Shadow Board, present at the meeting, highlighted:
(1) The challenges of presenting reports they had not authored, on subjects outside their expertise, and the support they had received to enable them to do so.
(2) The benefits of the programme in helping them think at a strategic level and to take a wider perspective of the Trust.
(3) The rich discussions which had been generated at the meeting.

Mrs. Bessant also updated the Board on forthcoming presentations of Living the Values Awards and the meeting of Trust Chairmen, for the North of the Region, which was due to be held on 3rd December 2018.

In addition, Mr. Jennings reported on the matters discussed at the recent meeting of the Northern Chairs Network in Leeds, which he had attended on behalf of Mrs. Bessant.

The Board noted that the event had been facilitated by NHS Improvement (NHSI) and had included:
(1) Discussions on national policy priorities. Although these were, generally, focussed on acute services there were elements, e.g. finance, integration and uncertainty, which were relevant to the Trust.
(2) An interesting debate on finance including that a number of acute trusts in the North West region had not accepted their control totals.

(3) Initial discussions on the role and functions of the NHSI/NHS England Regional Offices.
(4) A presentation from Lord Carter during which he had sought to prompt different approaches and highlighted the accountability and leadership role of Board Members.
(5) A presentation from Mr. Ian Dilks, the Chairman of NHS Resolution, which had provided a sense of the benchmarking data held by the organisation and the research undertaken on learning from claims relating to suicides.

In response to a question, it was noted that a claims scorecard for the Trust was received from NHS Resolution on an annual basis and presented to the Board.

18/309 GOVERNOR ISSUES

No issues were raised.

18/310 REPORT OF THE GUARDIAN OF SAFE WORKING

The Board received and noted the quarterly report of the Guardian of Safe Working (GoSW).

Board Members raised the following matters:
(1) Further to minute 18/207 (19/7/18), the progress being made on the implementation of a "hospital at night" system.

Dr. Whaley reported that progress had been slow but there were plans to introduce tablets at Roseberry Park and, if the trial was successful, to roll out the system to other hospitals.

(2) The differences in approach, between GoSW, to undertaking the role and whether this was benchmarked.

Dr. Whaley made the following observations:
(a) Each GoSW had developed their own approach to fulfilling the role.
(b) He had benefited from the support he had received from the Trust and from his previous experiences both in terms of his understanding of systems and the networks he had developed.
(c) Any benchmarking between GoSW was informal.

Dr. Whaley also advised that concerns had been raised, at a recent national meeting of the GoSW, that the role was not effective. He disagreed with this assessment but recognised the difficulties faced by some GoSW arising from the structure of their organisations; their inability to effect cultural change with limited resources; and the lack of the right infrastructure to support their activities.

(3) Whether there were any patient safety issues arising from the spike in antisocial hours activity in North Durham.

It was noted that:

(a) Busy daytime shifts followed by high levels of on-call activity had result in the junior doctors being tired and worried about their own performance.

(b) Junior doctors, particularly foundation doctors and GP trainees, were now less likely to tolerate non-resident on-call rotas.

(c) Nationally there were calls to abandon on-call rotas and, whilst this would be difficult in TEWV due to the nature of some services, there would be benefits, were practicable, of maximising the use of resident rotas and supporting education.

(d) Dr. Whaley had written to medical staff in North Durham to reaffirm the requirement to provide support and supervision to junior doctors out of hours.

18/311 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed notes of the informal meeting held on 4th October 2018 (Annex 1 to the report).

(2) The key issues considered by the Committee at its meeting held on 1st November 2018.

The Board discussed the following matters:

(1) The Committee's concerns, arising from its consideration of the York and Selby LMGB report, about the relationship between high caseloads and sickness absence levels in community teams and the lack of an early warning system when they got into difficulties.

The Chairman explained that the concerns arose from:

(a) Pressure arising from high caseloads and sickness absence levels in community teams, which were not escalated properly or made known, being a recurring theme in serious incidents.

(b) There being no mechanism in place, similar to that for inpatient services, to identify when community teams were under pressure.

It was noted that the Committee considered that systematic escalation processes for community teams, based on triggers, were required.

In relation to this matter:

(a) The Board was informed that a pilot escalation process for community teams, based on that used in inpatient services, was being developed and would be tested in the York and Selby Locality.

(b) Mr. Martin advised that, in the specific case considered by the Committee, the issues were visible within the Locality; however, he recognised that there were risks that pressure on teams could become normalised and not escalated.

(c) The Chairman highlighted the need for locality management teams to be more aware of their ability to raise issues with the Board, and to receive support, where they were struggling and finding it difficult to cope.

(d) It was also considered that enquiring about the caseload of community teams should be routine for the QuAC.

The Chairman asked for a progress report, on the implementation of an early warning system for community teams, to be provided to the Board in the New Year.

Action: Mrs. Moody

(2) The reporting arrangements to the QuAC from the merged North Yorkshire and York Locality.

On this matter:

(a) In response to a question, Mr. Martin advised that:
- Following a transitionary period, a single report would be provided from the merged Locality to the QuAC from the beginning of the new financial year.
- As the merged Locality would have fewer teams than either the County Durham and Darlington and Tees Localities, the arrangement should continue to provide visibility on the issues within the areas.

(b) The Chairman asked for a report to be provided to the Board on the outcome of the merger to provide assurance that it had not led to any unintended consequences.

It was suggested that the report should be presented to the meeting to be held on 30th April 2019.

Action: Mrs. Hill

(3) The circumstances which had led to a coroner writing to the Trust to suggest that if staff discovered a patient at home, in suspicious circumstances, they had a duty to notify the police.

Mrs. Illingworth provided an overview of the particular case and advised that:

(a) The issue had arisen at the Inquest as a result of a comment from the police that the circumstances of the death had not been reported to them.

(b) Ordinarily, notification of the police would be undertaken by the ambulance service; however, staff would be reminded to also undertake this role.

(c) From the Trust's perspective, there were no suspicious circumstances relating to the death.

(4) The Committee's discussions on the potential annual increase in the use of prone restraint if the number of incidents continued at the present rate.

It was noted that:

(a) A report would be provided to the QuAC on this matter.

(b) The increase in prone restraint appeared to be in AMH services.

18/312 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

The Board received and noted the exception report on nurse staffing for October 2018 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").

The report included an assurance statement that the Trust was meeting its requirements for safe staffing within the current legislative framework.

Board Members:

(1) Noting that the reasons for two of the top three inpatient areas, with low staffing fill rates, were not due to direct Trust staffing issues, suggested that it would be beneficial to discount those wards and to report the next relevant ones in order that staffing problems elsewhere were not masked.

Mrs. Illingworth undertook to raise this matter with the Head of Quality Data.

Action: Mrs. Illingworth

(2) Raised the time it was taking to amend the health roster system to reflect changes to ward establishments for example in the case of The Orchards.

It was noted that:

(a) Changes to the health roster system were the responsibility of the IT Department, based on information provided by the Head of Quality Data.

(b) The reasons for the delays in amending the system in relation to The Orchards were not known but the change should have been implemented within one roster cycle.

(3) Sought clarity on the position on missed breaks.

On this matter:

(a) Mr. Levy advised that the grievance raised by the RCN remained at the appeal stage.

(b) Mrs. Illingworth undertook to provide further information on the number of missed breaks by area in the next nurse staffing report.

Action: Mrs. Illingworth

(c) It was noted that, generally, the prevalence of missed breaks was linked to the acuity of individual patients.

(d) The Chairman advised that, at the Shadow Board meeting, the relationship between staffing issues and missed breaks had been raised together with the extent that the Trust was well sighted on this matter.

(4) Questioned, with reference to Acomb Garth, when high staffing fill rates due to levels of acuity would be considered to be normal and the staffing establishment changed to reflect the position.

The position at Westerdale South, where the staffing establishment had been increased but the ward still remained amongst those with the highest fill rates, was also raised.

Mrs. Illingworth drew attention to the report on Observation and Engagement, provided to the Board meeting on 25th September 2018 (minute 18/242 refers), which highlighted the variations in staffing between similar wards with equivalent levels of acuity, and the work being undertaken on different ways of engaging staff and managing patients (i.e. zonal observation).

The Chairman observed that the combination of high acuity and agency staffing was resulting in significant challenges for the staff on the wards and the Trust needed to be mindful of their wellbeing.

It was noted that, in response to these issues, work was being undertaken to increase the use of temporary staff who were regularly working on, and familiar with, wards. At present these accounted for approximately 60% of temporary shifts.

The Chairman asked for a report to be provided to the Board meeting to be held on 26th February 2019 on the issues raised in the discussions.

Action: Mrs. Illingworth

18/313 REPORT OF THE MENTAL HEALTH LEGISLATION COMMITTEE

Further to minute 18/282 (30/10/18) the Board received and noted the report of the Mental Health Legislation Committee including:

(1) The confirmed minutes of its meeting held on 12th July 2018 (Annex 1 to the report).
(2) The key issues considered at its meeting held on 18th October 2018.

Mr. Simpson, the Chairman of the Committee, reported that:

(1) The meeting held on 18th October 2018 had become inquorate and asked the Executive Director Members of the Committee to attend its meetings if possible.
(2) Concerns had been raised about the delays in the completion of DOLS assessments by Middlesbrough Council and he had contacted Mr. Martin with regard to taking up this matter with the local authority.
(3) Discussions had commenced on increasing the diversity of the Associate Hospital Manager group.

It was noted that, in view of the absence of the Equality and Diversity Lead, it was expected that this would take some time to progress.

Mr. Levy asked for further discussions with Mr. Simpson outside the meeting on this matter.

The Chairman highlighted the discharging of patients by tribunals and panels against the advice of the clinical teams, in view of the issue being identified in a couple of recent serious incident reviews, and sought clarity on whether the Committee had visibility on what happened to individuals once they had been discharged.

The following points were raised in the discussions on this matter:

(1) There was a difference between panels and tribunals with the Trust having no control over the latter's operation.

(2) It was unlikely that individuals were tracked, generally, following discharge; however, this would be undertaken by the MHL Office if they were re-admitted.

(3) Where a panel agreed to discharge against the recommendation of the Responsible Clinician and the clinical team the Committee received additional narrative on the case.

(4) There was the need for assurance on the appropriateness of recommendations to Panels in addition to tracking individuals who had been discharged by them against the recommendation.

It was noted that there were instances where the Medical Director had held discussions with Responsible Clinicians when there was a pattern of discharges against their recommendations.

(5) Whilst there were no national benchmarks, it was evident from discussions amongst MHL leads that individuals were less likely to be discharged by Panels against recommendations in the Trust compared to others.

At the conclusion of the discussions, Mr. Simpson undertook, for assurance, to ask the Head of Mental Health Legislation, together with the Patient Safety Team, to look into what had happened to individuals who had been discharged against recommendation.

Action: Mr. Simpson

In addition, the Non-Executive Directors sought clarity on the use of police stations as places of safety, in order to increase understanding of the reasons and to support learning, in view of the imminent publication of a national report on the issue.

Mr. Martin responded that:

(1) There were regular discussions on the issue through the Crisis Concordat.

(2) There were various reasons why police stations might be used as a place of safety and it would be interesting to digest the findings of the national report.

(3) Other trusts might find information on the Trust's development and implementation of street triage and crisis liaison services to be useful.

18/314 SELF-ASSESSMENT REPORT IN RELATION TO MULTI-PROFESSIONAL EDUCATION AND TRAINING – HEALTH EDUCATION ENGLAND

Consideration was given to the Trust's response to the annual Health Education England education assessment process for multi-professional training (appended to the covering report).

It was noted that the self-assessment report had been signed off by the Director of Nursing and Governance, under her delegated powers, on 26th October 2018 but it was required to be received by the Board.

Further to discussions at the recent meeting of the Shadow Board, the Chairman considered that there was a need for the Board to have greater visibility on the Right

Staffing Programme particularly in relation to how new roles were harmonised with traditional ones and incorporated into teams; and how they supported the Trust deal with the issues it was facing.

Whilst noting that an update on the Programme would be provided to the Business Planning event on 8th January 2019, it was considered that the Board also required an in-depth discussion on this matter. Mr. Martin was, therefore, asked to reprioritise the Board Seminar Programme to facilitate this being held early in the New Year.

Action: Mr. Martin

In addition, in response to a question, Mr. Martin advised that, although Health Education England was a statutory body, it was due to cease being a separate entity and become accountable to NHS Improvement. No details of the timing of the change had yet been provided and its impact would probably become known following the publication of the NHS Operational Plan and funding settlement.

Agreed - *that the self-assessment report for multi-professional training be endorsed.*

Action: Mrs. Moody

18/315 FINANCE REPORT AS AT 31ST OCTOBER 2018

The Board received and noted the Finance Report as at 31st October 2018.

The following matters were raised:

(1) The phasing of incentive Provider Sustainability Funding (PSF).

Mr. Kendall confirmed that the PSF funding was received on a quarterly basis.

(2) Whether the capital rebate relating to prior year schemes was expected and whether it was planned to use the funding to accelerate existing schemes or commence new ones.

In response it was noted that:

(a) The rebate had been expected.
(b) Most capital schemes were already known about if not detailed in the plan e.g. the mist system at Roseberry Park.
(c) If the rebate had not been received the capital plan would have needed to be adjusted accordingly.

(3) The timescale for the completion of work on understanding the use of agency staff in the Trust.

On this matter it was noted that:

(a) Agency staffing expenditure, as a percentage of the pay budget, had increased, from approximately 2%, generally, to 3.25% in October 2018.
(b) The Trust's Use of Resources rating had reduced to "3" due to agency expenditure. Discussions were being held with NHSI on this matter and there might be a need to seek a renegotiation of the control total.

(c) Although there were challenges with medical staffing in some areas, the 95% increase in additional shifts over the last 12 months related predominantly to agency shifts for healthcare assistants.
(d) The demand for bank shifts was also increasing. The Trust, therefore, needed to understand both the reasons for this and how to address supply issues.
(e) It was considered that the demand for agency staff should start to reduce from Quarter 3, 2019/20.

(4) The need for the Board to have further assurance on the development and delivery of CRES plans particularly in view of the risks, previously discussed, on the use of non-recurrent resources to meet any shortfalls.

Mr. Jennings, the Chairman of the Audit Committee, also highlighted that, although an Internal Audit review of CRES had been deferred for operational reasons, it remained a matter of interest to the Committee.

Mr. Martin considered that the processes governing the development and delivery of CRES plans were now more robust.

It was noted that:
(a) CRES proposals for 2019/20 were due to be reviewed by the EMT during December 2018 and would be subject to Quality Impact Assessments.
(b) Proposed schemes would be discussed at the business planning event in January 2019 and detailed in the draft Business Plan which was due to be reviewed at the Board Seminar in February 2019.

The Chairman also reminded the Board that it had also been agreed that the Resources Committee would be kept updated on the development of CRES plans.

18/316 PERFORMANCE DASHBOARD AS AT 31ST OCTOBER 2018

Consideration was given to the Performance Dashboard Report as at 31st October 2018.

The Non-Executive Directors sought clarity on the statement in the report, in relation to KPIs 6 and 7 (outcome measures), that “A number of actions were agreed including gaining an understanding of the variation in where outcomes have not been recorded due to it not being clinically appropriate.”

Mrs. Pickering responded that the Service Development Groups were undertaking a review to ensure the Trust had a standardised approach to recording outcome measures and, where their use was considered to be not clinically appropriate, whether the reasons for the variation were legitimate.

The Chairman, following discussions at the Shadow Board, highlighted the potential risks that, by tackling waiting times in one service, it might have a detrimental impact on others where there was less acuity, for example, addressing waiting times in MHSOP

could increase waiting times for memory services which would be counterproductive as there were benefits in identifying issues as early as possible.

The Board received assurance that:

(1) Through report out and escalation processes, concerns about waiting times should be identified and addressed within the Localities. This was supported by the IIC which enabled heads of service to drill down into the performance of individual teams.

(2) In addition, where potential issues were identified during the production of the Performance Dashboard reports, the Performance Department could also drill down into particular teams and this should support detection.

It was also noted that, in relation to MHSOP, the work to provide a consistent approach through the development of the new dementia pathway, had created additional capacity in teams which should reduce the risks identified by the Shadow Board.

18/317 STRATEGIC DIRECTION PERFORMANCE REPORT

Consideration was given to the Strategic Direction Performance Report for Quarter 2, 2018/19 including:

(1) A proposal to amend KPI 14 (Percentage of delayed transfer of care due to non-Trust issues).

Mrs. Pickering explained that, at present, delayed transfers of care (DTOCs) were aggregated according to whether responsibility for them was attributable to Social Services, the NHS or both. As “NHS” could be either the CCG or the Trust there was no way to identify those delays solely due to non-Trust issues. The Executive Management Team had recommended monitoring all delayed transfers of care as most of them required the Trust to work collaboratively with its partners in social services and/or the CCGs.

In response to a question, it was noted that, if DTOCs arose exclusively from issues within the Trust, it would be expected that they would be picked up through locality management arrangements and, if cross-Trust, for conversations between to Localities to be held; however, these latter cases were very few in number.

(2) The proposals to amend the Trust Business Plan as set out in Appendix 1 to the report.

In response to a question, Mrs. Pickering assured the Board that the proposed change to the wording of the metric on the priority “Implement Phase 2 of the Recovery Strategy and develop Phase 3” from “Integrated approach in place” to “Agreed Recovery elements to be included in training materials and syllabus in place” did not reflect a reduction of ambition but recognised that there were a number of priorities which required a more integrated and broader approach to training.

In addition, Mr. Martin reported that the MHSOP team in Teesside had won the "Psychiatric team of the year - Quality improvement" in the Royal College of Psychiatrists Awards 2018.

The Board concurred with Mrs. Pickering's assessment that the overall position, as shown in the report, was balanced with concerns about performance against the KPIs offset by the good progress being made on the delivery of the Business Plan and the significant amounts of qualitative intelligence particularly for Strategic Goal 1.

Agreed –

(1) that the amendment of KPI 14 ("Percentage delayed transfers of care due to non-Trust issues") to monitor all delayed transfers of care, be approved; and

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

Action: Mrs. Pickering

18/318 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.

18/319 DATE OF NEXT MEETING

It was noted that a special meeting of the Board of Directors was due to be held, in conjunction with a seminar, at 9.30 am on Tuesday 18th December 2018 in the Boardroom, West Park Hospital, Darlington.

18/320 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 which, if published would, or be likely to, inhibit -

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 12.00 noon.

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 18TH DECEMBER 2018 IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Dr. H. Griffiths, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mrs. R. Hill, Chief Operating Officer
Dr. A. Khouja, Medical Director
Mr. P. McGahon, Director of Finance and Information
Mrs. E. Moody, Director of Nursing and Governance
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Ms. H. Griffiths, Public Governor for Harrogate and Wetherby
Mr. A. Williams, Public Governor for Redcar and Cleveland
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Mr. M. Griffiths, Member of the Trust
Mr. J. Manson, Member of the Trust
Mr. J. Venable, Member of the Trust
Mr. N. Ayre, North Yorkshire Healthwatch
Mrs. A. Lamb, Member of the Public

Dr. K. Passmore, Shadow Board Member

18/330 DECLARATIONS OF INTEREST

There were no declarations of interest.

18/331 CHAIRMAN'S REPORT

The Chairman reported on the matters discussed at a recent meeting of the Chairmen of Trusts in the North East region which included an interesting update on the development of the Integrated Care System (ICS) for Cumbria and the North East from its Chair, Mr. Alan Foster.

Mrs. Bessant observed that the development of the ICS appeared to be focused on acute Trusts and seen as a means of tackling duplication and a range of operational issues. Issues relating to mental health seemed to be regarded as already addressed through the Trust and Northumberland, Tyne and Wear NHS Foundation Trust. The

corollary of the approach was that the ICS was not engaging with local authorities, and developing relationships with them, which would be essential to its success. The approach contrasted with the development of the ICS in the south of the Trust's area where the local authorities had been embraced and included within its governance arrangements.

It was also noted that the Sir John Burn, Chairman of Newcastle upon Tyne Hospitals NHS Foundation Trust had advised that the event on ICSs, scheduled to be held in January 2019, had been postponed and would be rearranged for March 2019. Details of the event would be circulated to Board Members in due course.

18/332 GOVERNOR ISSUES

No issues were raised.

18/333 REPORT OF THE QUALITY ASSURANCE COMMITTEE

Dr. Griffiths, the Chairman of the Quality Assurance Committee advised that:

(1) No matters had been escalated to the Board from the Committee's meeting held on 6th December 2018.

(2) At the meeting, the Committee had received the outcome of the fourth audit of emergency response bags.

It was noted that:

(a) The audit had provided assurance that the position had very much improved.

(b) The Committee had also agreed future monitoring and assurance arrangements.

18/334 DEVELOPING WORKFORCE STANDARDS

The Board received and noted a report which provided an overview of the recent guidance and associated reporting framework "Developing Workforce Standards", published by NHS Improvement which was due to commence from April 2019.

It was noted that the guidance (summary provided in Appendix 1 to the report) built on previous NQB safe staffing guidance and significantly strengthened the expectations placed on Trusts, including some specific assurance requirements for Board Members.

Board Members:

(1) Welcomed the report.

(2) Recognised the significant amount of work required to comply with the new guidance.

(3) Questioned the extent of changes which would be needed in order to comply with the requirement for trusts to include a specific workforce statement in their Annual Governance Statement.

(4) Sought clarity on whether the outcome indicators and productivity measures, to be included in reporting, were the ones used at present by the Trust or whether new ones would need to be developed.

Mrs. Moody advised that:

(a) Significant changes were not expected to the Trust's outcome measures as they were already based on the previous NQB guidance (including the use of the Hurst Tool) upon which the NHSI guidance had been built.

(b) Productivity would be measured through the Model Hospital and through the Trust's Right Staffing Programme.

It was noted that, whilst intended to facilitate comparison and benchmarking, feedback received from acute trust colleagues suggested the Model Ward approach had limitations as it did not look at the quality of care and not all services were directly comparable.

The Non-Executive Directors emphasised the importance of the Board receiving benchmarking data albeit with caveats.

(5) Highlighted the level of central oversight being introduced through the guidance and questioned its impact on the freedoms and flexibilities of foundation trusts.

(6) Sought clarity on the timing of the introduction of the guidance in terms of the provision of evidence under the Single Oversight Framework and the preparation of the Annual Governance Statement.

In response to questions Mrs. Moody advised that:

(a) Further information on the introduction of the guidance was being sought from NHSI.

(b) With regard to internal reporting, due to the limited time available before the presentation of the next six monthly nurse staffing report to the Board in January 2019, the initial data was likely to be included in the June 2019 report.

(c) Clarity was also awaited on compliance with, and enforcement of, the new guidance.

(7) Observed that the new guidance confused strategic and operational functions with many of the responsibilities placed on Boards being more appropriate for the Executive Management Team.

(8) Sought clarity on whether the existing performance dashboard would be suitable to cover the new reporting requirements or whether a new dashboard would be needed.

It was noted that a separate quality dashboard would need to be prepared and this would require the agreement of thresholds and testing.

18/335 STAFF FLU CAMPAIGN 2018/19

Consideration was given to a progress report on the Trust's 2018-19 staff flu vaccination campaign.

An assessment of the campaign, against the best practice management checklist, produced by NHS senior leaders on 7th September 2018, was provided in Appendix 3 to the report.

It was noted that the report was the first of two to be presented to the Board. The second report would be provided to its meeting to be held on 26th February 2019 to coincide with the end of the vaccination campaign.

Mr. Levy advised that, further to the publication of the report, the vaccination rate had increased to 58% of frontline staff by 14th December 2018.

Board Members raised the following matters:

(1) The extent to which a proactive approach had been taken to encourage staff to be vaccinated as the communications plan seemed very dependent on "InTouch".

It was noted that:

(a) Together with articles on "InTouch" both the flu fighters and the Heads of Nursing had key roles in encouraging vaccinations.

(b) Social media, such as Facebook and Twitter, had also been used in conjunction with more traditional methods such as core brief and the EMT roundup.

In response to a question it was noted that the impact of using social media was not known at the present time.

(c) As in previous years the clinical evidence supporting vaccination had also been circulated but it was clear that some staff did not believe it.

(d) The impact of national media articles, which cast doubt on the effectiveness of the vaccine, was considered to have undermined the campaign and made encouraging staff to be vaccinated more difficult.

(2) The reasons why the Trust seemed to be achieving a lower vaccination rate than other mental health trusts and whether this was due to cultural reasons.

Mr. Levy explained that, previously, there was a significant gap in vaccination rates between the Trust and others. Although there had been a recent focus on achieving similar rates, the Trust was still trying to catch up with them. The geography of the Trust and its number of sites also made it more difficult to deliver vaccinations.

With regard to addressing this matter, it was noted that the Trust was becoming more rigorous in its approach and had expanded the number of flu fighters but the changes would take time to embed.

Mr. Martin added that in the last couple of years the Trust had taken a broad approach to the flu campaign but, as data on uptake became available, it would be better placed to focus on particular areas and groups.

He recognised that there was more to do in the next couple of months and the flu fighters were working very hard but opportunities to be vaccinated needed to be available where required.

In addition, the Non-Executive Directors drew attention to the conclusions section of the report where only three, of the four, amber rated elements of the checklist had been included and only two of them had been explained.

Agreed -

(1) that the NHS senior leader's ambition for 100% of healthcare workers with direct patient contact to receive a flu vaccination be endorsed; and

(2) that the Staff Flu Campaign 2018-19 – Healthcare workers flu vaccination best practice management checklist assessment (Appendix 3 to the report) be endorsed.

Action: Mr. Levy

18/336 FINANCE REPORT AS AT 30TH NOVEMBER 2018

The Board received and noted the Finance Report as at 30th November 2018.

It was noted that the information contained in the report was based on the revised financial plan submitted to NHS Improvement in October 2018 which increased the planned year end surplus to £9,863k (including £4,663k of Provider Sustainability Funding).

The focus of discussions was on agency expenditure which was 53% higher than the capped target and rated at "4" as a component of the Trust's Use of Resources assessment.

In response to questions it was noted that:

(1) The position on agency usage had been raised by NHS Improvement at the last Quarterly Review Meeting. The regulator had wanted the Trust to engage with its national team, which had taken place, and to receive assurance that all expected actions were being taken to reduce demand.

(2) NHSI understood the Trust's position and there was, at present, no adverse regulatory impact.

(3) The Trust's recruitment cap was comparatively low, compared to other trusts, reflecting the historic position.

(4) The significant change in recent months was the increase in demand for agency healthcare assistants (HCAs).

(5) Recruitment in North Yorkshire and York remained challenging. It was considered that the Trust had, to date, not placed sufficient weight on using training to support recruitment and changes were being made to the way posts were advertised.

(6) The Trust was taking forward a number of actions to seek to reduce agency expenditure including reviewing the potential introduction of a monitoring tool; working with Northumberland, Tyne and Wear NHS Foundation Trust; seeking to increase the number of junior doctors; and undertaking work to better describe the career path for HCAs.

(7) The Trust had also recently been complimented on its apprenticeship scheme and it was important to raise awareness of this given the competition to attract staff.
(8) It was recognised that the Trust needed to make headway on the issue early in the New Year.

18/337 DATE OF NEXT MEETING

It was noted that the next ordinary meeting of the Board of Directors was due to be held at 9.30 am on Tuesday 29th January 2019 in The Durham Centre, Belmont Industrial Estate, Durham, DH1 1TN

18/338 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).

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

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

Following the transaction of the confidential business the meeting concluded at 11.05 am.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th January 2019**
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

	Minute No.	Action	Owner(s)	Timescale	Status
22/05/2018	18/144	The objectives of the Research and Development Strategy to be used as the framework for future annual reports	Prof. JR	May-19	
22/05/2018	18/153	A Board Seminar to be held on outcome measures including a personal view on patient reported outcome measures and their impact on recovery	CM	~~Mar-19~~ Jul-19	
03/07/2018	18/185	Discussions to be held with the regional group on the provision of benchmarking information on serious incidents	EM	~~Dec-18~~ Feb-19	
19/07/2018	18/208	A briefing to be provided to a Board Seminar on the use of restraint and physical interventions in Tier 4 CAMHS	PB	~~Feb-19~~ Mar-19	
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	~~Dec-18~~ Mar-19	
25/09/2018	18/239	The impact of staffing issues on the quality of care and the risks of serious incidents arising from this matter is to be reviewed and reported in the next six monthly nurse staffing report	EM	Jan-19	See agenda item 8
25/09/2018	18/241	The Quality Assurance Committee is to be provided with a copy of the action plan developed in response to the NQB Guidance on working with bereaved families and carers	EM	Dec-18	Completed

	Minute No.	Action	Owner(s)	Timescale	Status
25/09/2018	18/241	A report/seminar briefing to be provided on the system-wide work being undertaken on learning from deaths	AK	Feb-19	
25/09/2018	18/242	Further consideration to be given to the application and operationalisation of NICE guidance in the forthcoming review of the Engagement and Observation Policy	EM	Apr-19	
25/09/2018	18/242	Dr Griffiths to be provided with a copy of the metrics being collated to support the evaluation of the pilot of zonal care	EM	Jan-19	
30/10/2018	18/274	The position on the research bid by Dr. Paul Tiffin of York University, in relation to supporting the Trust's understanding of the variations in outcomes, and the reasons for them, between different types and sizes of wards, to be reviewed	EM	~~Jan-19~~ Mar-19	
30/10/2018	18/278	The Director of Quality Governance to be asked to consider whether the streamlined approach to reporting from the QuAGs in the York and Selby Locality could provide a template for LMGB reports to the QuAC	EM	Mar-19	
30/10/2018	18/285	A report is to be presented to the Board providing an analysis of waiting times, taking into account “hot spots”, areas of concern and outcome measures, in order to support learning and the development of sustainable solutions	RH	Feb-19	
30/10/2018	18/289	Case studies on requests to change care records to be provided to the Board	EM	Mar-19	
27/11/2018	18/306	The Board to be updated on the outcome of the discussions between the Director of Therapies and the Chaplains in relation to the holding of an annual event/ceremony to remember people who have died in the Trust's services	CM	Feb-19	
27/11/2018	18/311	A progress report on the implementation of an early warning system for community teams to be presented to the Board	EM	Jun-19	
27/11/2018	18/311	A report to be presented to the Board on the outcome of the merger of the North Yorkshire and York and Selby Localities	RH	30/04/2019	

	Minute No.	Action	Owner(s)	Timescale	Status
27/11/2018	18/312	Discussions to be held with the Head of Data Quality on discounting those wards with low fill rates which are not due to direct Trust staffing issues from the monthly nurse staffing reports so that staffing problems elsewhere are not masked	EM	-	Completed
27/11/2018	18/312	Further information on the number of missed breaks by area to be included in the next nurse staffing report	EM	Jan-19	See agenda item 8
27/11/2018	18/312	A report to be provided to the Board on when high staffing fill rates of wards, due to levels of acuity, would be considered to be normal and the establishment changed to reflect the position	EM	Feb-19	
27/11/2018	18/313	The MHL Department, in conjunction with the Patient Safety Team, to look into what has happened to individual patients who were discharged by a panel against the recommendation of the RC and clinical team	EM (on behalf of RS)	Feb-19	
27/11/2018	18/314	The Board Seminar Programme to be reprioritised to facilitate an in-depth discussion on the Right Staffing Programme particularly in relation to how new roles are to be harmonised with traditional ones and incorporated into teams; and how they support the Trust deal with the issues it is facing	CM	Jan-19	Completed
27/11/2018	18/314	To note the Board's endorsement of the self-assessment report for multi-professional training	EM	-	To note
27/11/2018	18/317	In relation to the Strategic Direction Performance Report, to note the approval of: - The amendment of KPI 14 to monitor all delayed transfers of care - The changes to the Business Plan set out in Appendix 1 to the report	SP	-	To note

	Minute No.	Action	Owner(s)	Timescale	Status
18/12/2018	18/335	To note the Board's endorsement of: - The NHS senior leader's ambition for 100% of healthcare workers with direct patient contact to receive a flu vaccination - The Staff Flu Campaign 2018-19 – Healthcare workers flu vaccination best practice management checklist assessment (as presented in Appendix 3 to the report)	DL	-	To note

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

County Durham and Darlington

Levi Buckley
Director of Operations

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Locality Context

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- New senior leadership team
- Continued development of TAPs and Care Hubs – Durham and Darlington
- AMH/ LD integrated team review – managing TEWV/LA relationship
- IAPT and secondary care interface
- Developing MH&LD Partnership and NCM

Recent Successes

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- **Core 24**
  - ✓ Accessible urgent and out of hours response increased
  - ✓ For Adults, Older People and Children
  - ✓ Plus Street Triage

- **Children's ASD service**
  - ✓ Extended service across two bases

- **Enhanced LD Community Infrastructure**
  - ✓ To support reduced inpatient bed numbers

Our key challenges

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Demand and pace of workload
- Staffing – recruitment, retention and wellbeing
- AMH Community and Access Teams – capacity, burnout, leadership competencies and skills
- Medical recruitment – some positives!
- Managing impact of H&R bed closures
- Achieving Business Plan and CRES
- Compliance with Key Performance Indicators
- Pace of corporate ‘enabling’ work

Our key challenges

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Safety for patients – SI thematic review (interface liaison/crisis/IP/Community), CQC Action Plan, Demand/Capacity issues, impact on level of acuity and risk behaviour in inpatients, Dual diagnosis, physical health
- Focus on patient experience, listening to patients and increasing areas of co-production eg CPA, formulation to treatment plans, peer support
- MDT composite in Inpatients to enable more recovery focussed Trauma informed care

Opportunities

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Durham, Darlington and Teesside NHS Mental Health and Learning Disability Partnership (formerly ACP) – including case management work
- Crisis, Liaison and Urgent Care Reviews
- North East & North Cumbria STP – be a system leader e.g. what we can offer via PPS/QIS

  to multiagency pathways?
- Care Pathways e.g. Dementia Care
- New Models of Care - AED
- Estate Optimisation

making a difference together

Our Key Priorities

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Staff Health and Wellbeing
- Innovative approaches to staffing and recruitment

  e.g. AC/RC roles, PWPs, Specialty Doctors, NMPs, ANPs
- Recovery – college and philosophy
- Peer Roles
- Crisis Concordat – Crisis Review
- Stakeholder Engagement -

  patient voice in Locality decision making
- 5YFV and 10 Year Plan, CYP Trailblazer, IPS bids, IC+

We have a plan……..

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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ITEM NO. 7

Trust Board of Directors

DATE:	**January 2019**
TITLE:	**Guardian of Safe Working Quarterly Report**
REPORT OF:	**Julian Whaley, Guardian of Safe Working**
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:

It is the responsibility of the Guardian of Safe Working to provide a quarterly report to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.
The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017. Mandated monitoring processes for the quarter up to December have not identified any breaches to terms and conditions of service requiring the levy of a fine.
The Trust Exception Reports mainly reflect variation in work on non-resident rotas. Processes are in place for ongoing scrutiny and review of work schedules to provide assurance of safe working environments and consideration of training and service needs. There has been extensive Junior Doctor engagement in planning forthcoming rota changes and recording non-resident activity.

Recommendations:

The Board are asked to read and note this Quarterly report from the Guardian of Safe Working.

MEETING OF:	**Trust Board**
DATE:	**January 2019**
TITLE:	**Quarterly Report by Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

The Board receive a quarterly report from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for Junior Doctors. This includes aggregated data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern. This will provide assurance to the Board and if needed (not on this occasion) ask for approval for action to rectify a safety concern.

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours and during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.
The Guardian role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The guardian is required to levy a fine against a department(s) if a doctor works on average over 48 hours/week, works over 72 hours in 7 days or misses more than 25% of required rest breaks. The work of the guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

3. KEY ISSUES:

- A detailed breakdown of Junior Doctor numbers, status, exception reporting and locum usage is contained in Appendices 1&2 with a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendix is shared with the corresponding Health Education England body.
- I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified timeframes. The medical staffing department have supported doctors' supervisors to action these appropriately and maintain a log that enables trends to be spotted and reports submitted to locality forums.
- The majority of exception reports have been placed for additional hours of work. High levels of exception reports relate to the high degree of variation in out of hours non-resident on call rota work. I am satisfied that doctors are paid for work they are undertaking. There has been no justification to levy a fine on any department within the organisation. The Trust continues to provide compensatory rest arrangements that exceed the requirements set out in the contract.
- Junior Doctors can find the DRS reporting system cumbersome and following trial, review and LNC agreement, an on-call log form is to be commenced for use under a local agreement by doctors undertaking non-resident on-call work from February 2019. This will enable the junior doctor to maintain a log of out of hours

work over an 8 week cycle which they then submit to their medical staffing officer who advise on submission of an exception report if they have worked beyond their scheduled hours. They will continue to submit exception reports in the usual way for all other work or if their night-time work breaches safety limits.

- Changes to the delivery of mental health services across Hambleton & Richmond has triggered extensive consultation on the best way to deliver out of hours Junior Doctor cover. A number of options have been considered with broad consensus agreement reached for a hybrid resident rota for Harrogate and Hambleton & Richmond. This will mean that Monday to Thursday Junior Doctors working in Harrogate will be on a 1 in 8 resident rota and Junior Doctors working in Northallerton will rotate a long day shift until 9pm after which it is felt there will be no requirement for an 'on-site' Junior. Friday to Sunday, the two sets of Junior Doctors combine to provide a 1 in 13 resident rota. Due to the notice requirements of the contract and to enable scenarios to be explored and mitigated against, whereby a Junior Doctor may previously have been called outwith the mental health in-patient setting in Northallerton, this rota will commence in May 2019.
- Positive feedback continues to be received following the change in the South Durham rota to a resident shift system. Options for enabling increased attendance at local training events continue to be explored and one of the IT leads for Skype is attending the next Junior Doctor Forum.
- There continue to be concerns for the running of a local agreement to fill vacant resident night-shifts in York with non-resident locum doctors. The complexity of the service makes it difficult for key members of staff to understand the implications of calling the doctor, who may then have to take time from their substantive job to maintain their safety. A standard process is under development to mitigate this risk without which I would ask that this practice ceases.
- More broadly, I have asked Medical Staffing Officers to consider asking internal locums to provide a record of hours worked in locum shifts to provide assurance that doctors under our employment are not exceeding hours limits through additional work.
- Issues relating to physical health workload on one of the Scarborough wards has been raised at the relevant QuAG and shared within the locality forum.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour. This report evidences maintenance of these standards.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board understands that extra costs will be incurred for additional anti-social hours work and breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to junior doctors is necessary and appropriate.

4.3 **Legal and Constitutional (including the NHS Constitution):**
The Learning and Development Agreement signed by the Trust with Health Education England clearly sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow junior doctors to fulfil their curriculum needs within a sound learning environment.

4.4 **Equality and Diversity:**
The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity has therefore been co-opted to the quarterly trustwide Junior Doctor Forum. An Equality Impact Assesment has been completed and is updated within the forum. The Champion of Flexible Working is a core member of the Junior Doctor forum and holds an additional forum / network for less that full time doctors.

4.5 **Other implications:**
It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.

5. RISKS:
Failure to anticipate scenarios following service change may lead to a Junior Doctor being placed in an unsafe situation. Non-psychiatry training programmes may refuse to allow junior doctors in Northallerton to participate in a Harrogate rota.
The high levels of exception reporting are being reported in the medical press and without adequate understanding of our processes may lead to reputational risk.
Junior Doctor Locality Forums are running in each area, including operational and educational leaders as well as the guardian, in order to find systemic soutions. These inform the quarterly Junior Doctor forum, chaired by the guardian who also attends LNC & MEQAS meetings. These systems should provide assurance of interventions to mitigate some of the potential risks highlighted.

6. CONCLUSIONS:
The organisation continues to fulfil requirements of the new 2016 Junior Doctor Contract and junior doctors are appropriately submitting exception reports which are being handled appropriately. I am satisfied that processes are in place to identify and rectify issues of safety.
The ongoing need for whole system engagement with these issues cannot be underestimated.

7. RECOMMENDATIONS:
The Board are asked to read and note this Quarterly report from the Guardian of Safe Working.

Author: Dr Julian Whaley
Title: Guardian of Safe Working for Junior Doctors

Background Papers: Appendices 1 & 2: detailed information on numbers, exception reports and locum usage; contained with this report.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	80
Number of doctors / dentists in training on 2016 TCS (total):	74
Number of clinical supervisors	70
Amount of time available in job plan for guardian to do the role:	1.5 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors: trainee	0.125 PA per

Exception reports (with regard to working hours) from 1st October 2018 up to 31st December 2018

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	5	5	0
F2 –North Durham	0	1	1	0
F2 – South Durham	0	2	2	0
CT1-2 Teesside & Forensic Services Juniors	0	5	5	0
CT1-2 –North Durham	0	15	15	0
CT1-2 – South Durham	0	2	2	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	11	11	0
CT3 – North Durham	0	4	4	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Trust Doctors - North Durham	0	1	1	0

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	0	0	0
Total	**0**	**46**	**46**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	14	14	0
Teesside & Forensic Senior Registrars	0	7	7	0
North Durham Juniors	0	21	21	0
South Durham Juniors	0	4	4	0
South Durham Senior Registrars	0	0	0	0
Total	**0**	**46**	**46**	**0**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Locality	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
Teesside & Forensic Juniors	CT3	43	None done	1B	Yes
Teesside & Forensic Senior Registrars	N/A	N/A	N/A	N/A	N/A
Teesside CAMHS	N/A	N/A	N/A	N/A	N/A
Durham & Darlington CAMHS	Not undertaken within this timeframe.				
South Durham Juniors	CT3	44:23	None done	1B	Yes
South Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				
North Durham Juniors	N/A	N/A	N/A	NA	N/A
North Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Teesside & Forensic Services	F2	New	Unknown	15	15	0	15	x2 F2s from Dec 2018
	CT3	New	Unknown					
	CT3	New	Unknown					
	GP	New	Unknown					
	MTI	New	Unknown					
	CT3	New	Unknown					
	CT3	Old	Yes					
	CT3	New	Unknown					
	MTI	New	MTI					
	CT1	New	CT1					
North Durham	CT3	Old	No	13	13	0	13	x2 doctors on long term sick leave
	GP Reg	New	Unknown					
	F2	New	Unknown					
	Spec Dr	n/a	No					
	CT2	New	Yes					
	CT2	New	Yes					
	CT3	New	Unknown					
	CT1	New	Unknown					
South Durham	ST6	New	Yes	11	11	0	11	A part time F2 doctor 0n the rota from Dec'18
	MTi	New	Unknown					
	Trust Dr	New	No					
	GP Reg	New	Unknown					
	MTi	New	No					
	ST4	New	Unknown					
	MTi	New	Unknown					
Total				**39**	**39**	**0**	**39**	**2.5**

Narrative around Exception Reporting

Durham & Darlington

There were 25 exception reports raised during that period for the Durham & Darlington locality. This includes data from the following rotas – South Durham junior doctors, North Durham junior doctors, North and South Durham Senior Registrars and Durham and Darlington CAMHS Senior Registrars. The majority of the exception reports (21) have come from the North Durham Junior doctor rota as this is a non-resident rota and trainees have been advised to fill an exception report when their on-call work exceeds the additional time that they have been given in their work schedules. The South Durham junior doctor rota has become a resident rota from August 2018.

Teesside & Forensics

Three reports were from an F2 who had stayed back by 3 hours on 3 occasions during a week of long days. Supervisor was informed and the issue was being new to PARIS so it took longer to enter data. All other reports were for enhanced time during on call that is not included in work schedule.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	52
Number of doctors / dentists in training on 2016 TCS (total):	55
Number of clinical supervisors	43
Amount of time available in job plan for guardian to do the role:	2 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors:	0.125 PA per trainee

Exception reports (with regard to working hours) Up to from 1st October 2018 up to 31st December 2018

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	4	4	0
F1 - York	0	0	0	0
F2 - Northallerton	No F2 Doctors in North Yorkshire			
F2 - Harrogate				
F2 - Scarborough				
F2 - York	0	0	0	0
CT1-2 - Northallerton	0	18	18	0
CT1-2 - Harrogate	0	2	2	0
CT1-2 - Scarborough	0	17	17	0
CT1-2 - York	0	0	0	0
CT3/ST4-6 – Northallerton	0	2	2	0
CT3/ST4-6 – Harrogate	0	1	1	0
CT3/ST4-6 – Scarborough	0	0	0	0
CT3/ST4-6 – York	0	4	4	0
Trust Doctors - Northallerton	0	3	3	0
Trust Doctors - Harrogate	0	4	4	0
Trust Doctors - Scarborough	0	17	17	0
Trust Doctors - York	0	0	0	0
Total	**0**	**72**	**72**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	23	23	0
Harrogate	0	7	7	0
Scarborough	0	38	38	0
York	0	4	4	0
Total	**0**	**72**	**72**	**0**

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
Northallerton	CT2	New	Yes	18	18	0	18	1x CT1 1x overseas Trust Dr no out of hours
	CT3	Old	Yes					
	ST2	New	Unknown					
	Trust Doctor	Yes	No					
	Trust Doctor	Yes	No					
	Trust Doctor	Yes	Yes					
	SAS Doctor	N/A	Yes					
	SAS Doctor	N/A	Yes					
Harrogate	CT1	New	Yes	21	21	0	21	1xLTFT GP no out of hours 1x 0.4 CT3 vacancy 1x TD not doing out of hours
	CT2	New	Yes					
	CT3	Old	Unknown					
	Trust Doctor	New	Unknown					
	Trust Doctor	New	No					
	Trust Doctor	New	No					
	Trust Doctor	New	No					
	SAS Doctor	N/A	Yes					
	SAS Doctor	N/A	Yes					
	CT1	New	Yes					
Scarborough	CT1	New	Unknown	23	23	0	23	1x 0.2 TD vacancy 1x 0.5 ST2 vacancy 1x TD no out of hours 1x CT1 no out of hours
	CT2	New	Yes					
	Trust Doctor	New	Yes					
	Trust Doctor	New	No					

Locum bookings by locality								
Locality	**Grade of Locum**	**Locum on New/Old Contract**	**Locum Opted Out of EWTD**	**No. of shifts requested**	**No. of shifts worked**	**Agency Locum Used**	**Internal Locum Used**	**Vacancies on Rota**
	SAS Doctor	N/A	Yes					
York & Selby	CT2	New	Yes	46	46	4	42	1x F2 vacancy 2x CT2 vacancy 1x 0.2 CT3 vacancy 1x ST1 no nights 1x TD no nights
	CT3	New	Unknown					
	CT3	Old	Unknown					
	CT3	New	Unknown					
	ST2	New	Unknown					
	ST2	New	Yes					
	ST6	New	Unknown					
	F2	New	Unknown					
	SAS Doctor	N/A	Yes					
	ST2	New	Unknown					
	Trust Doctor	New	No					
Total				**108**	**108**	**4**	**108**	**15**

Narrative around Exception Reporting

York & Selby

There were 4 exceptions during the reporting period in the York & Selby locality. 3 exceptions were reported by a higher trainee. The other exception was logged by a CT3 who remained on duty for an additional hour until locum cover could be arranged. The twilight shift has been replaced by a 12noon – 6pm shift on Saturdays and Sundays. Locum shifts arise mainly due to vacant posts, maternity risk assessments and on the advice from Occupational Health.

Scarborough

During the reporting period there were 38 exceptions from the Scarborough locality. 22 exceptions were due to additional hours worked during the out of hours on call period. However, 9 exceptions were submitted as a result of late finishes to the normal working day. These exceptions were mainly from a FY1 doctor and a Trust Doctor in the same service. Those on the Scarborough rota received 2 hours plain time and 1 hour enhanced time paid in their work schedule. Locum shifts have arisen as one of the doctors is not doing on call work and another is LTFT.

Northallerton

There were 23 exception reports raised during the reporting period in the Northallerton locality. The majority of exceptions were due to additional hours worked during the out of hours on call period. 19 exceptions were due to additional hours worked during the out of hours on call period. Doctors in this locality are paid 2 additional hours at plain rate in their work schedule. There has been a CT vacancy on the rota since 21 September 2018.

Harrogate

There were 7 exception reports in the reporting period due largely working additional hours when on call out of hours. This represents a significant reduction in exceptions since the last report. Doctors on this rota receive 4 hours at plain rate and 1 hour at enhanced rate. Locums have been needed mainly due to occupational health advice and LTFT doctors.

ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 29 January 2019**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

The purpose of the report is to advise the Board of a 6 monthly review (1st June 2018 to 30th November 2018) of in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) and in line with the NQB Guidance.

The 'Right Staffing' programme board has been established to oversee a work plan to ensure the Trust has robust systems and processes in place to assure them that there is sufficient capacity and capability to provide high quality care to patients. Right Staffing is one of the strategic business priorities for the Trust board and the workstreams have been established. The programme provides regular updates to the Executive Management Team and the Strategic Change Oversight Board including deep dives on selected topics

In conclusion, the following is of relevance:

- There has been further national guidance on Safe Staffing from NHS-I, "Developing workforce Safeguards - Supporting providers to deliver high quality care through safe and effective staffing", which is referred to within the report, this builds on the NQB 2016 guidance which the Right Staffing programme was originally built around. A paper summarising this guidance has been produced for EMT and was presented to December Board. There has also been further specific guidance over the implementation of the new Nursing Associate role, including the requirement for a Quality Impact Assessment, which is being addressed through a paper to EMT in January.
- Changes to numbers of staff in post can be observed as follows:
  - Durham & Darlington – an increase of 5.8 WTE registered nurses and 6.3 WTE of unregistered nurses can be observed. The RN increase pertains to Willow, Maple and Tunstall Wards and the HCA increase pertains to Farnham and Hamsterly Wards.
  - A decrease of 1.2 WTE registered nurses and 13.4 WTE unregistered nurses can be observed within Forensic Services. The reduction is following the package of care on Eagle ASD coming to

an end.
  - North Yorkshire – a decrease of 6.9 WTE registered nurses and 5.8 WTE unregistered nurses can be observed. The largest reduction can be attributable to Cedar Ward.
  - Within Teesside an increase of 0.7 WTE registered nurses and a decrease of 14.9 unregistered nurses can be observed. The largest reductions are attributable to Stockdale, Evergreen and Westwood.
  - A reduction of 0.2 WTE registered nurses and an increase of 0.1 WTE unregistered nurses can be observed within York and Selby.
- In line with 'NQB guidance for Right Skills', the paper sets out a number of development programmes in place to enhance the skills of our workforce.
- Regarding staffing activity, the 6 month average shows:
  - The actual hours worked exceeding the planned hours across all months. Future establishment reviews will consider the gap further. All metrics are reporting above the 89.9% tolerance.
  - The Lodge was highlighted as having the lowest fill rate for unregistered nurses on days of 44.5% and relates to the to the transfer of the package of care to a private provider.
  - The Orchards (NY) was cited as having the second lowest fill rate for registered nurses on nights of 60.652.1%. This is linked to the HealthRoster system not reflecting the current budgeted establishment. The system change has been made however, due to the number of rosters created using the old template has delayed the recording and reporting of the new template.
  - Esk Ward was highlighted as having the third lowest fill rate for registered nurses on days of 56.7%. This is linked to the number of vacancies.
  - Sickness is the biggest factor impacting on staffing with 44 wards (this is an increase of 3 when compared to the previous 6 month report). Agency usage (25 wards) and Maternity (14 wards) were cited as the second and third highest.
  - 14,185 additional duties were created with a reason of 'enhanced observations'. This is an increase of 1,190 duties when compared to the previous 6 month report. The 14,185 additional duties created equate to 151,003 hours which would equate to 12,583 12 hour shifts.
  - Westerdale South was cited as the highest user of additional duties with a reason of 'enhanced observations'.
  - Bank usage greater than 25% equated to 10 wards in 3 separate localities. Mandarin is the highest user with a bank fill rate of 34.6%.
  - Agency usage related to 23 wards in 4 separate localities. Cedar (NY) had the highest with an agency usage rate of 54.2%.
  - The majority of inpatient wards are using overtime to fill shifts however, those in excess of 4% equates to 20 wards. Teesside are using the most overtime whilst York and Selby are using the least.
  - There are 49 wards from all localities that have utilised bank, agency and overtime within the reporting period.
- Triangulation of quality data over the 6 month average:
  - 129 incidents were raised during the reporting period citing concerns with staffing levels. This is an increase of 20 when compared to the previous 6 month report (109 incidents raised).
  - Triangulation of SIs, level 4 incidents, level 3 self-harm, complaints and incidents control and restraint with bank usage and the fill rates did not highlight any direct correlations between these strands of data.
  - Triangulation of falls that have resulted in significant harm, pressure ulcers, medication errors, breaks not taken, with that of bank usage and the fill rate indicators. From this it is not possible to draw any meaningful conclusions from this data for the period of this report.
  - In terms of patient, staff and carer feedback an analysis of the data from complaints, friends and family test and compliments has been undertaken but there were no specific issues raised with regards to staffing levels.
- The Right Staffing programme has developed a ward dashboard of quality nursing indicators. An interim approach being utilised within the Trust is the use of 9 quality nursing indicators and the monthly performance report out at EMT. This is an interim measure while an options paper is produced which considers the commercially available solutions alongside this approach.

- The CHPPD across all inpatient areas was 10.0 (3.6 registered nurses and 6.4 healthcare assistants) with an inpatient average of 13.1 CHPPD. Page 27 and 28 of the report breaks this down by locality and by the benchmarking groups. Attached at appendix 6 and 7 is the 6 month Care Hours per Patient Day. The next 6 month report will include the CHPPD for Allied Health Professionals
- The Trust has been advised that its Monitor Risk rating has been impacted upon in the last quarter by a breach of the Agency Cap. This applies particularly in the North Yorkshire and York and Selby areas. An exercise is underway to better understand these issues, and develop an action plan using a nationally recognised diagnostic tool which will be reported back to EMT to consider appropriate corrective action.

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:	**Tuesday, 29 January 2019**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of a 6 monthly review (1st June to 30th November 2018) in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) following the format of the new NQB 2016 Guidance.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Further to the emergent lessons from the Francis review there were a number of issues raised about the impact of the nurse staffing arrangements upon the poor quality of care and increased patient mortality exposed in that organisation. It is well accepted that safe and sustainable staffing is fundamental to good quality care however this includes many variables beyond numbers of staff.

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. (Nurse staffing - Tees Esk and Wear Valleys NHS Foundation Trust). The full monthly data set of day by day staffing for each of the 72 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

2.3 The 'Right Staffing' programme board will consider the broader multidisciplinary workforce whilst continuing to ensure the Trust has robust systems and processes in place to assure them that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards / clinical areas day or night, every day of the week as appropriate. This is being led by the Director of Nursing and Governance, supported by the programme manager in adopting the new Trust programme approach.

2.4 The Right Staffing programme continues to utilise a work stream approach, and will report to EMT and the Strategic Change Oversight Board. The workstreams have been restructured and consider developmental approaches alongside the task based aspects to ensure compliance with national guidelines, and are:

- Staffing Establishments
- Temporary Staffing
- Recruitment
- Staff Retention
- Workforce Roles
- Training and Development

2.5 The national work stream looking at service specific guidance published specific guidance for Learning Disability and Mental Health last year. This guidance has been considered within the trust Right Staffing programme to support and direct its work streams.

2.6 Right Staffing is one of the strategic business priorities for the Trust Board, accordingly the Executive Management Team have approved the Right Staffing Programme that will manage the implementation of the NQB guidance in addition to the broader aspects of the workforce identified in 2.4 of this report

2.7 New guidance was published by NHS-I in October 2018, "Developing Workforce Safeguards - Supporting providers to deliver high quality care through safe and effective staffing". This was accompanied by a letter to Directors of Nursing from NHS-I executives, highlighting the new guidance and advising of the establishing of a National faculty for Safe Staffing programme

NHS-I will be monitoring organisations against the updated guidance from April 2019. This approach includes:

- Assessing Trusts' compliance with a 'triangulated approach' to deciding staffing requirements, as described in NQB's guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time

- Using information collected through the Single Oversight Framework (SOF) and also asking Trusts to include a specific workforce statement in their annual governance statement

A separate paper was submitted to Trust Board in December, giving greater detail on the above requirements. Much of the existing Trust programme was built on similar previous NQB guidance, but the programme will review the Trust position against this latest document. The Trust Programme Manager was successful in securing a place on the national faculty, which will be a vital resource in terms of networking and ensuring the Trust approach is up to date.

3.0 TRIANGULATED APPROACH TO STAFFING DECISIONS:

3.1 Right Staff

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

3.1.2 Results from the Trust wide inpatient establishment review exercise resulted in significant investment by the Trust to support in acute AMH staffing in the 20 bedded units to provide equitable care hours per patient day across the Trust in these areas.

The Trust is currently participating in the national Mental Health Acuity and Dependency Development Group (NHSi and HEE) to test the Mental Health Optimal Staffing Tool (MHOST). This is an evidenced based tool that has been further developed by Dr Keith Hurst from the previous 2015 version known as the "Hurst Tool". The MHOST is currently only available for inpatient services, although a community version is under development. At the present time, updates are awaited on the finalisation of this tool which was expected to be published late 2018.

A standardised operating procedure, currently under development, for establishment reviews within the trust will utilise the MHOST to support this review process. The phased approach in the programme plan will accommodate the availability of the MHOST accordingly. Consideration will be given towards the potential for using the Allocate Safecare module, or other IT solutions following the planned options appraisal exercise, to support this.

3.1.3 As an interim approach the budgeted staffing establishments as at 1st June and the 30th November 2018 have been obtained from HealthRoster and have been used to compare the actual establishments in post. Attached at appendix 2 of this report is the full breakdown by ward and locality. The key points are as follows:

- Durham & Darlington – registered nurses in post has increased by 5.8 WTE and an increase of 6.3 WTE unregistered nurses can be observed. The increases in registered nurses pertain to Willow, Maple and Tunstall wards whilst the increases in unregistered nurses pertain to Farnham and Hamsterley Wards.
- Forensic Services – registered nurses in post has decreased by 1.2 WTE and a reduction of 13.4 WTE for unregistered nurses. The reduction of unregistered nurses can largely be attributable to the ending of a package of care on Eagle ASD.
- North Yorkshire – registered nurses in post has decreased by 6.9 WTE and a reduction of 5.8 WTE unregistered nurses. The reduction of registered nurses can be observed across the service with the largest reduction at Cedar Ward (NY). In terms of the reduction of unregistered nurses this can be attributable to Danby Ward and Cedar (NY).
- Teesside – registered nurses in post has increased by 0.7 WTE and 14.9 WTE less unregistered nurses. Stockdale, The Evergreen Centre and Westwood Centre can be observed with the largest reduction of unregistered nurses.
- York and Selby – registered nurses in post have decreased by 0.2 WTE and an increase of 0.1 WTE unregistered nurses.
- Across all inpatient areas, this has resulted in a decrease of approximately 3.4 registered nurses and a reduction of 55.5 WTE unregistered nurses in post.

The Trust is participating in a national collaborative programme, the aim of which is to increase the retention of clinical staff, in particular registered nurses, led by NHS-I. The emphasis on retention highlights that there may be diminishing returns with efforts to focus on recruitment of staff, and that in any event patient safety may be improved incrementally with more experienced staff being retained within an organisation. The emphasis is on improving internal support, well-being, internal development routes and offering career options which increase the likelihood of retaining such staff. The Trust appears in cohort three of this scheme. Initially our data for this topic were seen as comparing well with peer mental health Trusts. There have been meetings to review progress with NHS-I representatives at which early positive overall feedback on the Trust position and work in

progress were received. The Trust submitted an action plan as required in July 2018, describing a small number of key focus issues to improve our retention of staff, with a one year timeline for initial implementation and review. It was agreed with NHSI prior to submitting the retention plan that there ought to be a focus upon North Yorkshire and York in particular given these localities higher labour turnover rates and lower recruitment fill rates compared to other TEWV localities. Subsequent contact with NHS-I about agency spend is consistent with the focus agreed though there was not an awareness of the impact upon TEWVs financial risk rating at the time when the plan was submitted. A specific workstream has been established to lead the work on understanding and correcting this position, under the staffing establishment group of the Right Staffing programme, chaired by the Chief Operatig Officer. As part of our response to the high agency spend issue, a meeting with NHS-I and Trust representation from Director of Human Resources, Temporary Staffing Services, Clinical Services and Right Staffing is scheduled for 23rd January 2019.

3.2 Right Skills

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

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

3.2.3 There was 1 ward within the Trust who in November 2018 is reporting less than 75% compliance for mandatory training at the time of writing the report, as follows:

Locality	WARD	Speciality	November 2018
North Yorkshire	Ward 15	Adults	70.19%

3.2.4 The Trust continues to respond to the changing world of nurse and professional education, and the new approaches emerging to assist in the recruitment and retention of staff. There is strong partnership working with all the local HEIs and the Open University, this includes the development of pre-registration training courses at a relatively new provider, Sunderland University, and ongoing dialogue with Coventry University at Scarborough.

There are new education standards from the Nursing and Midwifery Council, which will begin to be implemented from later this year by the various institutions. As the Universities may be switching to new models at different times, this poses a risk to the organisation in terms of having students on various different programmes which have specific assessment requirements, potentially in the same workplace, however we are working in close partnership with the Universities to try to address this and there is encouraging movement on standardising the assessment processes across the region. The new standards will potentially enable the Trust to support more nurse learners in practice which will assist with

future recruitment. The Professional Nursing team are devising a communication and training plan in conjunction with the Universities to help embed the new approaches.

In addition, the Trust has recently supported 25 learners onto the new Apprentice Degree programme for pre-registration at Sunderland University, and smaller group of four onto the Open University course. These programmes represent considerable investment by the organisation in terms of backfill cost and other support, but do enable the organisation to make strong use of its Apprenticeship levy contribution. As these cohorts work through the pipeline they will ensure a much stronger position for the Trust in nurse recruitment in future years, but just as importantly they illustrate the Trust approach to supporting and developing its staff which will assist with retention in years to come. They also highlight the benefits obtained from the Trust HCA framework, which has led to us having some high quality internal candidates for these training positions. This is in addition the support which the Trust provided to maintain the Learning Disability programmes at Teesside University, in early 2018, sponsoring our own students, for which the training group are well underway, and positive feedback has been received on the benefits of this approach from the University. Recent feedback from Teeside would indicate they are now finding it easier to recruit to the LD pre-registration nursing course this year unlike in other areas of the country where the courses have been terminated.

The Trust continues to invest in the new role of Nursing Associate, which is a new member of the nursing family to bridge the gap between registered nurses and HCA's and now regulated by the Nursing and Midwifery Council. We have three cohorts of up to ten each, currently in training, with the first group due to qualify and register with the NMC in April. Work is underway to identify suitable first destination posts for this group and establish a process for future cohorts. There has been some new guidance from the NMC and NQB on the introduction of these roles, which includes the requirement to have a QIA approach to the impact of their recruitment into services and executive oversight. In line with this a paper summarising the issues and options, and a suggested QIA document, has been produced for the January EMT. Dialogue is underway with the University of York, and Coventry University at Scarborough, on the development of local courses for this role from September 2019, which will be of great benefit in these difficult-to-recruit areas (the previous programmes have been based in Teesside University).

Within the Right Staffing programme there is a workstream underway to establish the Trust positon on advanced roles, such as Advanced Clinical Practice (ACP) and Accountable Clinician (AC), and other supporting roles such as Physician Associate. There is a new national framework for the ACP role which we are working within as we review the Trust requirements for these roles. Several local Universities are providing, or working towards suitable preparation courses at Masters Level, with an Apprenticeship option, however there are also substantial in-service training and mentorship requirements for these roles which require careful planning. There is joint working with the Medical Development team in recognition that many of these roles are intended to support some of the issues in recruitment to traditional medical posts.

3.3 Right place and right time

3.3.1 The NQB guidance states that Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective

management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.

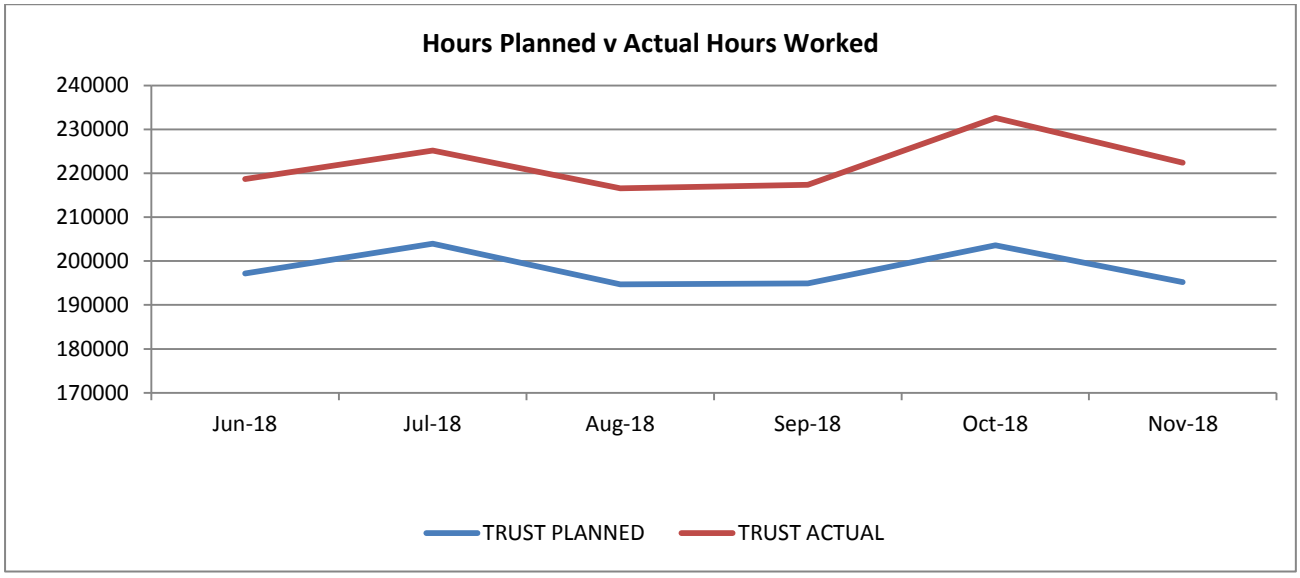
Within this domain, the Trust has developed a programme of annual reviews of the usage of the Health Roster system. Currently around 60% rosters have been reviewed and completed, and action plans are being monitored for follow up. This work, which is highlighting some significant issues with roster practices and ownership, remains on schedule to be completed before end of Q4 2018/19

The longer term solution of embedding review process and ongoing support for governance of data quality for rosters into Business as usual is being explored and developed.

In addition a pilot implementation is underway of HealthRoster for four CMHTs, to examine the benefits for community teams as indicated in the requirements analysis and as part of the generalisation of the Right Staffing programme from in-patient to community settings. Further developments regarding CMHT rostering will also be considered in the options appraisal regarding roster provision by Q4 18/19.

Further within this approach, the organisation has developed Escalation procedures in both in-patient and community settings, which are discussed in section 3.5

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



3.3.3 It is important to highlight that at no point during the 6 month review did the actual hours match the planned, and that the actual hours were always in excess of planned hours rather than in deficit. The establishment reviews will consider this gap between actual and planned hours in conjunction with the utilisation of temporary staffing. The programme will address this and will be further informed by new NHSI guidance for making effective use of staff banks.

3.3.4 Appendix 3 of the report shows the average fill rate (1st June to 30th November 2018) for both days and nights for both registered and non-registered staff. The 6 monthly position shows that there were 19 (28%) fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts. In terms of unregistered nurses this equated to 4 (6%) fill rates below 89.9%. This shows that although the trust usually meets its planned staffing numbers there is often a deficit of the planned skill mix from registered to non-registered. This presents risks in terms of CQC compliance and limits the quality and safety of interventions that can be offered from a registered nursing perspective. We are aiming to improve this with recent investment in registered nursing posts and the focus on recruitment and retention.

3.3.5 In terms of the night time shifts the 6 monthly position shows that there were 4 (6%) fill rates of less than 89.9% (shown as red) for registered nurses and unregistered nurses there were 2 (3%) fill rates ward who had a fill rate below 89.9%.

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

Month	Actual Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Jun-18	95.20	↓	116.00	→	101.60	↓	128.20	↓
Jul-18	94.90	↓	115.60	↓	100.70	↓	126.90	↓
Aug-18	94.00	↓	116.50	↑	103.40	↑	125.50	↓
Sep-18	93.70	↓	118.70	↑	101.00	↓	127.80	↑
Oct-18	97.80	↑	120.10	↑	102.00	↑	132.70	↑
Nov-18	97.90	↑	118.20	↓	101.20	↓	134.50	↑

From the table it is important to highlight the following:

- All fill rate indicators are within the 89.9% tolerance.
- The average fill rate for registered nurses on day shifts has improved from 95.20% in June 2018 when compared to 97.90% in November 2018 (2.7% increase).
- The average fill rate for health care assistants on day shifts has increased from 116% in June 2018 when compared to 118.20% in November 2018 (2.2% increase).
- The average fill rate for registered nurses on night shifts has decreased from 101.6% in June 2018 when compared to 101.20% in November 2018 (0.4% decrease).
- The average fill rate for health care assistants on night shifts has increased from 128.20% in June 2018 when compared to 134.50% in November 2018 (6.3% increase).

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3.3.7 The overall total red rated occurrences utilising the average fill rate (i.e. less than 89.9%) was 40 occurrences. The table below shows the breakdown by locality:

Locality	Total Number of Red Occurrences	Trend on previous 6 months
Durham & Darlington	7	↓ (10)
Teesside	9	↓ (11)
North Yorkshire	3	↑ (2)
Forensic Services	8	↓ (14)
York and Selby	2	↓ (3)

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

3.3.8 The 6 month average highlights The Lodge (Teesside, Adult LD) as having the lowest fill rate of 44.5% for unregistered nurses on days. The low fill rate is as a result of transferring the package of care to a private provider. Any shortfall was being provided for by the private provider as part of the transition.

3.3.9 The second lowest fill rate utilising the 6 month average highlights The Orchards NY (North Yorkshire) with a fill rate of 52.1% for registered nurses on Nights. This is linked to the HealthRoster system not reflecting the current budgeted establishment. The required changes to the electronic system have been implemented however, due to the number of rosters that had been created utilising the old template has resulted in a delay in reporting.

3.3.10 The third lowest fill rate utilising the 6 month average highlights Esk Ward (North Yorkshire) with a fill rate of 56.7% for registered nurses on Days. This is due to a number of vacancies and assurances have been provided by the ward that all nurse in charge shifts were filled using overtime or community nurses.

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

- 44 wards who had sickness absence rates greater than 5% loss of actual hours
- 25 wards who had agency usage greater than 4% of actual hours worked
- 14 wards who had maternity absence greater than 5% loss of the actual hours
- 10 wards who had bank usage greater than 25% of actual hours worked
- 8 wards who had vacancies greater than 10% loss of actual hours

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

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

Month	Number of duties	Number of Hours
June	2,495	26,016
July	2,322	24,586
August	2,139	22,744

September	2,216	23,354
October	2,501	26,993
November	2,512	27,308
TOTAL	**14,185**	**151,003**

- This table highlights that the number of additional duties being created with a reason of 'enhanced observations' within the trust is consistently high (ranging from 2,139-2,512 across the period)

- 14,185 additional duties/shifts were created within the reporting period this is an increase of 1,190 duties when compared to the previous 6 month period.

- The 14,185 additional duties/shifts created equates to 151,003 hours within the reporting period this is an increase of 13,996 hours when compared to the previous 6 month period. The additional 151,003 hours created would equate to 12,583, 12 hour shifts.

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

Locality	Ward / Team	Number of Duties	Number of Hours
Teesside	Westerdale South	1,424	16,096
York & Selby	Acomb Garth	1,029	11,511
Forensics	Merlin Ward	753	8,317
Forensics	Mandarin	678	7,361
York & Selby	Meadowfields	594	6,696
Forensics	Northdale Centre	633	6,117
North Yorkshire	Springwood	521	5,491
Forensics	Kestrel/Kite.	551	5,336
Teesside	The Evergreen Centre	471	5,301
Teesside	Bedale Ward	455	5,176
	TOTAL	**7,109**	**77,408**

3.3.14 Further analysis of the usage of 'enhanced observations' in relation to budgeted establishments is required to fully understand the level of clinical need, practices at ward level and to seek an effective solution to bank usage. Right Staffing has facilitated the liaison with peers who have participated in the NHSI observation collaborative to better understand the benefits of zonal engagement and observation practices to support effective utilisation of staff to better support service users and deliver high quality care. Senior staff from Acomb Garth and Westerdale South has participated in this exercise, the outcomes of which will be presented to the Right Staffing Programme Board and EMT for consideration of utilising in the Trust. This will form an ongoing and key part of the proposed work plan for right staffing programme. The paper will be presented to the Right Staffing Programme Board provisionally in January, and has been informed by reviews of practices in Trust areas which appear to make less use of observations including in Durham and Darlington locality.

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

Locality	Ward Name	Bank	
		Hours	% loss against Actual Hours
Forensics	Mandarin	8179.7	34.6%
Forensics	Northdale Centre	10897.1	34.5%
Teesside	Westerdale South	11903.4	31.6%
Forensics	Merlin	9104.5	31.5%
Forensics	Clover / Ivy	7425.9	31.4%
Forensics	Kestrel / Kite.	8243.4	30.6%
Durham & Darlington	Birch Ward	6226.6	30.2%
Forensics	Lark	4783.8	28.9%
Durham & Darlington	Elm Ward	4936.9	28.0%
Forensics	Mallard	6033.7	27.0%

- This equates to 10 wards in 3 separate localities.

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

3.3.17 The Trust has been advised that its NHSI financial risk rating has been impacted upon in the last quarter by a breach of the Agency Cap. This appears to apply particularly in the North Yorkshire and York and Selby areas including HCA spend. Work is being undertaken to better understand these issues and develop appropriate corrective action. The method used will be based around the NHS-I Diagnostic Toolkit for reducing Agency usage, together with other actions based on local knowledge. As previously stated, part of our response to the high agency spend issue, a meeting with NHS-I and Trust representation from Director of Human Resources, Temporary Staffing Services, Clinical Services and Right Staffing is scheduled for 23rd January 2019.

In terms of specific Agency usage as a proportion of actual hours worked averaged over the 6 month period 'RAG' rated independently of the overall fill rate. Those wards using greater than 4% agency usage to deliver their fill rates are identified below:

Locality	Ward Name	Agency	
		Hours	% loss against Actual Hours
North Yorkshire	Cedar (NY)	10671.7	54.2%
York and Selby	Acomb Garth	13660.9	42.6%
York and Selby	Meadowfields	8334.8	35.6%
North Yorkshire	Rowan Ward	7480.0	33.1%
North Yorkshire	Springwood	5234.2	22.6%

York and Selby	Oak Rise	5129.3	19.2%
North Yorkshire	Ward 15	3301.1	17.9%
York and Selby	Ebor Ward	1878.5	11.2%
Teesside	Bedale Ward	2943.5	10.9%
North Yorkshire	Ayckbourn Danby Ward	2985.5	16.4%
North Yorkshire	Rowan Lea	4287.6	16.4%
York and Selby	Cherry Tree House	3364.7	15.7%
Teesside	Westerdale North	3007.3	13.0%
Teesside	Westerdale South	3896.8	10.3%
Durham & Darlington	Hamsterley	2109.7	9.5%
Teesside	The Evergreen Centre	2632.2	8.0%
York and Selby	Minster Ward	1297.4	7.6%
Teesside	Bransdale	1272.5	7.1%
North Yorkshire	Ayckbourn Esk Ward	1084.5	7.0%
Teesside	Stockdale	1173.0	6.5%
Durham & Darlington	Bek-Ramsey Ward	1522.2	6.2%
Durham & Darlington	Elm Ward	924.2	5.2%
Teesside	The Lodge	368.0	5.0%

- This equates to 23 wards in 4 separate localities.

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

Locality	Ward Name	Overtime	
		Hours	% Overtime against Actual Hours
Teesside	Baysdale	1816.06	11.5%
North Yorkshire	Ward 14	1260.4	8.4%
Teesside	Thornaby Road	914.5	8.0%
Teesside	Westwood Centre	2592.56	7.4%
York and Selby	Minster Ward	1234.25	7.2%
Forensics	Oakwood	895.09	6.4%
Teesside	Bankfields Court Unit 2	896.35	6.2%
Durham & Darlington	Bek-Ramsey Ward	1500.91	6.1%
Durham & Darlington	Harland Rehab Ward	703.25	5.9%
Forensics	Harrier / Hawk	1335.92	5.8%
Forensics	Newtondale	1201.07	5.1%
York and Selby	Cherry Tree House	1056.5	4.9%
York and Selby	Oak Rise	1292.71	4.8%
Teesside	Bedale Ward	1207.3	4.5%
Teesside	Aysgarth	602.92	4.5%
North Yorkshire	Rowan Lea	1175.99	4.5%

North Yorkshire	Springwood	1042.68	4.5%
Durham & Darlington	Tunstall Ward	796.03	4.4%
North Yorkshire	The Orchards (NY)	523.88	4.2%
Teesside	Newberry Centre	1164.95	4.2%

- The majority of the inpatient wards across the trust are using overtime.
- Teesside are using the most overtime (15,292) whilst York & Selby are using the least (4,552).
- There are 49 wards who have utilised bank, agency and overtime within the reporting period as outlined below:

Locality	Ward Name	Overtime usage Vs actual Hours	Agency usage Vs actual Hours	Bank usage Vs actual Hours
North Yorkshire	Danby Ward	3.5%	16.4%	13.1%
North Yorkshire	Esk Ward	1.4%	7.0%	16.9%
Teesside	Bedale Ward	4.5%	10.9%	15.4%
Teesside	Bilsdale	2.3%	3.8%	7.1%
Durham & Darlington	Birch Ward	1.3%	3.0%	30.2%
Teesside	Bransdale	1.5%	7.1%	16.9%
Durham & Darlington	Cedar	2.7%	1.4%	20.3%
North Yorkshire	Cedar (NY)	1.4%	54.2%	8.7%
York and Selby	Ebor Ward	1.7%	11.2%	9.7%
Durham & Darlington	Elm Ward	2.9%	5.2%	28.0%
Durham & Darlington	Farnham Ward	2.2%	4.0%	12.6%
Teesside	Kirkdale	3.3%	1.0%	19.0%
Teesside	Lustrum Vale	1.8%	2.3%	22.2%
Durham & Darlington	Maple	1.9%	2.8%	22.8%
York and Selby	Minster Ward	7.2%	7.6%	6.2%
Teesside	Overdale	3.2%	2.3%	1.5%
Durham & Darlington	Primrose Lodge	1.7%	0.3%	8.3%
Teesside	Stockdale	1.5%	6.5%	13.6%
Durham & Darlington	Tunstall Ward	4.4%	1.5%	5.1%
North Yorkshire	Ward 15	2.0%	17.9%	24.7%
Durham & Darlington	Willow Ward	3.1%	1.4%	21.4%
Teesside	Newberry Centre	4.2%	1.1%	11.8%
Teesside	Evergreen Centre	3.3%	8.0%	16.4%
Teesside	Westwood Centre	7.4%	2.2%	7.0%
Forensics	Clover / Ivy	2.2%	3.6%	31.4%
Forensics	FLD Eagle ASD	3.4%	3.4%	17.2%
Forensics	Harrier / Hawk	5.8%	0.1%	20.7%
Forensics	Kestrel / Kite.	3.0%	0.6%	30.6%
Forensics	Northdale Centre	3.3%	2.4%	34.5%
Forensics	Oakwood	6.4%	0.1%	22.9%
Forensics	Thistle	3.1%	0.1%	17.7%

Durham & Darlington	Bek-Ramsey Ward	6.1%	6.2%	9.1%
York and Selby	Oak Rise	4.8%	19.2%	15.7%
Teesside	The Lodge	4.0%	5.0%	2.8%
York and Selby	Acomb Garth	0.8%	42.6%	4.3%
Durham & Darlington	Ceddesfeld	1.7%	2.9%	6.9%
York and Selby	Cherry Tree House	4.9%	15.7%	15.1%
Durham & Darlington	Hamsterley	2.6%	9.5%	24.7%
York and Selby	Meadowfields	1.9%	35.6%	12.1%
Durham & Darlington	Oak Ward	1.1%	1.4%	8.5%
Durham & Darlington	Roseberry Wards	0.3%	0.1%	10.2%
North Yorkshire	Rowan Lea	4.5%	16.4%	21.5%
North Yorkshire	Rowan Ward	1.3%	33.1%	9.6%
North Yorkshire	Springwood	4.5%	22.6%	10.7%
North Yorkshire	Ward 14	8.4%	3.8%	7.7%
Teesside	Westerdale North	1.7%	13.0%	9.1%
Teesside	Westerdale South	0.7%	10.3%	31.6%
Durham & Darlington	Harland Ward	5.9%	2.1%	17.5%
Teesside	Kiltonview	1.0%	0.2%	14.4%

- There are no wards that are appearing as ‘red’ across overtime, agency and bank.

3.4 Patient outcomes, people productivity and financial sustainability

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

3.4.2 In turning to the triangulation of staffing data with other safety indicators. Appendix 5 provides an overview of all quality indicators for all inpatient wards. Firstly there were 10 SI’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 SIs	Ward	Bank Usage	Agency Usage	Staffing Fill Rate			
				RN Days	RN Nights	HCA Day	HCA Night
1	Tunstall Ward	5.1%	1.5%	**114.5%**	**106.8%**	**108.4%**	**113.1%**
1	Newberry Centre	11.8%	1.1%	**100.3%**	**136.2%**	**143.7%**	**159.6%**
1	Clover / Ivy	31.4%	3.6%	**95.0%**	**106.2%**	**97.0%**	**150.8%**
1	Cherry Tree House	15.1%	15.7%	**114.2%**	**107.3%**	**120.1%**	**154.9%**
2	Hamsterley	24.7%	9.5%	**93.7%**	**101.2%**	**139.2%**	**155.8%**
1	Roseberry Wards	10.2%	0.1%	**101.6%**	**105.0%**	**101.0%**	**103.8%**

1	Rowan Ward	9.6%	33.1%	**92.5%**	**152.9%**	**162.8%**	**158.3%**
1	Westerdale North	9.1%	13.0%	**107.8%**	**115.9%**	**128.2%**	**173.6%**
1	Westerdale South	31.6%	10.3%	**104.9%**	**100.9%**	**221.5%**	**266.3%**

- From those wards that did have an SI within the reporting period all reported as either 'green' or 'blue' for their staffing fill rates.
- There was only Westerdale South that reported as 'red' for their bank and agency usage. Clover/Ivy reported 'red' for bank usage and 'amber' for agency.

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. During the reporting period there were 7 cases reviewed at Directors Panel which highlighted a contributory finding regarding staffing:

- 2018/6908 – The report highlights a number of challenges that were faced by the team in providing continuity of care due to staffing pressures.

- 2018/10851 – There are currently a number of staff vacancies at Rowan Ward as such the use of flexible staffing was shown on occasions to impact on the completion and quality of documentation. Attempts continue to be made to recruit to vacant positions and efforts are being made to block book temporary staff wherever possible for the purpose of consistency.

- 2018/13213 – On the day of the fall there had been some challenges in relation to staffing following unplanned leave on compassionate grounds and an Agency worker who did not attend for duty. The physical health care practitioner and the Ward Manager worked alongside the HCA's to provide cover. The ward was described as being exceptionally busy with fifteen patients on the ward, some of whom were unsettled and required the staff to be especially vigilant due to their potential for behaviours that challenge (e.g. aggression towards others). One patient in particular needed intensive support.

- 2018/13869 – Wait time for Step 3 treatment was longer than normal at the time due to staffing issues; the service were waiting for a CBT therapist to join the team (starting date was 4th January 2019)

- 2018/16525 – A clinician saw a patient at the CAS suite had been unable to attend a RCA meeting. The clinician could not remember any details of the contact made with the patient due to the length of time that had passed. The clinician's primary role was with the Street Triage Team but had working in the Assessment Suite on an overtime shift. The shift had been particularly busy with 8 referrals received that day. The clinician worked longer to ensure a triage assessment took place. As the night shift staff commenced there were fewer staff than the recommended cover therefore the clinician remained on duty as the night staff would have had limited capacity to see the patient in a timely manner. Other staff from the day shift also stayed back to provide additional support. The on call manager was notified of the lower staffing levels and the head of service was aware of the staffing difficulties at the time following unprecedented sickness levels. All relevant actions had been put into place.

- 2018/18043 - Patient had 10 day Intensive Home Treatment input and was then discharged back to the care of his GP. The decision to discharge was appropriate and well-reasoned. However, it was identified that the 72 hour formulation did not go ahead and there was no intervention plan and because of this the aims of involvement lacked clarity. Care was delivered 'day by day' and was not guided by an overarching plan. Also, of note was that the daily huddle meeting were not recorded. The team were experiencing exceptionally high caseloads with significantly high staff sickness and absence during this time and this contributed to the lack of 72 hour formulation and intervention plan. Administrative staff, team managers and advanced practitioners who all have a roll in driving the formulation meeting forward do not work 'out of hours'.

- 2018/18734 – The staffing levels on the ward had a direct impact on the ability of the MDT to following the Frailty CLiP. Visual baseline falls assessment was not completed on admission. The Frailty Assessment was not commenced within a week of admission. There was a long delay before the patient was discussed at an MDT frailty meeting. When the frailty meeting was held not all information was available. The level of agency staff on the ward meant that the systems for feeding clinical information into the MDT were not operating as intended, impacting on the team's ability to identify and respond to the patient's falls risk.

The Right Staffing programme will consider as part of its delivery the skill mix of staffing establishments.

3.4.3 There were a total of 8 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.of L4 Incidents	Ward	Bank Usage	Agency Usage	Staffing Fill Rate			
				RN Days	RN Nights	HCA Day	HCA Night
1	Newberry Centre	11.8%	1.1%	**100.3%**	**136.2%**	**143.7%**	**159.6%**
1	Clover / Ivy	31.4%	3.6%	**95.0%**	**106.2%**	**97.0%**	**150.8%**
1	Cherry Tree	15.1%	15.7%	**114.2%**	**107.3%**	**120.1%**	**154.9%**
2	Hamsterley	24.7%	9.5%	**93.7%**	**101.2%**	**139.2%**	**155.8%**
1	Rowan Ward	9.6%	33.1%	**92.5%**	**152.9%**	**162.8%**	**158.3%**
1	Westerdale North	9.1%	13.0%	**107.8%**	**115.9%**	**128.2%**	**173.6%**
1	Westerdale South	31.6%	10.3%	**104.9%**	**100.9%**	**221.5%**	**266.3%**

- From those wards that did have a L4 incident within the reporting period all had a 'green' or 'blue' rating for their staffing fill rates.
- There was only Westerdale South that reported as 'red' for their bank and agency usage. Clover/Ivy reported 'red' for bank usage and 'amber' for agency.

3.4.4 There were 46 level 3 self-harm incidents occurred within the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No.of L3 (Self Harm Incidents)	Ward	Bank Usage	Agency Usage	Staffing Fill Rate			
				RN Days	RN Nights	HCA Day	HCA Night
2	Danby Ward	13.1%	16.4%	**104.2%**	**96.3%**	**117.0%**	**132.3%**

3	Bilsdale	7.1%	3.8%	97.8%	99.6%	126.8%	110.5%
2	Bransdale	16.9%	7.1%	104.3%	102.7%	129.3%	139.8%
4	Cedar	20.3%	1.4%	106.2%	101.3%	74.8%	75.0%
3	Cedar (NY)	8.7%	54.2%	100.7%	103.4%	100.3%	113.8%
3	Ebor Ward	9.7%	11.2%	82.8%	100.4%	77.5%	109.1%
2	Elm Ward	28.0%	5.2%	96.6%	97.9%	95.7%	112.8%
1	Farnham Ward	12.6%	4.0%	111.7%	102.2%	135.2%	130.9%
3	Lustrum Vale	22.2%	2.3%	92.2%	102.3%	140.8%	123.5%
4	Overdale	1.5%	2.3%	103.2%	100.0%	112.9%	110.7%
1	Stockdale	13.6%	6.5%	102.2%	102.8%	130.7%	139.7%
2	Tunstall Ward	5.1%	1.5%	114.5%	106.8%	108.4%	113.1%
3	Ward 15	24.7%	17.9%	79.5%	107.6%	160.6%	140.5%
3	Newberry Centre	11.8%	1.1%	100.3%	136.2%	143.7%	159.6%
4	Evergreen	16.4%	8.0%	84.9%	113.8%	123.0%	145.2%
1	Westwood	7.0%	2.2%	99.2%	107.8%	117.1%	115.8%
1	Kestrel / Kite.	30.6%	0.6%	99.8%	108.1%	117.2%	151.5%
3	Brambling	22.3%	0.0%	103.2%	106.7%	105.6%	117.4%
1	Bek-Ramsey	9.1%	6.2%	118.6%	100.6%	111.2%	102.2%

- From the 46 level 3 self-harm incidents this equated to 19 wards across 5 localities.
- Teesside had the highest number of level 3 incidents in the reporting period with 21 incidents in total.
- Cedar D&D, Overdale and Evergreen had the highest number of level 3 incidents across the reporting period with 4 incidents each.
- 2 out of 19 wards reported as ‘red’ for their bank usage whilst all the others reported either as ‘amber’ or ‘green’.
- 10 out of 19 wards reported as ‘red’ for their agency usage whilst all the others reported as either ‘amber’ or ‘green’.
- There was only Elm Ward that reported as ‘red’ for both their bank and agency usage.
- There were 6 fill rate indicators that reported as ‘red’ whilst the others all reported as either ‘green’ or ‘blue’.

3.4.5 There were 41 complaints raised during the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No.of Complaint	Ward	Bank Usage	Agency Usage	Staffing Fill Rate			
				RN Days	RN Nights	HCA Day	HCA Night
1	Bedale Ward	15.4%	10.9%	90.1%	84.1%	137.5%	188.1%
1	Bilsdale	7.1%	3.8%	97.8%	99.6%	126.8%	110.5%
1	Bransdale	16.9%	7.1%	104.3%	102.7%	129.3%	139.8%
1	Cedar	20.3%	1.4%	106.2%	101.3%	74.8%	75.0%
2	Cedar (NY)	8.7%	54.2%	100.7%	103.4%	100.3%	113.8%
1	Ebor Ward	9.7%	11.2%	82.8%	100.4%	77.5%	109.1%
3	Elm Ward	28.0%	5.2%	96.6%	97.9%	95.7%	112.8%
1	Minster Ward	6.2%	7.6%	79.8%	100.4%	85.7%	108.1%
2	Overdale	1.5%	2.3%	103.2%	100.0%	112.9%	110.7%

4	Stockdale	13.6%	6.5%	102.2%	102.8%	130.7%	139.7%
4	Tunstall Ward	5.1%	1.5%	114.5%	106.8%	108.4%	113.1%
3	Ward 15	24.7%	17.9%	79.5%	107.6%	160.6%	140.5%
1	Newberry Centre	11.8%	1.1%	100.3%	136.2%	143.7%	159.6%
3	Evergreen	16.4%	8.0%	84.9%	113.8%	123.0%	145.2%
1	Harrier / Hawk	20.7%	0.1%	92.3%	103.6%	107.5%	114.3%
4	Kestrel / Kite.	30.6%	0.6%	99.8%	108.1%	117.2%	151.5%
3	Northdale Centre	34.5%	2.4%	97.8%	131.6%	111.2%	128.5%
1	Jay Ward	8.8%	0.0%	91.6%	104.6%	95.2%	100.7%
1	Sandpiper Ward	18.8%	0.0%	99.4%	91.8%	100.4%	131.0%
1	Bankfields Unit 2	23.2%	0.0%	100.4%	101.9%	107.9%	121.4%
1	Acomb Garth	4.3%	42.6%	83.7%	87.1%	183.6%	256.6%
1	Rowan Ward	9.6%	33.1%	92.5%	152.9%	162.8%	158.3%

- None of the complaints raised cited issues with staffing levels or skill mix. However, there were 4 complaints that did raise concerns with regards to staff attitude being negative (Kite Ward, Elm Ward, Bankfields Unit 2 and Hawthorne).
- Teesside locality had the highest number of complaints in the reporting period with 14 complaints raised.
- From those that had complaints raised 3 wards reported as ‘red’ for bank usage whilst the remaining wards reported either as ‘amber’ or ‘green’
- From those wards that had complaints raised 11 wards reported as ‘red’ for their agency usage whilst the remaining wards reported as either ‘amber’ or ‘green’.
- Elm Ward was the only ward that had complaints raised that reported as ‘red’ for both their bank and agency usage.
- 11 fill rate indicators were reporting as ‘red’ with 5 of these relating to registered nurses. All other metrics are reporting as either ‘green’ or ‘blue’.

3.4.6 The Trust’s Positive and Safe team 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 positive and safe remit.

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

Ward	Bank Usage	Agency Usage	Incidents of restraint			
			Incidents	PRO Used	Other	Restraint Total
Westwood Centre	7.0%	2.2%	1042	8	1817	1825
Newberry Centre	11.8%	1.1%	331	2	449	451
Sandpiper Ward	18.8%	0.0%	185	13	414	427
Cedar	20.3%	1.4%	165	7	267	274
Springwood	10.7%	22.6%	129		209	209
Oak Rise	15.7%	19.2%	126		167	167
Acomb Garth	4.3%	42.6%	122		139	139
Bek-Ramsey Ward	9.1%	6.2%	117	19	160	179

Birch Ward	30.2%	3.0%	106		168	168
Bedale Ward	15.4%	10.9%	100	13	159	172

- The Westwood Centre had 1042 incidents requiring the use of restraint during the reporting period. This equated to 1825 restraints of which 8 was recorded as 'Prone'.
- Birch Ward was the only ward who had a 'red' rating for their bank usage whilst the others reported as either 'amber' or 'green'.
- There were 5 wards that were identified within the top 10 users of restraint who reported as 'red' for their agency usage.
- There were no wards identified within the top 10 that reported 'red' for both their bank or agency usage.

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

Ward	Staffing Fill Rate			
	RN Days	RN Nights	HCA Days	HCA Nights
Westwood Centre	99.2%	107.8%	117.1%	115.8%
Newberry Centre	100.3%	136.2%	143.7%	159.6%
Sandpiper Ward	99.4%	91.8%	100.4%	131.0%
Cedar	106.2%	101.3%	74.8%	75.0%
Springwood	75.7%	99.5%	132.1%	215.6%
Oak Rise	110.8%	103.2%	128.2%	129.3%
Acomb Garth	83.7%	87.1%	183.6%	256.6%
Bek-Ramsey Ward	118.6%	100.6%	111.2%	102.2%
Birch Ward	82.2%	102.2%	111.3%	132.0%
Bedale Ward	90.1%	84.1%	137.5%	188.1%

3.4.9 The use of Prone restraint will continue to be monitored within the Positive and Safe team; however, it is worth highlighting that during the reporting period there were 135 episodes of Prone used. This is an increase of 18 when compared to the previous 6 month report.

3.4.10 Until the MH and LD TEWV safer staffing dashboard is created, NICE Guidance for Safe Staffing for nursing in adult inpatient wards in acute hospitals provides helpful indicators to support Right Staffing that has been used as below to provide indicative information on whether safe nursing care is being provided.

The 9 indicators include:

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

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

3.4.12 Falls that have resulted in significant harm for all inpatient services have been examined. Within the reporting period there have been a total of 5 incidents across 5 wards. The ward and teams that these each relate to are as follows:

Ward / Team	Locality	Speciality	Number of incidents
Cherry Tree House	York and Selby	MHSOP	1
Hamsterley	Durham & Darlington	MHSOP	1
Rowan Ward	North Yorkshire	MHSOP	1
Westerdale North	Teesside	MHSOP	1
Westerdale South	Teesside	MHSOP	1

- All of the falls incidents occurred within the older people's service. This is anticipated due to the 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 the following is of relevance:

  - All fill rate indicators are reporting as either 'green' or 'blue'.
  - Westerdale South was the only ward to report as 'red' for their bank usage whilst the others reported as either 'amber' or 'green'.
  - All wards reported as 'red' for their agency usage
  - There was only Westerdale South to report 'red' for both their bank and agency usage.
  - Cherry Tree was the only ward to report as 'red' for overtime usage whilst the others reported 'green'.

3.4.13 Data in relation to pressure ulcers was obtained covering the reporting period. There were 6 incidents reported across 4 wards as follows:

Ward / Team	Locality	Speciality	Number of incidents
Oak Ward	Durham & Darlington	MHSOP	3
Roseberry Wards	Durham & Darlington	MHSOP	1
Rowan Lea	North Yorkshire	MHSOP	1
Westerdale South	Teesside	MHSOP	1

- All of the incidents occurred within older people's service which would be expected.
- In turning to the triangulation of staffing data:
  - Rowan Lea had 1 fill rate indicator that reported as 'red', all other fill rate indicators reported as either 'green' or 'blue'.
  - Westerdale South reported as 'red' and Rowan Lea reported as 'amber' for bank usage.
  - Rowan Lea and Westerdale South both reported as 'red' for their agency usage.
  - Rowan Lea reported as 'red' for overtime usage.

3.4.14 It is not possible to draw any meaningful conclusions from this data however the data does support the need to further review levels of clinical activity and safe nursing indicators across MHSOP. This will be picked up through the establishment review process.

3.4.15 There were 462 incidents of medication errors reported within the reporting period across 64 wards. The top 6 wards are shown as follows:

Ward / Team	Locality	Specialty	Number of incidents
Minster Ward	York and Selby	Adults	47
Elm Ward	Durham and Darlington	Adults	28
Ebor Ward	York and Selby	Adults	27
Lustrum Vale	Teesside	Adults	17
The Evergreen Centre	Teesside	CYPS	16
Rowan Ward	North Yorkshire	MHSOP	15

- There are 5 fill rate indicators reporting as 'red' for Ebor, Minster and Evergreen Centre. All other fill rate indicators are reporting as either 'green' or 'blue'.
- Elm ward is the only ward to report as 'red' for their bank usage; whilst Lustrum Vale and the Evergreen Centre are reporting as 'amber'. All others are reporting as 'green'.
- All wards with the exception of Lustrum Vale are reporting as 'red' for their agency usage.
- Minster is reporting as 'red' and the Evergreen Centre are reporting as 'amber' for their overtime usage.

3.4.16 In terms of shifts worked without a break there were 2,330 shifts worked within the reporting period where breaks were not given. The top 5 wards were as follows:

Ward	**No of eligible shifts**	**No. of eligible shifts without breaks 01/12/17 to 31/05/18**	**% of shifts without break**	**Days without breaks**	**Nights without break**
Thornaby Road	1343	316	23.53%	108	208
Newberry Centre	3227	161	4.99%	120	41
Evergreen Centre	3445	154	4.47%	151	3
Oak Rise	2497	116	0.36%	106	10
Cedar Ward (NY)	1986	101	5.09%	60	41

- 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. This was related to issues raised regarding having a suitable place to take a place and that staff should raise a grievance. An agreement has been reached and will be reflected in the data in future reports.

- The absence of breaks is however now being monitored on the report-out walls by localities and EMT and verbal reasons given for those wards not achieving 98% of breaks.

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

Ward / Team	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours	Staffing Fill Rate			
				RN Day	RN Night	HCA Day	HCA Night
Thornaby Road	5.1%	0.0%	8.0%	**89.7%**		**136.5%**	**109.1%**
Newberry Centre	11.8%	1.1%	4.2%	**100.3%**	**136.2%**	**143.7%**	**159.6%**
Evergreen Centre	16.4%	8.0%	3.3%	**84.9%**	**113.8%**	**123.0%**	**145.2%**
Oak Rise	15.7%	19.2%	4.8%	**110.8%**	**103.2%**	**128.2%**	**129.3%**
Cedar Ward (NY)	8.7%	54.2%	1.4%	**100.7%**	**103.4%**	**100.3%**	**113.8%**

- There are 2 fill rate indicators' that are reporting as 'red' and are in relation to registered nurses on days. All other indicators are reporting as either 'green' or 'blue'
- All wards listed are reporting as either 'amber' or 'green' for bank usage
- 4 of the 5 wards have utilised agency workers
- All wards listed have utilised overtime.

3.5 Reporting, investigating and acting on incidents

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

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

3.5.3 It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. Within the reporting period there were 129 incidents raised citing issues with staffing. This is an increase of 20 when compared to the previous 6 month report. The incidents citing staffing problems were from across the following localities which may demonstrate the increased focus on appropriate escalation:

Locality	Number of incidents raised	Trend on previous 6 month
North Yorkshire	32	↓ (36)
Durham & Darlington	13	↓ (14)
Teesside	36	↑ (17)
Forensics	22	↓ (28)
York and Selby	26	↑ (14)

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

- 129 incidents were reported citing staffing levels as the reason of which 75 were in relation to nights and 54 were in relation to day shifts.

Key themes:

- 20% (25) incidents attributed to 1 ward (Thornaby Road) where staff claim they are unable to take a break because there is no facility to do so and therefore report as staffing levels prevent them from taking a break.
- Enhanced observations increasing staffing requirements
- Agency staff failing to attend for work
- Sickness is reported to have caused issues across the trust.
- Staff taken from Crisis team to staff wards leaving Crisis team short of staff

Issues reported:

- Observations not carried out
- Breaks not being taken
- Staff and patient safety compromised
- Wards not running on required staffing levels
- Patient activities being cancelled
- Unable to offer emergency cover to adjoining wards
- Male member of staff working alone on female ward
- Staff not knowing ward or patients because most are bank/agency staff.
- Unsettled patients due to new staff each day.
- Inexperienced nurse not feeling comfortable taking charge
- Quality of service impaired.

The Trust adopted an escalation process to ensure a standard approach was adopted across the organisation and a timely response to ensure patient safety is not compromised. The escalation process has been reviewed as part of the Right Staffing programme to ensure that it is delivering what it was intended to do since its introduction and that the outcome of the 'incident' is reported through Datix. Monthly monitoring of this occurs within the monthly Safe Staffing reports and is highlighted to Heads of Nursing.

A community team (CMHT) version of the process was developed building on from the inpatient model, and this format was approved by the Right Staffing working group. This approach is currently being piloted in York, to feedback to the programme board in January 2019.

Further discussion is taking place at the establishment workstream, including with Heads of Nursing, to further investigate the potential blocks that may contribute to under reporting via the Datix system.

It is anticipated that the recent introduction of the Duty Nurse Coordinator on site at night will support and enhance practice out of hours and lead to improved escalation and resolution of incidents.

3.6 Patient, staff and carer feedback

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

3.6.2 A further analysis of the 41 complaints has been undertaken to identify whether there were any specific issues rose citing staffing levels. The review concluded that there were no complaints raised citing concerns with staffing levels or skill mix. There were however, 4 complaints that did highlight concerns with regards to negative staff attitude.

3.6.3 In addition analysis has been undertaken with regards to patient and carer feedback that has been submitted in relation to the friends and family test. In April 2017 the Trust introduced a new system (Meridian) to capture the friends and family test and a new question was introduced; is there anything we could do to make the service better? 199 comments were received that suggested improved staffing was required within our inpatient wards trust wide to support further activities including supporting leave and enhance communication.

3.6.4 The trust receives compliments and these are captured and published via the weekly e-Bulletin. A total of 442 compliments were received during the reporting period specifically in relation to highlighting a number of individuals and commend the work they have undertaken. These compliments cover all localities. From the total number of compliments there was nothing highlighted that was specific to actual staffing levels.

3.6.5 Future development of this particular aspect will be undertaken as part of the Right Staffing programme that will seek to triangulate specific comments against a range of care quality indicators and metrics ensuring that this is accessible in a single dashboard.

3.7 Care hours per Patient Day (CHPPD)

3.7.1 From April 2018, all MH trusts reported CHPPD for the first time to NHS Improvement. This is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. This was further expanded in December (November's data) to include other healthcare groups such as allied health professionals (AHP's).

3.7.2 This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight. The CHPPD across all inpatient areas was 10.0 (3.6 registered nurses and 6.4 healthcare assistants) with an inpatient average of 13.1 CHPPD. This can be broken down by locality as follows:

Locality	Care Hours per Patient Day			Trend on Previous 6 Months
	Registered Nurse	Healthcare Assistants	Overall	
Durham & Darlington	4.0	6.6	10.6	↑ (7.3)
Forensics	5.3	8.5	13.8	↓ (16.0)
North Yorkshire	3.7	6.1	9.8	↑ (8.1)
Teesside	5.7	10.1	15.8	↑ (9.5)
York & Selby	4.0	8.5	12.4	↓ (17.6)

This can be further examined by looking at the benchmarking groups as follows:

Speciality	Registered Nurses	Healthcare Assistants	Overall	Trend on Previous 6 Months
Acute	2.7	4.0	6.7	↓ (7.1)
Adult LD	6.4	15.3	21.7	↓ (27.0)
Child LD	7.5	13.6	21.1	↓ (28.7)
Eating Disorders	3.2	5.5	8.7	↓ (9.5)
Forensic LD	4.3	9.1	13.4	↓ (20.5)
High Dependency	3.0	5.0	8.0	↓ (8.3)
Locked Rehab	3.2	5.6	8.9	↓ (8.4)
Long Term Complex continuing care	3.3	3.9	7.3	↑ (7.2)
Low Secure	3.2	5.2	8.3	↓ (10.8)
Medium Secure	3.3	6.0	9.3	↓ (10.6)
Older Adults Acute	3.2	6.3	9.5	↓ (10.2)
Other Specialist MH Beds	4.8	11.8	16.5	↔ (16.5)
PICU	7.7	11.8	19.5	↓ (23.9)
TIER 4	6.8	10.6	17.3	↑ (16.6)

3.7.3 Appendix 6 shows the CHPPD covering the reporting period and Appendix 7 shows this graphically.

3.7.4 It is important to highlight that the NQB guidance states that CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. This will be further developed as part of the Right Staffing Programme and will be considered in more detail within the 6 monthly safe staffing report.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

No direct risks to patient safety from the staffing data have been identified in this 6 monthly report. Systems are in place for escalation and operational management of staffing levels on a daily basis. There is however a risk to CQC compliance if we fail to achieve our planned registered nursing levels on a regular basis. This will need to be closely monitored through the monthly and 6 monthly staffing reports to Board; mitigation is being addressed through the initiatives set out in this report that will be delivered through the Right Staffing programme.

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

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

The Trust has complied with these directives to date.

4.4 Equality and Diversity:

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

4.5 Other implications:

There are no other implications identified

5.0 RISKS:

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

6.0 CONCLUSIONS:

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

6.2 The Right Staffing programme and its workstreams will continue to review existing processes and prepare for the new requirements and any new guidance throughout the next two financial years. Data collection and analysis will be further developed and reported upon in future reports.

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

6.4 It is clear that flexible staffing is being used on a regular basis to meet patient need and demand. Initiatives set out in this paper attempt to address having the right staff in the right place at the right time in order that staffing resources can be better planned and utilised.

7.0 RECOMMENDATIONS:

- That the Board of Directors notes the outputs of the reports and raises any issues for further investigation and development.

Emma Haimes, Head of Quality Data and Patient Experience – January 2019
Stephen Scorer, Deputy Director of Nursing
Joe Bergin, Right Staffing Programme Manager
Elizabeth Moody, Director of Nursing and Governance

Budgeted and Actual Staffing Establishments in WTE

Appendix 1

Locality	WARD	Speciality	Establishment at 1/6/2018				Establishment at 30/11/2018				Comparison 1/6/2018 to 30/11/2018 Budget v Actual WTE			
			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	14.30	15.60	14.80	14.20	14.30	14.80	14.30	14.20	0.00	-0.80	-0.50	0.00
	Birch Ward	Adults	8.60	11.90	14.30	11.00	12.30	12.70	14.30	10.60	3.70	0.80	0.00	-0.40
	Primrose Lodge	Adults	8.60	7.80	11.40	11.00	8.60	7.00	11.40	11.00	0.00	-0.80	0.00	0.00
	Willow Ward	Adults	8.60	6.60	12.40	11.60	8.60	8.60	11.40	10.60	0.00	2.00	-1.00	-1.00
	Maple Ward	Adults	8.60	10.30	11.40	11.20	11.40	11.80	11.40	11.20	2.80	1.50	0.00	0.00
	Elm Ward	Adults	8.60	8.70	11.40	10.80	11.40	8.70	11.40	9.80	2.80	0.00	0.00	-1.00
	Farnham Ward	Adults	8.60	8.60	11.40	8.80	11.40	9.70	11.40	12.70	2.80	1.10	0.00	3.90
	Tunstall Ward	Adults	8.60	10.40	11.40	11.10	11.40	12.40	11.40	11.10	2.80	2.00	0.00	0.00
	Holly Unit	CYPS	5.60	4.80	5.60	5.60	5.60	3.70	5.60	5.60	0.00	-1.10	0.00	0.00
	Bek, Ramsey	LD	8.60	9.60	22.90	22.00	8.60	7.60	20.00	21.00	0.00	-2.00	-2.90	-1.00
	Ceddesfeld Ward	MHSOP	8.60	8.80	13.20	15.70	8.60	8.80	13.20	15.70	0.00	0.00	0.00	0.00
	Hamsterley Ward	MHSOP	8.60	8.40	13.20	10.80	8.60	9.40	13.20	17.50	0.00	1.00	0.00	6.70
	Oak Ward	MHSOP	8.60	7.80	12.40	13.50	8.60	8.90	11.40	12.60	0.00	1.10	-1.00	-0.90
	Roseberry Wards	MHSOP	8.60	7.60	12.40	11.90	8.60	8.60	11.40	11.90	0.00	1.00	-1.00	0.00
Forensics	Clover/Ivy	Forensics LD	8.10	8.90	20.20	16.10	8.10	9.70	20.20	15.50	0.00	0.80	0.00	-0.60
	Thistle Ward	Forensics LD	10.70	8.00	14.80	13.90	8.50	8.00	15.30	13.40	-2.20	0.00	0.50	-0.50
	Northdale Centre	Forensics LD	8.10	10.00	26.80	21.50	8.10	8.60	26.80	24.40	0.00	-1.40	0.00	2.90
	Oakwood	Forensics LD	9.10	6.50	6.60	8.00	8.10	7.10	6.60	8.00	-1.00	0.60	0.00	0.00
	Eagle ASD	Forensics LD	6.00	3.80	6.00	6.00	6.00	0.00	6.00	0.00	0.00	-3.80	0.00	-6.00
	Harrier/Hawk	Forensics LD	8.10	8.80	20.20	18.00	8.10	9.70	20.20	19.10	0.00	0.90	0.00	1.10
	Langley Ward	Forensics LD	8.10	7.00	8.30	7.00	8.40	6.90	9.30	7.00	0.30	-0.10	1.00	0.00
	Kestrel/Kite	Forensics LD	8.10	8.70	22.00	22.00	8.10	9.70	22.10	21.20	0.00	1.00	0.10	-0.80

	Brambling Ward	Forensics MH	8.10	7.90	13.20	11.10	8.10	7.80	13.70	10.90	0.00	-0.10	0.50	-0.20
	Jay Ward	Forensics MH	8.10	7.90	13.20	12.40	8.10	8.50	13.20	13.40	0.00	0.60	0.00	1.00
	Sandpiper Ward	Forensics MH	10.70	13.10	17.10	18.40	10.70	13.80	17.60	14.90	0.00	0.70	0.50	-3.50
	Merlin	Forensics MH	10.70	9.80	15.30	15.10	10.70	10.40	15.30	15.20	0.00	0.60	0.00	0.10
	Swift Ward	Forensics MH	8.10	8.60	15.30	15.50	8.10	6.60	15.80	15.40	0.00	-2.00	0.50	-0.10
	Lark	Forensics MH	8.10	8.00	13.20	12.90	8.10	8.00	13.70	12.90	0.00	0.00	0.50	0.00
	Kirkdale Ward	Forensics MH	8.10	8.90	15.30	13.80	8.10	6.90	15.30	12.80	0.00	-2.00	0.00	-1.00
	Mallard Ward	Forensics MH	8.10	6.80	15.30	14.70	8.10	9.00	15.30	14.50	0.00	2.20	0.00	-0.20
	Mandarin	Forensics MH	8.10	8.80	13.20	13.00	8.10	10.50	13.20	11.30	0.00	1.70	0.00	-1.70
	Nightingale Ward	Forensics MH	8.10	8.50	13.20	14.40	8.10	7.50	13.20	14.10	0.00	-1.00	0.00	-0.30
	Linnet Ward	Forensics MH	8.10	9.20	13.20	13.80	8.10	9.30	13.20	12.80	0.00	0.10	0.00	-1.00
	Newtondale Ward	Forensics MH	10.70	10.00	17.90	18.00	10.80	10.00	18.90	15.40	0.10	0.00	1.00	-2.60
North Yorkshire	The Orchards	Adults	11.40	9.90	5.40	6.60	8.80	9.50	8.10	5.70	-2.60	-0.40	2.70	-0.90
	Danby Ward	Adults	8.10	8.00	10.70	11.00	9.50	10.00	10.70	8.00	1.40	2.00	0.00	-3.00
	Esk Ward	Adults	12.10	6.40	10.70	9.90	10.60	5.40	10.70	9.80	-1.50	-1.00	0.00	-0.10
	Ward 15 Friarage	Adults	10.60	7.50	10.70	9.70	9.60	6.80	10.70	11.00	-1.00	-0.70	0.00	1.30
	Cedar Ward (NY)	Adults	10.10	7.40	15.20	11.00	10.10	4.10	15.20	6.00	0.00	-3.30	0.00	-5.00
	Ward 14	MHSOP	9.10	7.70	10.00	8.50	8.10	5.90	10.00	8.00	-1.00	-1.80	0.00	-0.50
	Rowan Ward	MHSOP	9.69	8.30	12.70	10.10	9.10	7.60	10.70	11.50	-0.59	-0.70	-2.00	1.40
	Springwood	MHSOP	9.10	8.60	12.50	12.60	8.10	7.00	12.50	12.40	-1.00	-1.60	0.00	-0.20
	Rowan Lea	MHSOP	9.10	9.00	17.90	14.70	9.60	9.60	17.90	15.90	0.50	0.60	0.00	1.20
Teesside	Bedale Ward	Adults	8.20	11.00	13.70	14.70	13.70	12.00	13.70	13.70	5.50	1.00	0.00	-1.00
	Bilsdale Ward	Adults	9.20	9.60	11.00	11.70	8.20	7.80	11.00	11.70	-1.00	-1.80	0.00	0.00
	Bransdale Ward	Adults	9.20	9.00	10.00	13.10	8.20	9.00	11.00	12.70	-1.00	0.00	1.00	-0.40
	Overdale Ward	Adults	9.20	8.60	11.00	11.20	8.20	7.60	11.00	10.50	-1.00	-1.00	0.00	-0.70
	Stockdale Ward	Adults	9.20	9.20	11.00	13.50	8.20	7.40	11.00	10.50	-1.00	-1.80	0.00	-3.00
	Lustrum Vale	Adults	10.80	13.70	11.00	10.50	11.10	11.30	11.00	10.50	0.30	-2.40	0.00	0.00
	Baysdale	CYPS	7.70	5.30	12.70	15.10	6.70	6.00	12.70	13.30	-1.00	0.70	0.00	-1.80

	Newberry Centre	CYPS	15.70	20.10	15.20	20.80	15.00	18.70	15.20	19.20	-0.70	-1.40	0.00	-1.60
	The Evergreen Centre	CYPS	15.30	19.70	18.70	21.20	16.20	19.20	18.70	15.40	0.90	-0.50	0.00	-5.80
	Westwood Centre	CYPS	17.10	17.40	16.50	27.10	17.10	17.00	16.50	24.80	0.00	-0.40	0.00	-2.30
	Thornaby Road	LD	3.80	4.00	11.90	9.00	11.40	12.40	11.40	11.10	7.60	8.40	-0.50	2.10
	Aysgarth	LD	6.00	5.00	11.50	9.30	6.00	6.40	11.50	8.60	0.00	1.40	0.00	-0.70
	Bankfields Court Flats	LD	14.30	14.20	58.30	36.30	14.30	15.20	58.30	39.30	0.00	1.00	0.00	3.00
	Bankfields Unit 2	LD	7.60	7.80	9.50	9.60	7.60	7.50	9.50	8.90	0.00	-0.30	0.00	-0.70
	The Lodge	LD	4.70	4.60	4.10	7.00	11.40	4.60	11.40	5.00	6.70	0.00	7.30	-2.00
	Westerdale South	MHSOP	8.70	14.90	11.00	18.60	10.80	14.40	12.20	19.60	2.10	-0.50	1.20	1.00
	Westerdale North	MHSOP	9.70	15.80	11.00	13.90	10.60	14.10	11.10	12.90	0.90	-1.70	0.10	-1.00
York & Selby	Ebor Ward	Adults	9.40	9.40	11.70	10.10	8.70	8.60	11.00	10.00	-0.70	-0.80	-0.70	-0.10
	Minster Ward	Adults	10.40	8.90	11.70	9.80	8.20	7.90	9.00	9.80	-2.20	-1.00	-2.70	0.00
	Cherry Tree House	MHSOP	12.40	10.70	14.50	11.20	8.90	11.40	13.70	11.20	-3.50	0.70	-0.80	0.00
	Oak Rise	ALD	9.40	7.60	21.20	12.70	8.20	7.60	18.80	12.80	-1.20	0.00	-2.40	0.10
	Acomb Garth	MHSOP	11.00	8.20	13.50	14.20	11.40	9.10	13.70	14.30	0.40	0.90	0.20	0.10
	Meadowfields	MHSOP	9.30	7.80	14.50	10.60	8.20	7.80	16.70	10.60	-1.10	0.00	2.20	0.00

Average fill rate covering the period of 1st June 2018 to 30th November 2018

Appendix 2

Ward Name	Locality	Speciality	Bed Numbers (NOV)	6 Months - 1st June 2018 to 30th November 2018					
				Registered Average %		Unregistered Average %		Bank Usage vs Actual Hours	
				Day	Night	Day	Night	Hours	% against Actual Hours
Ayckbourn Danby Ward	North Yorkshire	Adults	11	104.2%	96.3%	117.0%	132.3%	2375.75	13.1%
Ayckbourn Esk Ward	North Yorkshire	Adults	11	56.7%	97.6%	131.2%	106.9%	2604.00	16.9%
Bedale Ward	Teesside	Adults	10	90.1%	84.1%	137.5%	188.1%	4156.75	15.4%
Bilsdale	Teesside	Adults	14	97.8%	99.6%	126.8%	110.5%	1173.00	7.1%
Birch Ward	Durham and Darlington	Adults	15	82.2%	102.2%	111.3%	132.0%	6226.59	30.2%
Bransdale	Teesside	Adults	14	104.3%	102.7%	129.3%	139.8%	3040.75	16.9%
Cedar	Durham and Darlington	Adults	10	106.2%	101.3%	74.8%	75.0%	5284.00	20.3%
Cedar (NY)	North Yorkshire	Adults	14	100.7%	103.4%	100.3%	113.8%	1712.17	8.7%
Ebor Ward	York and Selby	Adults	12	82.8%	100.4%	77.5%	109.1%	1625.75	9.7%
Elm Ward	Durham and Darlington	Adults	20	96.6%	97.9%	95.7%	112.8%	4936.86	28.0%
Farnham Ward	Durham and Darlington	Adults	20	111.7%	102.2%	135.2%	130.9%	2430.16	12.6%
Kirkdale	Teesside	Adults	16	92.3%	103.2%	99.6%	100.3%	3479.23	19.0%
Lustrum Vale	Teesside	Adults	20	92.2%	102.3%	140.8%	123.5%	4170.17	22.2%
Maple	Durham and Darlington	Adults	20	101.7%	101.1%	125.1%	119.0%	3954.50	22.8%
Minster Ward	York and Selby	Adults	12	79.8%	100.4%	85.7%	108.1%	1058.00	6.2%
Overdale	Teesside	Adults	18	103.2%	100.0%	112.9%	110.7%	242.50	1.5%
Primrose Lodge	Durham and Darlington	Adults	15	86.9%	100.0%	112.6%	100.0%	1333.92	8.3%
Stockdale	Teesside	Adults	18	102.2%	102.8%	130.7%	139.7%	2466.40	13.6%
The Orchards (NY)	North Yorkshire	Adults	10	84.0%	52.1%	103.0%	143.2%	583.50	4.6%
Tunstall Ward	Durham and Darlington	Adults	20	114.5%	106.8%	108.4%	113.1%	919.00	5.1%
Ward 15	North Yorkshire	Adults	12	79.5%	107.6%	160.6%	140.5%	4565.25	24.7%
Willow Ward	Durham and Darlington	Adults	15	90.4%	102.1%	147.3%	101.9%	3735.96	21.4%
Baysdale	Teesside	CYPS	6	107.9%	101.6%	112.7%	106.7%	1712.65	10.8%
Holly	Durham and Darlington	CYPS	4	175.7%	118.1%	200.8%	198.2%	1001.26	12.7%
Newberry Centre	Teesside	CYPS	14	100.3%	136.2%	143.7%	159.6%	3266.49	11.8%
The Evergreen Centre	Teesside	CYPS	16	84.9%	113.8%	123.0%	145.2%	5374.81	16.4%
Westwood Centre	Teesside	CYPS	12	99.2%	107.8%	117.1%	115.8%	2458.73	7.0%
Clover / Ivy	Forensics	Forensics LD	10	95.0%	106.2%	97.0%	150.8%	7425.87	31.4%
FLD Eagle ASD	Forensics	Forensics LD	1	100.3%	100.6%	142.0%	91.8%	1267.35	17.2%
Harrier / Hawk	Forensics	Forensics LD	10	92.3%	103.6%	107.5%	114.3%	4777.89	20.7%

Kestrel / Kite.	Forensics	Forensics LD	16	99.8%	108.1%	117.2%	151.5%	8243.44	30.6%
Langley	Forensics	Forensics LD	5	83.3%	100.0%	101.3%	100.6%	2278.25	18.4%
Northdale Centre	Forensics	Forensics LD	12	97.8%	131.6%	111.2%	128.5%	10897.09	34.5%
Oakwood	Forensics	Forensics LD	8	87.6%	101.4%	233.1%	135.0%	3198.35	22.9%
Thistle	Forensics	Forensics LD	5	78.4%	100.6%	97.7%	99.1%	3033.75	17.7%
Brambling	Forensics	Forensics MH	13	103.2%	106.7%	105.6%	117.4%	4050.08	22.3%
Jay Ward	Forensics	Forensics MH	5	91.6%	104.6%	95.2%	100.7%	1442.00	8.8%
Lark	Forensics	Forensics MH	17	95.3%	103.8%	102.6%	93.6%	4783.75	28.9%
Linnet Ward	Forensics	Forensics MH	17	84.9%	103.3%	100.2%	97.1%	1629.00	10.0%
Mallard	Forensics	Forensics MH	14	106.9%	114.1%	118.2%	147.5%	6033.73	27.0%
Mandarin	Forensics	Forensics MH	16	93.8%	118.7%	153.7%	181.6%	8179.73	34.6%
Merlin	Forensics	Forensics MH	10	113.9%	107.8%	142.7%	198.2%	9104.50	31.5%
Newtondale	Forensics	Forensics MH	20	108.2%	89.8%	101.1%	124.0%	4286.00	18.2%
Nightingale	Forensics	Forensics MH	16	88.2%	101.4%	98.4%	102.3%	2674.83	16.2%
Sandpiper Ward	Forensics	Forensics MH	8	99.4%	91.8%	100.4%	131.0%	4435.00	18.8%
Swift Ward	Forensics	Forensics MH	10	92.5%	101.1%	94.7%	100.2%	2275.25	12.7%
Aysgarth	Teesside	LD	6	108.3%	102.3%	100.6%	104.4%	2843.85	21.1%
Bankfields Court	Teesside	LD	18	123.1%	105.3%	114.3%	102.8%	2352.15	7.5%
Bankfields Court Flats	Teesside	LD	0	123.3%	110.8%	126.4%	100.1%	265.20	6.1%
Bankfields Court Unit 2	Teesside	LD	5	100.4%	101.9%	107.9%	121.4%	3346.03	23.2%
Bankfields Court Unit 3	Teesside	LD	0	97.8%	100.0%	100.1%	97.3%	224.00	5.5%
Bankfields Court Unit 4	Teesside	LD	0	108.3%	105.6%	94.5%	97.8%	248.67	6.7%
Bek-Ramsey Ward	Durham and Darlington	LD	6	118.6%	100.6%	111.2%	102.2%	2230.07	9.1%
Oak Rise	York and Selby	LD	8	110.8%	103.2%	128.2%	129.3%	4206.60	15.7%
The Lodge	Teesside	LD	1	89.9%	92.3%	44.5%	58.9%	206.59	2.8%
Acomb Garth	York and Selby	MHSOP	14	83.7%	87.1%	183.6%	256.6%	1382.00	4.3%
Ceddesfeld	Durham and Darlington	MHSOP	15	101.1%	99.5%	121.8%	119.4%	1413.90	6.9%
Cherry Tree House	York and Selby	MHSOP	18	114.2%	107.3%	120.1%	154.9%	3247.00	15.1%
Hamsterley	Durham and Darlington	MHSOP	15	93.7%	101.2%	139.2%	155.8%	5454.20	24.7%
Meadowfields	York and Selby	MHSOP	14	87.9%	97.1%	140.8%	192.4%	2822.50	12.1%
Oak Ward	Durham and Darlington	MHSOP	12	97.3%	102.1%	100.2%	101.3%	1385.18	8.5%
Roseberry Wards	Durham and Darlington	MHSOP	15	101.6%	105.0%	101.0%	103.8%	1650.50	10.2%
Rowan Lea	North Yorkshire	MHSOP	20	89.5%	103.9%	148.0%	135.0%	5603.89	21.5%
Rowan Ward	North Yorkshire	MHSOP	16	92.5%	152.9%	162.8%	158.3%	2170.25	9.6%
Springwood	North Yorkshire	MHSOP	14	75.7%	99.5%	132.1%	215.6%	2486.09	10.7%
Ward 14	North Yorkshire	MHSOP	10	86.2%	101.8%	101.8%	102.5%	1147.50	7.7%
Westerdale North	Teesside	MHSOP	20	107.8%	115.9%	128.2%	173.6%	2091.75	9.1%

Westerdale South	Teesside	MHSOP	14	**104.9%**	**100.9%**	**221.5%**	**266.3%**	11903.38	31.6%
Harland Rehab Ward	Durham and Darlington	Rehab	1	**99.2%**	**100.6%**	**76.1%**	**90.1%**	2069.42	17.5%
Kiltonview	Teesside	Day Unit	0	**83.5%**		**86.5%**		1680.17	14.4%
The Orchard	Teesside	Day Unit	0	**80.7%**		**77.6%**		644.00	11.5%
Thornaby Road	Teesside	Day Unit	5	**89.7%**		**136.5%**	**109.1%**	576.49	5.1%

KEY:

	Blue	Green	Red
Fill Rate	120% and over	90 - 119.9%	89.99% or less

	Green	Amber	Red
Bank Usage	0 - 10%	11 - 24.9%	25% and over

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

Ward Name	Locality	Speciality	Bed Numbers (May)	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
Danby Ward	North Yorkshire	Adults	11	631.25	3.5%	2985.5	16.4%	2375.8	13.1%	67.5	0.4%	402.5	2.2%	1106.3	6.1%
Esk Ward	North Yorkshire	Adults	11	217.75	1.4%	1084.5	7.0%	2604.0	16.9%	1432.5	9.3%	1096.0	7.1%	1837.5	11.9%
Bedale Ward	Teesside	Adults	10	1207.3	4.5%	2943.5	10.9%	4156.8	15.4%	0.0	0.0%	1662.5	6.2%	982.5	3.6%
Bilsdale	Teesside	Adults	14	387.15	2.3%	632.5	3.8%	1173.0	7.1%	982.5	5.9%	1479.0	8.9%	270.0	1.6%
Birch Ward	Durham & Darlington	Adults	15	260.58	1.3%	622.4	3.0%	6226.6	30.2%	0.0	0.0%	2610.5	12.7%	2388.8	11.6%
Bransdale	Teesside	Adults	14	274.2	1.5%	1272.5	7.1%	3040.8	16.9%	975.0	5.4%	2274.5	12.6%	637.5	3.5%
Cedar	Durham & Darlington	Adults	10	697.94	2.7%	371.0	1.4%	5284.0	20.3%	0.0	0.0%	2016.5	7.8%	727.5	2.8%
Cedar (NY)	North Yorkshire	Adults	14	272.95	1.4%	10671.7	54.2%	1712.2	8.7%	825.0	4.2%	318.0	1.6%	3735.0	19.0%
Ebor Ward	York and Selby	Adults	12	279.07	1.7%	1878.5	11.2%	1625.8	9.7%	0.0	0.0%	538.0	3.2%	1005.0	6.0%
Elm Ward	Durham & Darlington	Adults	20	517.28	2.9%	924.2	5.2%	4936.9	28.0%	975.0	5.5%	1541.3	8.8%	1597.5	9.1%
Farnham Ward	Durham & Darlington	Adults	20	422.01	2.2%	768.0	4.0%	2430.2	12.6%	0.0	0.0%	1717.5	8.9%	825.0	4.3%
Kirkdale	Teesside	Adults	16	602.15	3.3%	180.3	1.0%	3479.2	19.0%	465.0	2.5%	1506.8	8.2%	1436.3	7.8%
Lustrum Vale	Teesside	Adults	20	346.2	1.8%	434.0	2.3%	4170.2	22.2%	975.0	5.2%	1386.6	7.4%	573.8	3.0%
Maple	Durham & Darlington	Adults	20	329.27	1.9%	480.0	2.8%	3954.5	22.8%	172.5	1.0%	3313.9	19.1%	652.5	3.8%
Minster Ward	York and Selby	Adults	12	1234.25	7.2%	1297.4	7.6%	1058.0	6.2%	0.0	0.0%	648.0	3.8%	926.3	5.4%
Overdale	Teesside	Adults	18	540.59	3.2%	391.0	2.3%	242.5	1.5%	0.0	0.0%	147.0	0.9%	603.8	3.6%
Primrose Lodge	Durham & Darlington	Adults	15	270.33	1.7%	48.0	0.3%	1333.9	8.3%	0.0	0.0%	1461.5	9.1%	476.3	3.0%
Stockdale	Teesside	Adults	18	273.4	1.5%	1173.0	6.5%	2466.4	13.6%	885.5	4.9%	757.5	4.2%	528.8	2.9%
The Orchards (NY)	North Yorkshire	Adults	10	523.88	4.2%	0.0	0.0%	583.5	4.6%	0.0	0.0%	1482.0	11.8%	656.3	5.2%
Tunstall Ward	Durham & Darlington	Adults	20	796.03	4.4%	264.0	1.5%	919.0	5.1%	37.5	0.2%	780.0	4.3%	750.0	4.2%
Ward 15	North Yorkshire	Adults	12	368.2	2.0%	3301.1	17.9%	4565.3	24.7%	0.0	0.0%	951.6	5.1%	1402.5	7.6%
Willow Ward	Durham & Darlington	Adults	15	534.47	3.1%	252.0	1.4%	3736.0	21.4%	292.5	1.7%	1282.5	7.4%	622.5	3.6%
Baysdale	Teesside	CYPS	6	1816.06	11.5%	0.0	0.0%	1712.7	10.8%	4.5	0.0%	637.6	4.0%	603.8	3.8%
Holly	Durham & Darlington	CYPS	4	236.92	3.0%	0.0	0.0%	1001.3	12.7%	780.0	9.9%	202.0	2.6%	311.3	4.0%
Newberry Centre	Teesside	CYPS	14	1164.95	4.2%	317.3	1.1%	3266.5	11.8%	2180.5	7.9%	2438.2	8.8%	6723.8	24.3%
Evergreen Centre	Teesside	CYPS	16	1091.59	3.3%	2632.2	8.0%	5374.8	16.4%	1987.5	6.1%	930.0	2.8%	1106.3	3.4%
Westwood Centre	Teesside	CYPS	12	2592.56	7.4%	762.0	2.2%	2458.7	7.0%	1423.5	4.1%	1049.0	3.0%	952.5	2.7%
Clover / Ivy	Forensics	Forensics LD	10	514.22	2.2%	844.8	3.6%	7425.9	31.4%	266.3	1.1%	2662.1	11.3%	1920.0	8.1%
FLD Eagle ASD	Forensics	Forensics LD	1	253.25	3.4%	247.7	3.4%	1267.4	17.2%	0.0	0.0%	798.8	10.8%	487.5	6.6%

Harrier / Hawk	Forensics	Forensics LD	10	1335.92	5.8%	27.5	0.1%	4777.9	20.7%	0.0	0.0%	1807.0	7.8%	1702.5	7.4%
Kestrel / Kite.	Forensics	Forensics LD	16	803.42	3.0%	158.0	0.6%	8243.4	30.6%	2373.6	8.8%	1124.3	4.2%	1245.0	4.6%
Langley	Forensics	Forensics LD	5	244	2.0%	0.0	0.0%	2278.3	18.4%	0.0	0.0%	694.0	5.6%	1278.8	10.3%
Northdale Centre	Forensics	Forensics LD	12	1041.56	3.3%	765.2	2.4%	10897.1	34.5%	0.0	0.0%	3156.0	10.0%	2958.8	9.4%
Oakwood	Forensics	Forensics LD	8	895.09	6.4%	11.3	0.1%	3198.4	22.9%	0.0	0.0%	1458.8	10.4%	648.8	4.6%
Thistle	Forensics	Forensics LD	5	527.52	3.1%	22.5	0.1%	3033.8	17.7%	45.0	0.3%	491.5	2.9%	1421.3	8.3%
Brambling	Forensics	Forensics MH	13	173.25	1.0%	0.0	0.0%	4050.1	22.3%	0.0	0.0%	540.0	3.0%	645.0	3.6%
Jay Ward	Forensics	Forensics MH	5	522.5	3.2%	0.0	0.0%	1442.0	8.8%	108.8	0.7%	1020.5	6.2%	367.5	2.2%
Lark	Forensics	Forensics MH	17	556	3.4%	0.0	0.0%	4783.8	28.9%	1256.0	7.6%	2172.5	13.1%	1098.8	6.6%
Linnet Ward	Forensics	Forensics MH	17	429.75	2.6%	0.0	0.0%	1629.0	10.0%	1061.3	6.5%	422.5	2.6%	318.8	2.0%
Mallard	Forensics	Forensics MH	14	618.5	2.8%	0.0	0.0%	6033.7	27.0%	11.3	0.1%	1471.3	6.6%	945.0	4.2%
Mandarin	Forensics	Forensics MH	16	344.53	1.5%	0.0	0.0%	8179.7	34.6%	0.0	0.0%	2757.7	11.7%	1061.3	4.5%
Merlin	Forensics	Forensics MH	10	569.9	2.0%	0.0	0.0%	9104.5	31.5%	11.3	0.0%	195.0	0.7%	1316.3	4.6%
Newtondale	Forensics	Forensics MH	20	1201.07	5.1%	0.0	0.0%	4286.0	18.2%	982.5	4.2%	798.3	3.4%	1027.5	4.4%
Nightingale	Forensics	Forensics MH	16	509.98	3.1%	0.0	0.0%	2674.8	16.2%	0.0	0.0%	2239.5	13.5%	1038.8	6.3%
Sandpiper Ward	Forensics	Forensics MH	8	605.25	2.6%	0.0	0.0%	4435.0	18.8%	893.3	3.8%	2183.9	9.2%	363.8	1.5%
Swift Ward	Forensics	Forensics MH	10	417.5	2.3%	0.0	0.0%	2275.3	12.7%	1571.3	8.8%	1165.3	6.5%	637.5	3.6%
Aysgarth	Teesside	LD	6	602.92	4.5%	0.0	0.0%	2843.9	21.1%	0.0	0.0%	1244.3	9.2%	705.0	5.2%
Bankfields Court	Teesside	LD	18	1237.9	4.0%	0.0	0.0%	2352.2	7.5%	180.0	0.6%	82.8	0.3%	6461.3	20.6%
Bankfields Flats	Teesside	LD	0	71.5	1.6%	0.0	0.0%	265.2	6.1%	0.0	0.0%	106.5	2.4%	0.0	0.0%
Bankfields Unit 2	Teesside	LD	5	896.35	6.2%	0.0	0.0%	3346.0	23.2%	0.0	0.0%	912.0	6.3%	933.8	6.5%
Bankfields Unit 3	Teesside	LD	0	111.82	2.8%	0.0	0.0%	224.0	5.5%	0.0	0.0%	36.0	0.9%	75.0	1.8%
Bankfields Unit 4	Teesside	LD	0	25.51	0.7%	0.0	0.0%	248.7	6.7%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Bek-Ramsey Ward	Durham & Darlington	LD	6	1500.91	6.1%	1522.2	6.2%	2230.1	9.1%	840.0	3.4%	3736.0	15.3%	1012.5	4.1%
Oak Rise	York and Selby	LD	8	1292.71	4.8%	5129.3	19.2%	4206.6	15.7%	0.0	0.0%	1439.6	5.4%	1635.0	6.1%
The Lodge	Teesside	LD	1	291	4.0%	368.0	5.0%	206.6	2.8%	1708.5	23.2%	704.5	9.6%	1983.8	27.0%
Acomb Garth	York and Selby	MHSOP	14	253.5	0.8%	13660.9	42.6%	1382.0	4.3%	7.5	0.0%	1499.7	4.7%	1680.0	5.2%
Ceddesfeld	Durham & Darlington	MHSOP	15	346.5	1.7%	599.2	2.9%	1413.9	6.9%	0.0	0.0%	858.0	4.2%	382.5	1.9%
Cherry Tree House	York and Selby	MHSOP	18	1056.5	4.9%	3364.7	15.7%	3247.0	15.1%	710.0	3.3%	1035.5	4.8%	1151.3	5.4%
Hamsterley	Durham & Darlington	MHSOP	15	578.09	2.6%	2109.7	9.5%	5454.2	24.7%	111.0	0.5%	3518.0	15.9%	693.8	3.1%
Meadowfields	York and Selby	MHSOP	14	436	1.9%	8334.8	35.6%	2822.5	12.1%	0.0	0.0%	3230.0	13.8%	1533.8	6.6%
Oak Ward	Durham & Darlington	MHSOP	12	175.5	1.1%	233.5	1.4%	1385.2	8.5%	75.0	0.5%	580.0	3.6%	532.5	3.3%
Roseberry Wards	Durham & Darlington	MHSOP	15	42	0.3%	24.0	0.1%	1650.5	10.2%	0.0	0.0%	816.0	5.0%	918.8	5.7%
Rowan Lea	North Yorkshire	MHSOP	20	1175.99	4.5%	4287.6	16.4%	5603.9	21.5%	162.5	0.6%	864.7	3.3%	817.5	3.1%
Rowan Ward	North Yorkshire	MHSOP	16	298.25	1.3%	7480.0	33.1%	2170.3	9.6%	1245.0	5.5%	463.5	2.0%	1065.0	4.7%
Springwood	North Yorkshire	MHSOP	14	1042.68	4.5%	5234.2	22.6%	2486.1	10.7%	0.0	0.0%	2263.8	9.8%	510.0	2.2%
Ward 14	North Yorkshire	MHSOP	10	1260.4	8.4%	574.3	3.8%	1147.5	7.7%	0.0	0.0%	978.4	6.5%	881.3	5.9%

Westerdale North	Teesside	MHSOP	20	401.75	1.7%	3007.3	13.0%	2091.8	9.1%	0.0	0.0%	1799.0	7.8%	1942.5	8.4%
Westerdale South	Teesside	MHSOP	14	279.55	0.7%	3896.8	10.3%	11903.4	31.6%	1076.0	2.9%	2178.7	5.8%	1518.8	4.0%
Harland Ward	Durham & Darlington	Rehab	1	703.25	5.9%	252.0	2.1%	2069.4	17.5%	0.0	0.0%	355.4	3.0%	1443.8	12.2%
Kiltonview	Teesside	Day Unit	0	118	1.0%	24.0	0.2%	1680.2	14.4%	562.5	4.8%	855.0	7.3%	161.3	1.4%
The Orchard	Teesside	Day Unit	0	45.17	0.8%	0.0	0.0%	644.0	11.5%	157.5	2.8%	465.0	8.3%	75.0	1.3%
Thornaby Road	Teesside	Day Unit	0	914.5	8.0%	0.0	0.0%	576.5	5.1%	410.7	3.6%	269.0	2.4%	862.5	7.6%

	Green	Amber	Red
Overtime	0 - 2.9%	3- 3.9%	4% and over
Agency	0 - 2.9%	3- 3.9%	4% and over
Bank Usage	0 - 10%	11 - 24.9%	25% and over
Maternity	0 - 1.9%	2 - 4.9%	5% and over
Sickness	0 - 1.9%	2 - 4.9%	5% and over
Vacancies	0 - 4.9%	5 - 9.9%	10% and over

Quality Indicators - 6 Month Total

Appendix 4

Ward Name	Locality	Speciality	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Quality Indicators					Incidents of Restraints				Registered Average %		Unregistered Average %	
					Number of SIs	Number of L4 Incidents	Number of L3 (Self-Harm) Incidents	Number of Complaints	Number of PALS	Number of Incidents	Number of PRO Restraints Used	Number of Other Restraints Used	Total Number of Restraints Used	Day	Night	Day	Night
Danby Ward	North Yorkshire	Adults	13.1%	16.4%			2		2	18	1	33	34	104.2%	96.3%	117.0%	132.3%
Esk Ward	North Yorkshire	Adults	16.9%	7.0%					9	9	2	12	14	56.7%	97.6%	131.2%	106.9%
Bedale Ward	Teesside	Adults	15.4%	10.9%				1	4	100	13	159	172	90.1%	84.1%	137.5%	188.1%
Bilsdale	Teesside	Adults	7.1%	3.8%			3	1	6	8	2	9	11	97.8%	99.6%	126.8%	110.5%
Birch Ward	Durham & Darlington	Adults	30.2%	3.0%					3	106		168	168	82.2%	102.2%	111.3%	132.0%
Bransdale	Teesside	Adults	16.9%	7.1%			2	1	2	40	3	54	57	104.3%	102.7%	129.3%	139.8%
Cedar	Durham & Darlington	Adults	20.3%	1.4%			4	1	7	165	7	267	274	106.2%	101.3%	74.8%	75.0%
Cedar (NY)	North Yorkshire	Adults	8.7%	54.2%			3	2	2	64		130	130	100.7%	103.4%	100.3%	113.8%
Ebor Ward	York and Selby	Adults	9.7%	11.2%			3	1	5	57	1	64	65	82.8%	100.4%	77.5%	109.1%
Elm Ward	Durham & Darlington	Adults	28.0%	5.2%			2	3	16	45	5	56	61	96.6%	97.9%	95.7%	112.8%
Farnham Ward	Durham & Darlington	Adults	12.6%	4.0%			1		6	18	1	22	23	111.7%	102.2%	135.2%	130.9%
Kirkdale	Teesside	Adults	19.0%	1.0%					2	1		1	1	92.3%	103.2%	99.6%	100.3%
Lustrum Vale	Teesside	Adults	22.2%	2.3%			3		1	13	1	16	17	92.2%	102.3%	140.8%	123.5%
Maple	Durham & Darlington	Adults	22.8%	2.8%					6	13	1	14	15	101.7%	101.1%	125.1%	119.0%
Minster Ward	York and Selby	Adults	6.2%	7.6%				1	3	16		21	21	79.8%	100.4%	85.7%	108.1%
Overdale	Teesside	Adults	1.5%	2.3%			4	2	9	26	1	30	31	103.2%	100.0%	112.9%	110.7%
Primrose Lodge	Durham & Darlington	Adults	8.3%	0.3%					1	1		1	1	86.9%	100.0%	112.6%	100.0%
Stockdale	Teesside	Adults	13.6%	6.5%			1	4	8	28	2	31	33	102.2%	102.8%	130.7%	139.7%
The Orchards (NY)	North Yorkshire	Adults	4.6%	0.0%					6					84.0%	52.1%	103.0%	143.2%
Tunstall Ward	Durham & Darlington	Adults	5.1%	1.5%	1		2	4	6	7		7	7	114.5%	106.8%	108.4%	113.1%
Ward 15	North Yorkshire	Adults	24.7%	17.9%			3	3	4	9		11	11	79.5%	107.6%	160.6%	140.5%
Willow Ward	Durham & Darlington	Adults	21.4%	1.4%					1	7		10	10	90.4%	102.1%	147.3%	101.9%
Baysdale	Teesside	CYPS	10.8%	0.0%						1		1	1	107.9%	101.6%	112.7%	106.7%
Holly	Durham & Darlington	CYPS	12.7%	0.0%					1	3		3	3	175.7%	118.1%	200.8%	198.2%
Newberry Centre	Teesside	CYPS	11.8%	1.1%	1	1	3	1	3	331	2	449	451	100.3%	136.2%	143.7%	159.6%
The Evergreen Centre	Teesside	CYPS	16.4%	8.0%			4	3	4	1247	41	1750	1791	84.9%	113.8%	123.0%	145.2%

Westwood Centre	Teesside	CYPS	7.0%	2.2%			1		4	1042	8	1817	1825	99.2%	107.8%	117.1%	115.8%
Clover / Ivy	Forensics	Forensics LD	31.4%	3.6%	1	1			5	64	7	124	131	95.0%	106.2%	97.0%	150.8%
FLD Eagle ASD	Forensics	Forensics LD	17.2%	3.4%										100.3%	100.6%	142.0%	91.8%
Harrier / Hawk	Forensics	Forensics LD	20.7%	0.1%				1	18	8	1	13	14	92.3%	103.6%	107.5%	114.3%
Kestrel / Kite.	Forensics	Forensics LD	30.6%	0.6%			1	4	13	6		16	16	99.8%	108.1%	117.2%	151.5%
Langley	Forensics	Forensics LD	18.4%	0.0%										83.3%	100.0%	101.3%	100.6%
Northdale Centre	Forensics	Forensics LD	34.5%	2.4%				3	14	35	3	74	77	97.8%	131.6%	111.2%	128.5%
Oakwood	Forensics	Forensics LD	22.9%	0.1%										87.6%	101.4%	233.1%	135.0%
Thistle	Forensics	Forensics LD	17.7%	0.1%					1	29	1	38	39	78.4%	100.6%	97.7%	99.1%
Brambling	Forensics	Forensics MH	22.3%	0.0%			3		2	24		49	49	103.2%	106.7%	105.6%	117.4%
Jay Ward	Forensics	Forensics MH	8.8%	0.0%				1		7		7	7	91.6%	104.6%	95.2%	100.7%
Lark	Forensics	Forensics MH	28.9%	0.0%					1	1		1	1	95.3%	103.8%	102.6%	93.6%
Linnet Ward	Forensics	Forensics MH	10.0%	0.0%						2		2	2	84.9%	103.3%	100.2%	97.1%
Mallard	Forensics	Forensics MH	27.0%	0.0%					31	4		4	4	106.9%	114.1%	118.2%	147.5%
Mandarin	Forensics	Forensics MH	34.6%	0.0%						19		20	20	93.8%	118.7%	153.7%	181.6%
Merlin	Forensics	Forensics MH	31.5%	0.0%					1	62		106	106	113.9%	107.8%	142.7%	198.2%
Newtondale	Forensics	Forensics MH	18.2%	0.0%					7	2		3	3	108.2%	89.8%	101.1%	124.0%
Nightingale	Forensics	Forensics MH	16.2%	0.0%						4		4	4	88.2%	101.4%	98.4%	102.3%
Sandpiper Ward	Forensics	Forensics MH	18.8%	0.0%				1	4	185	13	414	427	99.4%	91.8%	100.4%	131.0%
Swift Ward	Forensics	Forensics MH	12.7%	0.0%					1	10		20	20	92.5%	101.1%	94.7%	100.2%
Aysgarth	Teesside	LD	21.1%	0.0%						5		5	5	108.3%	102.3%	100.6%	104.4%
Bankfields Court	Teesside	LD	7.5%	0.0%										123.1%	105.3%	114.3%	102.8%
Bankfields Flats	Teesside	LD	6.1%	0.0%										123.3%	110.8%	126.4%	100.1%
Bankfields Unit 2	Teesside	LD	23.2%	0.0%				1	3	4		5	5	100.4%	101.9%	107.9%	121.4%
Bankfields Unit 3	Teesside	LD	5.5%	0.0%					1	64		89	89	97.8%	100.0%	100.1%	97.3%
Bankfields Unit 4	Teesside	LD	6.7%	0.0%										108.3%	105.6%	94.5%	97.8%
Bek-Ramsey Ward	Durham & Darlington	LD	9.1%	6.2%			1		2	117	19	160	179	118.6%	100.6%	111.2%	102.2%
Oak Rise	York and Selby	LD	15.7%	19.2%					5	126		167	167	110.8%	103.2%	128.2%	129.3%
The Lodge	Teesside	LD	2.8%	5.0%						3		3	3	89.9%	92.3%	44.5%	58.9%
Acomb Garth	York and Selby	MHSOP	4.3%	42.6%				1	1	122		139	139	83.7%	87.1%	183.6%	256.6%
Ceddesfeld	Durham & Darlington	MHSOP	6.9%	2.9%					1	25		34	34	101.1%	99.5%	121.8%	119.4%
Cherry Tree House	York and Selby	MHSOP	15.1%	15.7%	1	1				24		30	30	114.2%	107.3%	120.1%	154.9%
Hamsterley	Durham & Darlington	MHSOP	24.7%	9.5%	2	2			1	17		17	17	93.7%	101.2%	139.2%	155.8%
Meadowfields	York and Selby	MHSOP	12.1%	35.6%						35		54	54	87.9%	97.1%	140.8%	192.4%
Oak Ward	Durham & Darlington	MHSOP	8.5%	1.4%						4		5	5	97.3%	102.1%	100.2%	101.3%
Roseberry Wards	Durham & Darlington	MHSOP	10.2%	0.1%	1				4	6		6	6	101.6%	105.0%	101.0%	103.8%
Rowan Lea	North Yorkshire	MHSOP	21.5%	16.4%						37		54	54	89.5%	103.9%	148.0%	135.0%

Rowan Ward	North Yorkshire	MHSOP	9.6%	33.1%	1	1		1	5	47		72	72	92.5%	152.9%	162.8%	158.3%
Springwood	North Yorkshire	MHSOP	10.7%	22.6%						129		209	209	75.7%	99.5%	132.1%	215.6%
Ward 14	North Yorkshire	MHSOP	7.7%	3.8%						5		6	6	86.2%	101.8%	101.8%	102.5%
Westerdale North	Teesside	MHSOP	9.1%	13.0%	1	1			2	17		20	20	107.8%	115.9%	128.2%	173.6%
Westerdale South	Teesside	MHSOP	31.6%	10.3%	1	1				72		81	81	104.9%	100.9%	221.5%	266.3%
Harland Ward	Durham & Darlington	Rehab	17.5%	2.1%						10		17	17	99.2%	100.6%	76.1%	90.1%
Kiltonview	Teesside	Day Unit	14.4%	0.2%										83.5%		86.5%	
The Orchard	Teesside	Day Unit	11.5%	0.0%										80.7%		77.6%	
Thornaby Road	Teesside	Day Unit	5.1%	0.0%						1		1	1	89.7%	0.0%	136.5%	109.1%

Quality Indicators - 6 Month Total **Appendix 5**

Ward Name	Locality	Speciality	Safe Nursing Indicators											
			Falls resulting in significant harm	Pressure Ulcers	Medication Errors	Missed Breaks	Staffing Fill Rate - Day - Registered Nurses	Staffing Fill Rate - Night - Registered Nurses	Staffing Fill Rate - Day - Unregistered Nurses	Staffing Fill Rate - Night - Unregistered Nurses	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours	**Mandatory Training (Nov)**
Ayckbourn Danby Ward	North Yorkshire	Adults			14	28	**104.2%**	**96.3%**	**117.0%**	**132.3%**	13.1%	16.4%	3.5%	94.19%
Ayckbourn Esk Ward	North Yorkshire	Adults			6	13	**56.7%**	**97.6%**	**131.2%**	**106.9%**	16.9%	7.0%	1.4%	96.46%
Bedale Ward	Teesside	Adults			3	64	**90.1%**	**84.1%**	**137.5%**	**188.1%**	15.4%	10.9%	4.5%	99.59%
Bilsdale	Teesside	Adults			8	40	**97.8%**	**99.6%**	**126.8%**	**110.5%**	7.1%	3.8%	2.3%	94.83%
Birch Ward	Durham and Darlington	Adults			10	19	**82.2%**	**102.2%**	**111.3%**	**132.0%**	30.2%	3.0%	1.3%	87.82%
Bransdale	Teesside	Adults			8	12	**104.3%**	**102.7%**	**129.3%**	**139.8%**	16.9%	7.1%	1.5%	95.65%
Cedar	Durham and Darlington	Adults			14	30	**106.2%**	**101.3%**	**74.8%**	**75.0%**	20.3%	1.4%	2.7%	91.49%
Cedar (NY)	North Yorkshire	Adults			8	101	**100.7%**	**103.4%**	**100.3%**	**113.8%**	8.7%	54.2%	1.4%	90.83%
Ebor Ward	York and Selby	Adults			27	45	**82.8%**	**100.4%**	**77.5%**	**109.1%**	9.7%	11.2%	1.7%	97.50%
Elm Ward	Durham and Darlington	Adults			28	29	**96.6%**	**97.9%**	**95.7%**	**112.8%**	28.0%	5.2%	2.9%	94.21%
Farnham Ward	Durham and Darlington	Adults			3	34	**111.7%**	**102.2%**	**135.2%**	**130.9%**	12.6%	4.0%	2.2%	89.23%
Kirkdale	Teesside	Adults			6	2	**92.3%**	**103.2%**	**99.6%**	**100.3%**	19.0%	1.0%	3.3%	91.77%
Lustrum Vale	Teesside	Adults			17	6	**92.2%**	**102.3%**	**140.8%**	**123.5%**	22.2%	2.3%	1.8%	98.48%
Maple	Durham and Darlington	Adults			7	1	**101.7%**	**101.1%**	**125.1%**	**119.0%**	22.8%	2.8%	1.9%	87.82%
Minster Ward	York and Selby	Adults			47	59	**79.8%**	**100.4%**	**85.7%**	**108.1%**	6.2%	7.6%	7.2%	95.57%
Overdale	Teesside	Adults			5	5	**103.2%**	**100.0%**	**112.9%**	**110.7%**	1.5%	2.3%	3.2%	99.19%
Primrose Lodge	Durham and Darlington	Adults			1	7	**86.9%**	**100.0%**	**112.6%**	**100.0%**	8.3%	0.3%	1.7%	88.41%
Stockdale	Teesside	Adults			6	10	**102.2%**	**102.8%**	**130.7%**	**139.7%**	13.6%	6.5%	1.5%	89.76%
The Orchards (NY)	North Yorkshire	Adults			1		**84.0%**	**52.1%**	**103.0%**	**143.2%**	4.6%	0.0%	4.2%	
Tunstall Ward	Durham and Darlington	Adults			1	22	**114.5%**	**106.8%**	**108.4%**	**113.1%**	5.1%	1.5%	4.4%	94.17%
Ward 15	North Yorkshire	Adults			3	26	**79.5%**	**107.6%**	**160.6%**	**140.5%**	24.7%	17.9%	2.0%	70.19%
Willow Ward	Durham and Darlington	Adults			14	1	**90.4%**	**102.1%**	**147.3%**	**101.9%**	21.4%	1.4%	3.1%	93.76%
Baysdale	Teesside	CYPS			4	9	**107.9%**	**101.6%**	**112.7%**	**106.7%**	10.8%	0.0%	11.5%	93.30%
Holly	Durham and Darlington	CYPS				1	**175.7%**	**118.1%**	**200.8%**	**198.2%**	12.7%	0.0%	3.0%	95.63%
Newberry Centre	Teesside	CYPS			7	161	**100.3%**	**136.2%**	**143.7%**	**159.6%**	11.8%	1.1%	4.2%	95.79
The Evergreen Centre	Teesside	CYPS			16	154	**84.9%**	**113.8%**	**123.0%**	**145.2%**	16.4%	8.0%	3.3%	91.09%

Westwood Centre	Teesside	CYPS			5	68	99.2%	107.8%	117.1%	115.8%	7.0%	2.2%	7.4%	94.61%
Clover / Ivy	Forensics	Forensics LD			8	44	95.0%	106.2%	97.0%	150.8%	31.4%	3.6%	2.2%	93.77%
FLD Eagle ASD	Forensics	Forensics LD			1	6	100.3%	100.6%	142.0%	91.8%	17.2%	3.4%	3.4%	
Harrier / Hawk	Forensics	Forensics LD			2	34	92.3%	103.6%	107.5%	114.3%	20.7%	0.1%	5.8%	99.46%
Kestrel / Kite.	Forensics	Forensics LD			5	41	99.8%	108.1%	117.2%	151.5%	30.6%	0.6%	3.0%	96.44%
Langley	Forensics	Forensics LD				4	83.3%	100.0%	101.3%	100.6%	18.4%	0.0%	2.0%	98.76%
Northdale Centre	Forensics	Forensics LD			13	38	97.8%	131.6%	111.2%	128.5%	34.5%	2.4%	3.3%	95.39%
Oakwood	Forensics	Forensics LD			4	29	87.6%	101.4%	233.1%	135.0%	22.9%	0.1%	6.4%	93.09%
Thistle	Forensics	Forensics LD			5	21	78.4%	100.6%	97.7%	99.1%	17.7%	0.1%	3.1%	95.85%
Brambling	Forensics	Forensics MH			6	46	103.2%	106.7%	105.6%	117.4%	22.3%	0.0%	1.0%	99.50%
Jay Ward	Forensics	Forensics MH			1	16	91.6%	104.6%	95.2%	100.7%	8.8%	0.0%	3.2%	96.75%
Lark	Forensics	Forensics MH			3	29	95.3%	103.8%	102.6%	93.6%	28.9%	0.0%	3.4%	94.43%
Linnet Ward	Forensics	Forensics MH			11	27	84.9%	103.3%	100.2%	97.1%	10.0%	0.0%	2.6%	94.96%
Mallard	Forensics	Forensics MH			1	61	106.9%	114.1%	118.2%	147.5%	27.0%	0.0%	2.8%	92.89%
Mandarin	Forensics	Forensics MH			3	28	93.8%	118.7%	153.7%	181.6%	34.6%	0.0%	1.5%	92.29%
Merlin	Forensics	Forensics MH			4	35	113.9%	107.8%	142.7%	198.2%	31.5%	0.0%	2.0%	98.58%
Newtondale	Forensics	Forensics MH			4	35	108.2%	89.8%	101.1%	124.0%	18.2%	0.0%	5.1%	95.53%
Nightingale	Forensics	Forensics MH			2	41	88.2%	101.4%	98.4%	102.3%	16.2%	0.0%	3.1%	96.01%
Sandpiper Ward	Forensics	Forensics MH			2	58	99.4%	91.8%	100.4%	131.0%	18.8%	0.0%	2.6%	96.30%
Swift Ward	Forensics	Forensics MH			5	19	92.5%	101.1%	94.7%	100.2%	12.7%	0.0%	2.3%	96.23%
Aysgarth	Teesside	LD			7	20	108.3%	102.3%	100.6%	104.4%	21.1%	0.0%	4.5%	92.94%
Bankfields Court	Teesside	LD				16	123.1%	105.3%	114.3%	102.8%	7.5%	0.0%	4.0%	93.81%
Bankfields Court Flats	Teesside	LD					123.3%	110.8%	126.4%	100.1%	6.1%	0.0%	1.6%	
Bankfields Court Unit 2	Teesside	LD			10	25	100.4%	101.9%	107.9%	121.4%	23.2%	0.0%	6.2%	83.20%
Bankfields Court Unit 3	Teesside	LD			3		97.8%	100.0%	100.1%	97.3%	5.5%	0.0%	2.8%	
Bankfields Court Unit 4	Teesside	LD					108.3%	105.6%	94.5%	97.8%	6.7%	0.0%	0.7%	
Bek-Ramsey Ward	Durham and Darlington	LD			4	23	118.6%	100.6%	111.2%	102.2%	9.1%	6.2%	6.1%	
Oak Rise	York and Selby	LD				116	110.8%	103.2%	128.2%	129.3%	15.7%	19.2%	4.8%	91.84%
The Lodge	Teesside	LD					89.9%	92.3%	44.5%	58.9%	2.8%	5.0%	4.0%	100.00%
Acomb Garth	York and Selby	MHSOP			7	31	83.7%	87.1%	183.6%	256.6%	4.3%	42.6%	0.8%	94.22%
Ceddesfeld	Durham and Darlington	MHSOP			6		101.1%	99.5%	121.8%	119.4%	6.9%	2.9%	1.7%	94.51%
Cherry Tree House	York and Selby	MHSOP	1		10	2	114.2%	107.3%	120.1%	154.9%	15.1%	15.7%	4.9%	97.57%
Hamsterley	Durham and Darlington	MHSOP	1		2	11	93.7%	101.2%	139.2%	155.8%	24.7%	9.5%	2.6%	81.33%
Meadowfields	York and Selby	MHSOP			3	25	87.9%	97.1%	140.8%	192.4%	12.1%	35.6%	1.9%	94.25%
Oak Ward	Durham and Darlington	MHSOP		3	4	18	97.3%	102.1%	100.2%	101.3%	8.5%	1.4%	1.1%	89.98%

Roseberry Wards	Durham and Darlington	MHSOP		1	3		101.6%	105.0%	101.0%	103.8%	10.2%	0.1%	0.3%	97.05%
Rowan Lea	North Yorkshire	MHSOP		1	10	39	89.5%	103.9%	148.0%	135.0%	21.5%	16.4%	4.5%	84.45%
Rowan Ward	North Yorkshire	MHSOP	1		15	32	92.5%	152.9%	162.8%	158.3%	9.6%	33.1%	1.3%	84.96%
Springwood	North Yorkshire	MHSOP			8	21	75.7%	99.5%	132.1%	215.6%	10.7%	22.6%	4.5%	90.65%
Ward 14	North Yorkshire	MHSOP			4	17	86.2%	101.8%	101.8%	102.5%	7.7%	3.8%	8.4%	91.36%
Westerdale North	Teesside	MHSOP	1		14	31	107.8%	115.9%	128.2%	173.6%	9.1%	13.0%	1.7%	96.26%
Westerdale South	Teesside	MHSOP	1	1	3	15	104.9%	100.9%	221.5%	266.3%	31.6%	10.3%	0.7%	84.46%
Harland Rehab Ward	Durham and Darlington	Rehab					99.2%	100.6%	76.1%	90.1%	17.5%	2.1%	5.9%	95.56%
Kiltonview	Teesside	Day Unit				1	83.5%		86.5%		14.4%	0.2%	1.0%	
The Orchard	Teesside	Day Unit					80.7%		77.6%		11.5%	0.0%	0.8%	90.83%
Thornaby Road	Teesside	Day Unit				316	89.7%	0.0%	136.5%	109.1%	5.1%	0.0%	8.0%	97.92%

Care Hours per Patient Day

APPENDIX 6

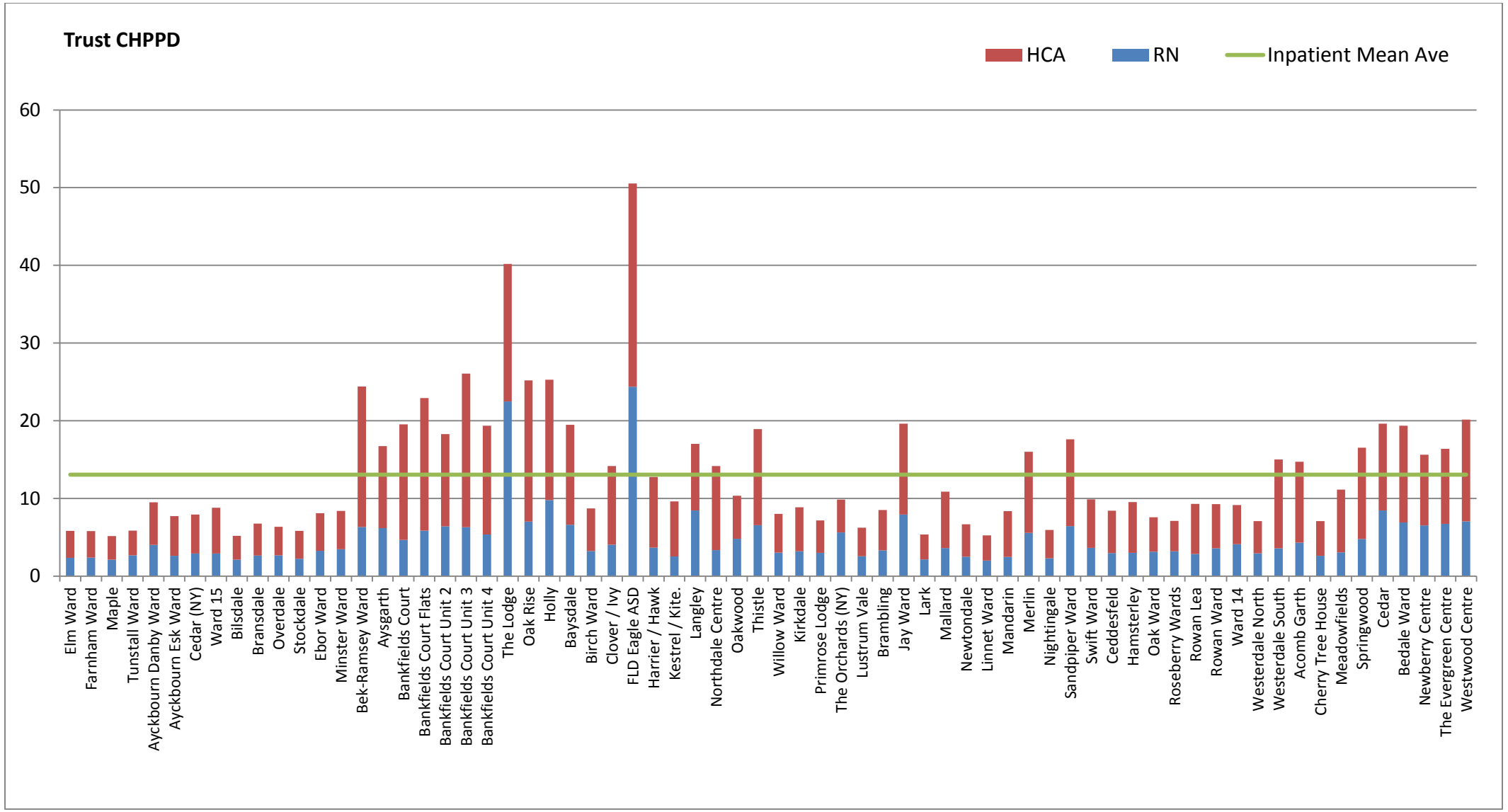
Ward Name	Locality	Speciality	Occupied Beds at Midnight							RN HOURS	HCA HOURS	CHPPD		
			Jun	Jul	Aug	Sept	Oct	Nov	TOTAL			RN	HCA	Overall
Elm Ward	Durham & Darlington	ACUTE	528	430	534	524	505	499	3020	7102.0	10503.2	2.4	3.5	5.8
Farnham Ward	Durham & Darlington	ACUTE	572	552	591	558	573	483	3329	7969.3	11379.8	2.4	3.4	5.8
Maple	Durham & Darlington	ACUTE	547	505	544	577	586	605	3364	7184.3	10178.7	2.1	3.0	5.2
Tunstall Ward	Durham & Darlington	ACUTE	580	473	565	433	475	554	3080	8287.8	9719.2	2.7	3.2	5.8
Danby Ward	North Yorkshire	ACUTE	302	321	308	340	367	269	1907	7689.3	10461.5	4.0	5.5	9.5
Esk Ward	North Yorkshire	ACUTE	332	350	354	331	333	290	1990	5223.8	10170.5	2.6	5.1	7.7
Cedar (NY)	North Yorkshire	ACUTE	409	410	437	405	434	390	2485	7224.9	12479.3	2.9	5.0	7.9
Ward 15	North Yorkshire	ACUTE	359	376	363	346	335	322	2101	6095.5	12387.1	2.9	5.9	8.8
Bilsdale	Teesside	ACUTE	508	566	525	517	546	525	3187	6815.2	9740.2	2.1	3.1	5.2
Bransdale	Teesside	ACUTE	526	417	426	381	424	479	2653	7070.2	10914.1	2.7	4.1	6.8
Overdale	Teesside	ACUTE	494	372	445	441	441	432	2625	7026.2	9627.5	2.7	3.7	6.3
Stockdale	Teesside	ACUTE	489	584	548	484	515	493	3113	7006.0	11108.9	2.3	3.6	5.8
Ebor Ward	York and Selby	ACUTE	381	341	357	320	341	323	2063	6764.1	9984.0	3.3	4.8	8.1
Minster Ward	York and Selby	ACUTE	345	327	358	341	363	304	2038	7072.4	10060.8	3.5	4.9	8.4
Bek-Ramsey Ward	Durham & Darlington	ALD	177	186	168	178	123	170	1002	6345.8	18103.6	6.3	18.1	24.4
Aysgarth	Teesside	ALD	124	129	155	128	141	127	804	4966.3	8493.2	6.2	10.6	16.7
Bankfields Court	Teesside	ALD	0	107	362	386	382	366	1603	7457.4	23867.0	4.7	14.9	19.5
Bankfields Flats	Teesside	ALD	103	88					191	1122.2	3253.4	5.9	17.0	22.9
Bankfields Unit 2	Teesside	ALD	140	139	132	134	125	119	789	5059.0	9367.7	6.4	11.9	18.3
Bankfields Unit 3	Teesside	ALD	90	66					156	984.7	3081.5	6.3	19.8	26.1
Bankfields Unit 4	Teesside	ALD	106	87					193	1032.9	2705.3	5.4	14.0	19.4
The Lodge	Teesside	ALD	30	31	31	30	31	30	183	4113.1	3243.0	22.5	17.7	40.2
Oak Rise	York and Selby	ALD	163	168	185	180	186	180	1062	7463.6	19300.4	7.0	18.2	25.2
Holly	Durham & Darlington	CLD	60	45	51	58	43	54	311	3043.1	4818.9	9.8	15.5	25.3
Baysdale	Teesside	CLD	135	140	162	125	125	126	813	5378.8	10463.6	6.6	12.9	19.5

Birch Ward	Durham & Darlington	EATING DISORDERS	396	429	418	350	385	387	2365	7669.2	12927.6	3.2	5.5	8.7
Clover / Ivy	Forensics	FLD	281	279	279	270	279	280	1668	6767.6	16877.4	4.1	10.1	14.2
FLD Eagle ASD	Forensics	FLD	30	31	31	30	24		146	3558.4	3820.2	24.4	26.2	50.5
Harrier / Hawk	Forensics	FLD	300	303	297	300	310	300	1810	6639.2	16491.5	3.7	9.1	12.8
Kestrel / Kite.	Forensics	FLD	445	447	465	469	496	480	2802	7120.1	19822.9	2.5	7.1	9.6
Langley	Forensics	FLD	130	138	137	123	101	98	727	6142.0	6249.3	8.4	8.6	17.0
Northdale Centre	Forensics	FLD	384	397	400	360	357	330	2228	7497.7	24101.4	3.4	10.8	14.2
Oakwood	Forensics	FLD	213	217	217	216	248	240	1351	6482.7	7494.8	4.8	5.5	10.3
Thistle	Forensics	FLD	150	155	155	150	155	140	905	5946.5	11173.5	6.6	12.3	18.9
Willow Ward	Durham & Darlington	HIGH DEPENDENCY REHABILITATION	331	381	378	372	352	361	2175	6594.7	10849.4	3.0	5.0	8.0
Kirkdale	Teesside	LOCKED REHAB	420	391	344	329	315	270	2069	6650.5	11682.6	3.2	5.6	8.9
Primrose Lodge	Durham & Darlington	LONGER TERM COMPLEX / CONTINUING CARE	373	349	348	385	400	382	2237	6707.9	9319.3	3.0	4.2	7.2
The Orchards (NY)	North Yorkshire	LONGER TERM COMPLEX / CONTINUING CARE	182	261	256	204	192	179	1274	7167.0	5406.0	5.6	4.2	9.9
Lustrum Vale	Teesside	LONGER TERM COMPLEX / CONTINUING CARE	534	499	441	422	573	553	3022	7792.9	11029.2	2.6	3.6	6.2
Brambling	Forensics	LOW SECURE	349	344	328	340	393	380	2134	7101.6	11048.8	3.3	5.2	8.5
Jay Ward	Forensics	LOW SECURE	120	155	149	140	124	150	838	6654.3	9803.6	7.9	11.7	19.6
Lark	Forensics	LOW SECURE	510	527	527	510	512	510	3096	6703.1	9869.7	2.2	3.2	5.4
Mallard	Forensics	LOW SECURE	376	341	341	330	341	330	2059	7422.9	14954.0	3.6	7.3	10.9
Newtondale	Forensics	LOW SECURE	600	595	586	567	596	581	3525	8881.1	14668.8	2.5	4.2	6.7
Linnet Ward	Forensics	MEDIUM SECURE	510	527	527	510	524	510	3108	6270.8	9998.1	2.0	3.2	5.2
Mandarin	Forensics	MEDIUM SECURE	431	465	482	476	493	480	2827	7027.3	16616.3	2.5	5.9	8.4
Merlin	Forensics	MEDIUM SECURE	287	308	310	297	301	300	1803	10028.0	18856.4	5.6	10.5	16.0
Nightingale	Forensics	MEDIUM SECURE	432	468	473	459	483	469	2784	6408.7	10130.9	2.3	3.6	5.9
Sandpiper Ward	Forensics	MEDIUM SECURE	240	248	217	210	216	210	1341	8650.5	14980.5	6.5	11.2	17.6
Swift Ward	Forensics	MEDIUM SECURE	300	310	296	300	310	300	1816	6638.8	11310.5	3.7	6.2	9.9
Ceddesfeld	Durham & Darlington	OLDER ADULTS - ACUTE	428	435	369	408	431	349	2420	7222.8	13147.5	3.0	5.4	8.4

Hamsterley	Durham & Darlington	OLDER ADULTS - ACUTE	270	365	427	396	439	423	2320	6936.8	15178.2	3.0	6.5	9.5
Oak Ward	Durham & Darlington	OLDER ADULTS - ACUTE	358	374	349	357	363	352	2153	6805.9	9509.5	3.2	4.4	7.6
Roseberry Wards	Durham & Darlington	OLDER ADULTS - ACUTE	366	417	326	381	374	419	2283	7294.3	8927.9	3.2	3.9	7.1
Rowan Lea	North Yorkshire	OLDER ADULTS - ACUTE	493	435	460	462	432	519	2801	8041.7	18039.9	2.9	6.4	9.3
Rowan Ward	North Yorkshire	OLDER ADULTS - ACUTE	473	455	408	388	397	321	2442	8780.3	13842.9	3.6	5.7	9.3
Ward 14	North Yorkshire	OLDER ADULTS - ACUTE	265	273	296	278	253	267	1632	6702.9	8235.3	4.1	5.0	9.2
Westerdale North	Teesside	OLDER ADULTS - ACUTE	502	545	588	555	511	558	3259	9639.3	13458.3	3.0	4.1	7.1
Westerdale South	Teesside	OLDER ADULTS - ACUTE	417	464	408	404	430	388	2511	9008.1	28701.7	3.6	11.4	15.0
Acomb Garth	York and Selby	OLDER ADULTS - ACUTE	407	306	323	399	403	343	2181	9390.0	22710.3	4.3	10.4	14.7
Cherry Tree House	York and Selby	OLDER ADULTS - ACUTE	510	519	527	453	523	499	3031	7924.1	13521.4	2.6	4.5	7.1
Meadowfields	York and Selby	OLDER ADULTS - ACUTE	392	329	346	303	357	373	2100	6440.7	16959.8	3.1	8.1	11.1
Springwood	North Yorkshire	OTHER SPECIALIST MENTAL HEALTH BEDS	210	232	235	240	248	234	1399	6675.2	16474.1	4.8	11.8	16.5
Cedar	Durham & Darlington	PICU	250	240	213	178	204	239	1324	11204.4	14797.0	8.5	11.2	19.6
Bedale Ward	Teesside	PICU	224	251	185	244	240	247	1391	9628.5	17317.2	6.9	12.4	19.4
Newberry Centre	Teesside	TIER 4	351	238	239	246	318	378	1770	11581.2	16089.9	6.5	9.1	15.6
The Evergreen Centre	Teesside	TIER 4	402	374	224	259	370	376	2005	13508.4	19330.6	6.7	9.6	16.4
Westwood Centre	Teesside	TIER 4	301	336	303	295	256	243	1734	12226.5	22716.0	7.1	13.1	20.2

Care Hours per Patient Day

Appendix 7



Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 29 January 2019**
TITLE:	**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 the QuAC formal meeting held on 06 December 2018

The Quality Assurance Committee has consistently reviewed all relevant Trust quality related processes, in line with the Committee's Terms of Reference.
Key matters considered by the Committee were:

- The top concerns for North Yorkshire and Forensic services
- Patient Safety update
- Medicines management
- Re-audit of clinical emergency response bags
- Compliance with CQC
- Safeguarding & Public Protection
- Placing automated defibrillators in non-inpatient settings
- Health, Safety, Security and Fire Update
- Research Governance
- Equality and Diversity
- Clinical Audit and Effectiveness

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 06 December 2018.
- Note the confirmed minutes of the formal meeting held on 01 November 2018 (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 29 January 2019**
TITLE:	**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 held on 06 December 2018.

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. Monthly compliance with the Care Quality Commission regulatory standards, with copies of assurance reports to support the regulatory standards were also considered.

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principal risks and concerns, together with assurances and progress from North Yorkshire and Forensic Services.

ARE OURSERVICES WELL-LED?

How do we gain assurance from each locality that they have effective systems and processes in place to ensure standards of care, compliance with relevant standards, quality, risk and assurance arrangements?

The Committee received key assurance and exception reports from LMGBs.

4.1 NORTH YORKSHIRE SERVICES LMGB

The Committee discussed the LMGB report for North Yorkshire Services.

The top areas of concern highlighted were:

- Meeting performance targets in MHSOP, which is linked to staffing challenges in key areas including appraisals and waiting times.
- LD bed pressures due to lack of investment in local Community services in relation to enhanced models.
- The numbers of suicides in AMH. Assurance was provided that the NY Suicide Prevention Group will provide an overview of the delivery of the NY Suicide Prevention Advisory Group strategic action plan to date. There are four priority areas of focus with 13 key outcomes.

- Committee members discussed how the locality would improve compliance with the flu vaccination campaign to try to reach the 75% target, however the difficulty in reaching this was acknowledged and the locality was on around the same trajectory as the previous year.

- Information was requested by members to be included as a statement in the Executive Summary of LMGB reports around mechanical restraint as an assurance statement for the CQC. This was cascaded to other locality leads.

4.2 FORENSIC SERVICES LMGB

The Committee discussed the LMGB report for Forensic Services.

The top areas of concern highlighted were:

- The use of tear proof clothing. Further work is required around fully understanding and monitoring this issue. This is underway.
- Transition from CAMHS secures services into Adult Forensic Service. Areas have been highlighted for development in order to enhance the patient experience and guidance is being developed to support young service users at the point of transition.
- Disclosure and barring service. A process has been developed for Ward Managers to monitor completion and outstanding DBS checks due to variation in the data received from the central team, which was due to staffing issues and records not being updated.

The Committee sought further assurances around the use of metal cuffs, restrictive practices and incidents of stained laundry on Lark Ward. This information was circulated to members following the meeting.

4.3 Compliance with CQC Requirements

The Board is asked to note that:

- Following the final CQC report published on 23 October 2018 the Trust is now busy rectifying the 16 'must do' actions identified that relate to potential regulatory breaches of the Health and Social Care Act 2008 which the Trust must act on to ensure compliance.
- There are also 25 'should do' actions to address and whilst these are not breaches in legislation or regulation the Trust will consider them in equal measure.

Assurance is provided that the Trust continues to maintain full registration with the CQC with no conditions.

ARE OUR SERVICES SAFE?

Are lessons learned and improvements made when things go wrong?

5.1 Patient Safety

The Committee discussed the Patient Safety Group report.

The key matters of assurance provided to the Board are around:

- The work that is underway to ensure that the Trust meets the eight recommendations within the NQB guidance on working with bereaved families and carers. A family conference, arranged for March 2019 will launch this work and a guidance booklet for bereaved families has been drafted and is out for consultation.
- From January 2019 the Trust will no longer record feeds under restraint as a medication incident but as a behavioural incident as it is the act of restraint that is being recorded as opposed to a true medication incident.
- A review of the patient safety metrics which will include, at the recommendation of the Quality Assurance Committee a re-look at the rag rating for medication errors per occupied bed days at level three or above which is currently rated as red. Members discussed how this metric could also be reported as green as the Trust is encouraging medication errors to be reported.

The Committee also requested some benchmarking with other Trusts around nasogastric feeding.

There are no significant risks to escalate to the Board.

5.3 Drug and Therapeutics

The Committee discussed the update on medicines management.

The key matter for the Board to note is that the Lloyds Pharmacy contract will expire in October 2019 and following EMT agreement a network of three internal dispensaries will be developed so that each locality will have one dispensary to supply all in-patient and community clinical supplies.

5.4 Re-audit of Clinical Emergency Response Bags

The key matters for the Board to note are:

- Following the fourth audit of clinical emergency response bags there has been significant improvements made with regards to policy compliance.
- For continued assurance and monitoring there will be a compliance statement included in LMGB reports from each locality, which report to the Quality Assurance Committee. This will provide a positive statement on the cycle of checks made on all resuscitation bags, in line with policy and where any wards have not made full checks additional monitoring will be put in place.
- In addition, there will be an annual re-audit of the clinical emergency response bags, due to take place in December 2019.

5.5 Safeguarding and Public Protection

The Committee received the six monthly assurance report, together with the monthly exception report for Safeguarding and Public Protection.

The key matters for the Board to note are:

- Additional Safeguarding Adult training will be required following the publication of the Intercollegiate Document for Safeguarding Adults/Prevent. This training for staff will need to be updated every three years instead of as a one off, as it is currently within Safeguarding Level 2 training.

- The South Tees Local Authorities are working towards a joint Safeguarding Children's hub with a target date of April 2019 for this to be in place. Within North Yorkshire there is a Multi-Agency Safeguarding Team (MAST) arrangement where developments are taking place around starting to have input into mental health cases.

- The Committee requested a check for accuracy around the information on cases upheld following allegations against staff and referral numbers into Teesside.

Assurance was provided that both the safeguarding adult and children teams continue to deliver a comprehensive safeguarding service within the Trust and are compliant with legislation.

5.6 Placing automated defibrillators in non-Inpatient settings

The Committee discussed a report setting out some options for the placing of automated defibrillators (AEDs) to none in-patient areas and/or community teams that do not currently have an emergency response bag.

The key matter for the Board to be aware of is that Committee members agreed that further work should be undertaken at EMT to have a wider discussion to establish the locations of the response bags and the associated costings with a final proposal taken back to the Quality Assurance Committee in due course.

5.7 Health, Safety, Security and Fire

The Committee discussed the six monthly update on Health, Safety, Security and Fire.

The key matters for the Board to note are:

- During Q1 and Q2 there were 42 out of 700 incidents of violence and aggression reported to the police. Whilst there was a decrease from Q1 to Q2, the Committee were interested to hear about the outcome of those reported incidents and any action taken by the Police. More information will be sought for the next update to the Quality Assurance Committee in June 2019.
- Smoking related incidents were reported as one for Primrose Lodge, however the reality was that this is still a real problem and something that was picked up on a recent Directors visit. Assurance was given that further impetus will be given to resolve this matter.

There are no significant risks to highlight to the Board.

ARE OUR SERVICES RESPONSIVE?

5.8 Research Governance

The Committee discussed the six monthly update around Research and Governance.

The key updates for the Board to note are:

- The collaboration with TEWV and the University of York is progressing very well with a number of major research grant successes, which is in line with the Research and Development Strategy.
- Funding has been agreed to extend the University of York support for a 0.5WTE Research Development Manager and EMT will consider a business case in 2019 to identify resources from TEWV to support the partnership.
- Assurance can be provided that the research and development activity in TEWV remains compliant with the UK policy framework for health and social care research.

5.9 Equality and Diversity

The Committee discussed an update around Equality and Diversity matters.

The key areas to note for the Board are:

- Assurance was provided following the EDHR Steering Group meetings held in August 2018 and October 2018 that all information relating to equality, diversity and human rights has been reviewed in line with the Group's Terms of Reference and agreed KPIs. Any issues have been addressed and are being progressed by the appropriate leads.
- The Trust Equality and Diversity team has been operating on reduced capacity due to a vacancy and long term sickness and this may impact on the timeliness of completed actions.

6.0 Clinical Audit and Effectiveness

The Committee noted an update on Clinical Audit and Effectiveness.

The key matter for the Board to note is that there are no issues with the completion of the clinical audit programme for Quarter 2 and no risks identified.

6.1 **Exceptions to report to the Board**
There are no exceptions to report to the Board.

6.2 **Matters to be escalated to the Board**

There are no matters to escalate to the Board.

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**
There are no issues to note.

8. CONCLUSIONS
The Quality Assurance Committee considered the corporate assurance and performance reports during the informal meeting. The Committee were assured that as far as practicable, all risks highlighted were being either managed or addressed with proposed mitigation plans.

9. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Quality Assurance Committee meeting on 06 December 2018.
(ii) Note the formal minutes of the meeting held on 01 November 2018.

Mrs E Moody
Director of Nursing and Governance
29 January 2019

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 01 NOVEMBER 2018, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Mr Colin Martin, Chief Executive
Mrs Elizabeth Moody, Director of Nursing & Governance
Mrs Shirley Richardson, Non-Executive Director
Mrs Ruth Hill, Chief Operating Officer
Dr Ahmad Khouja, Medical Director

In attendance:
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mr Stephen Davison, Lead Nurse, Positive and Safe
Dr Suresh Babu, Deputy Medical Director
Mrs Leanne McCrindle, Head of Quality Governance and Compliance
Dr Steven Wright, Deputy Medical Director, York and Selby
Mr John Savage, Head of Nursing, Durham and Darlington
Mr Patrick Scott, Director of Operations, York and Selby
Mr Chris Lanigan, Head of Planning and Business Development
Mr Anthony Davison, Head of Nursing, York and Selby

18/142 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Jennifer Illingworth, Director of Quality Governance, Mr Richard Simpson, Non-Executive Director and Mrs Karen Agar, Associate Director of Nursing and Governance.

18/143 NOTES OF THE PREVIOUS MEETING

The notes of the informal meeting held on 04 October 2018 were accepted as a recording of the discussions, subject to the following amendment:

(i) Page 1: Action log: 18/92, should read “Since the Durham locality was not present at the meeting this would be checked and confirmed at the ***November*** 2018 QuAC meeting”

At the meeting in November 2018 an issue was raised for factual accuracy around the Drug and Therapeutics item (minute 18/134) that the timescale for compliance around the Falsified Medicines Directive would not be ready for February 2019.

Assurance was received that this was correct.

The Chairman of the Committee proposed to conclude minute 18/127 from the 04 October 2018 meeting with a statement that the treatment of IM Clozapine had been discontinued and this has been included.

18/144 ACTION LOG

The Committee discussed the QuAC action log, noting the following updates:

18/77 Patient Experience Report to include statistics/data sets with rolling averages.

Completed

18/92 Durham and Darlington risk register regarding medical staffing currently scored at 20 to be aligned to the risk on the Board of Directors' risk register and scored at same level.
Since the Durham locality was not present at the meeting this would be checked and confirmed at the October 2018 QuAC meeting.
This matter was covered under agenda item number 3a (minute 18/145 refers)

Completed

18/108 CQC insight: Committee to be given further explanation in future reports.

Completed

18/110 Placing automated defibrillators into non-patient settings: develop and cost proposals further for EMT to consider and report back to QuAC.
This matter was deferred for a further month to the December 2018 QuAC meeting.

18/118 Issues around mechanical restraint to be included in future LMGB reports.
This matter had been discussed further and communicated to the Directors of localities for inclusion in all future Executive Summaries of the LMGB reports.

Completed

18/127 Update to QuAC on challenges around digital transformation and the roll out of Wi-Fi across the Trust.
It was noted that this issue had been discussed at the Board of Directors at its meeting held on 30 October 2018. Each locality would restrict access to Wi-Fi according to any associated risks and the Information Department were well cited on mitigating against any misuse of the internet.

18/131 To include in report to QuAC more details around the intentional and unintentional prone restraint.
This matter was included in agenda item number 7, the Positive and Safe Report (minute 18/150 refers).

Completed

18/131a Quality Governance Team to contact the reporting team for any prone restraint used for feeding to clarify and improve recording errors.

Completed

18/133 Meet to identify a set of risk factors around vulnerability for the use in assessment of individuals to feed into harm minimisation work.
It was noted that a meeting had been set up for November 2018.

Completed

18/138 Include more narrative around the assurance provided in the QuAC Assurance Tracker, any matters that are referred to the Board and to provide a reference link to the minute from which the matter relates.

Completed

18/145 DURHAM AND DARLINGTON SERVICES LMGB REPORT

The Committee received and noted the Durham and Darlington Services LMGB Report.

Arising from the report it was highlighted that the top issues to note were:

(1) A staff assault on Willow Ward.
Assurance was provided that this female member of staff was being fully supported and prosecution of the individual was being pursued with the Police. The patient had been transferred to the Forensic Service at Ridgeway. It was noted that there had not been any obvious triggers, no threats had been made and was an unpredictable incident.

(2) Bed pressures.
There were concerns around the acuity across wards with bed occupancy over 100% on Maple Ward with the average length of stay at 33 days. Staff had been working to maximum capacity and this posed a risk around staff resilience and wellbeing, which could in turn affect quality of care.
On this matter it was noted that readmission rates were high with 31% in August 2018, which was above the Trust target rate of 23%. There was no known reason for the variance in readmission rates, what was important was the home treatment work that could be done to prevent readmissions happening.

(3) Three serious incidents in C&YP services North Durham, which had resulted in 3 deaths from suicide. This was highly unusual; however two of the children were from the same community. Support work was taking place in schools and staff members were also being provided with support.
Assurance was provided to the Committee that there were no common themes between the three incidents.

Following discussion concerns were raised over:

(1) The whistle blowing incident around staff behaviour.
It was noted that student nurses had raised concerns after working on the LD Unit at Lanchester Road Hospital in July 2018.
Assurance was provided that this had been thoroughly investigated and disciplinary action had been taken where necessary. There had also been positive feedback from student nurses since that time.

The Chairman sought assurance on the escalation processes surrounding these kind of events and the assault on the member of staff, which the Board of Directors needed to be cited on at the earliest opportunity.

With regard to the staff behaviour at Lanchester Road it was confirmed that this had been escalated to EMT at the time of the feedback from the student nurses.

(2) The stability of Birch Ward.
It was noted that the Ward Manager had been off sick for a period of seven months, however recruitment has been successful and a new charge nurse and clinical lead had been appointed.

(3) A small number of informal patients being admitted to PICU
It was noted that this related to when someone had come into Hospital in the early hours of the morning and rather than disturb someone in an acute bed the individual was placed into a PICU bed for a short period of time.

Members requested whether this could be tracked and Mrs Hill undertook to bring back to the Committee a draft escalation protocol in the New Year.

Action: Mrs R Hill

18/146 YORK AND SELBY SERVICES LMGB REPORT

The Committee received and noted the York and Selby Services LMGB Report.

Arising from the report it was noted that the top issues at present were:

(1) Continued challenges in IAPT services linked to locally agreed prevalence target and recovery rates.
Discussions with Commissioners continued, in the meantime a deep dive had revealed some inconsistencies with outcome measures and people not getting to the right area quickly enough which impacted on DNA rates and recovery rates.
Assurance was provided that a refreshed action plan would be considered at the next Contract Management Board meeting.

(2) Financial pressures due to the use of bank and agency staff across all three inpatient units. There was a lack of community Consultant Psychiatry due to current vacancies and inability to recruit. Alternative roles such as nurse Consultants would be explored.

(3) Capacity and demand issues in CAMHS. A deep dive commissioned by EMT would report back in November 2018. There would be a look at shared learning from other areas across the organisation.

(4) Acuity pressures in Oak Rise, which were not new uses but related to the complexity of individuals and delayed transfers of care. Discussions would continue with Commissioners and Local Authorities to look at the blocks and possible system solutions.
Assurance was provided that various actions were underway internally and that Oak Rise continued to maintain very high standards in medicine management, CPA audit and sickness was low, demonstrating a strong team ethic.

Following discussion concerns were raised around the relationship between caseloads, sickness absence levels and what seemed to be the lack of an early warning system when community teams got into difficulties. There had also been serious incidents with reported staffing related issues.

Agreed: that this matter should be escalated to the Board of Directors.

Action: Mrs E Moody

Assurance was provided that the policy on staff escalation in the community was currently out for consultation.

The Chairman of the Trust provided assurance that the Board of Directors, when cited on teams in difficulty would step in to help resolve the issues.

18/147 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received a verbal update on Compliance with CQC Registration Requirements.

The following matters were highlighted:

(1) The Trust had maintained a 'Good' overall rating following the CQC well-led inspection for 2018. An action plan would now be produced in response to the report and submitted back to the CQC by 20 November 2018.

It was disappointing to note that the CQC had not amended any of the final report based on the contested points raised by the Trust.

(2) The Insight report received bi-monthly from the CQC for September 2018 had been included with the report for information and it was noted that this report would be used as an intelligence tool primarily for CQC operational staff to help monitor potential changes to the quality of care and to support regulatory decision making.

Following discussion the following was noted:

(1) One of the issues identified in the CQC Long Stay/Rehabilitation report had stated the Trust was not meeting legal requirements under Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment and that staff on Talbot Ward had not identified all ligature points during the environmental risk assessments.
On this matter it was pointed out that the Trust felt confident that Talbot Ward was an appropriate environment for the client group and that there as an overarching national issue whereby Inspectors were taking different views on ligature points.
Assurance was provided that this would be picked up at an Engagement Meeting by the Director of Nursing and Governance.

A Patient Safety Alert had been published about low level ligature points and this would be addressed by Nursing and Governance and reported back to QuAC in due course.

Action: Mrs E Moody

(2) In relation to issues raised following the CQC Mental Health Act Review inspections during August and September 2018, and problems with patients accessing the Independent mental health advocacy service (IMHA) it was noted that the Trust did have a clear process and policy for this and it was acknowledged that there was some reinforcement required around processes to ensure that staff were documenting the information.

18/148 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group Report and the Patient Safety Group Quality Report for August 2018.

The following matters were highlighted from the report:

(1) There had been several issues raised from Directors Panels, including support needed for relative's family/carers to be involved in attending appointments with the patient, notifications through Paris not being followed up with a telephone call to the service and information sharing between street triage and mental health teams. All these matters were being pursued at SDG level to make improvements.

(2) A Coroner had written to the Trust and suggested that if Trust staff discover a patient at home in suspicious circumstances that they had a duty to notify the Police.
It was felt by the Trust that this would ordinarily be something that would be undertaken by ambulance crew, however the matter would be looked into further before responding back to the Coroner.

(3) A draft leaflet, based on the guidance published from the National Quality Board had been discussed further by the Group and would be circulated to some families/carers and other staff groups for additional feedback. This leaflet would provide information to families following bereavement.

(4) A GAP analysis of the National Quality Board guidance on family engagement had been carried out and the Medical Director and Director of Quality Governance were currently agreeing action owners.

The Patient Safety Group provided assurance that all safety activities had been reviewed in line with the Group's terms of reference and any issues to be addressed had been documented and were being progressed via appropriate leads and monitored by the Group.

18/149 SAFEGUARDING & PUBLIC PROTECTION REPORT

The Committee received and noted the Exception Report for Safeguarding and Public Protection.

The key matters highlighted from the report were:

(1) The Trust had received a draft report from NHS England following the review of a homicide in York; comments had been submitted, however there was as yet no confirmed publication date. On this matter it was noted that one of the key recommendations had been that there would be a learning event planned.
(2) A domestic homicide review had been initiated in Middlesbrough; there had been minimal contact with the perpetrator by the Trust.

It was noted that following the learning lessons review initiated by Middlesbrough LSCB regarding the death of a teenager with potential issues of neglect, this had been parental neglect as there had been little input by the Trust.

Assurance was provided that both the safeguarding adult and children teams continued to deliver a comprehensive safeguarding service within the Trust and were compliant with legislation.

18/150 POSITIVE AND SAFE REPORT

The Committee received and noted the Positive and Safe report detailing information about the use of restrictive intervention.

The key issues highlighted from the report were:

(1) There had been a decrease of 1.45% on the use of physical interventions during Q2 for 2018/19 and a decrease of 1.7% compared to Q2 in 2017/18.

Positive assurance levels could be seen in relation to the use of physical interventions across the localities as Forensic Services had shown a 52% decrease in Q2 and in Durham and Darlington a 36% reduction.

Mr Davison undertook to find out the correct estimated annual figure for physical interventions which the reported stated had totalled 8.628 for 2017/18 with an estimated 9,768 for 2018/19.

Action: Mr S Davison

(2) Three wards, Evergreen, Westwood and Newberry Centres had been successfully placed into the national work streams led by NHS England and NHS Improvement to look at improved reporting of physical intervention, clear standards for physical intervention training and the development of a service improvement tool to be trialled over the next 18 months.
Assurance was provided to the Committee that this project would be a key piece of work in making further improvements around restrictive practices. TEWV's Positive and Safe Team had

supported the Expert Reference Panel to develop the service improvement tool which would enable some national comparisons to be made with the statistics.

(3) The use of prone (face down) had significantly dropped from Q1 to Q2 in a number of localities with a decrease of 74% in Durham and Darlington, Tier 4 CAMHS services had decreased by 18% however the use of prone still remained high. There had been an increase of 47% in Tees attributed to AMH services based at Roseberry Park Hospital.

(4) The use of seclusion was slowly reducing. Three Wards, Bedale PICU, Cedar PICU and Danby collectively represented 65% of the Trust total usage.
Assurance was provided that the seclusion rates for the Trust were significantly lower than other Trusts nationally.

(5) Tear proof clothing
There had been 64 incidents of the use of tear proof clothing in Q2. Some individuals were choosing to go into this clothing, especially at night as it gave them a feeling of safety.
On this matter it was noted that protecting the dignity of individuals, particularly if it were in relation to someone that had suffered abuse, when getting into tear proof clothing it was about using de-escalation techniques, however protecting an individual's life was paramount.

Members raised the following questions:

(a) How worried should the Committee be about the use of prone restraint in CAMHS used unintentionally for feeding?
It was noted that this typically occurred before feeding as some individuals were very strong and staff had ended up on the floor in the struggle unintentionally.
The medical Director requested that in the Executive Summary of future Positive and Safe reports the details around the number of mechanical, soft cuffs and mechanical restraint devices

Action: Mr S Davison

(b) What actions were being taken to reduce the number of prone restraints?
It was noted that prone restraint was predominantly used when administering rapid tranquilisation and supporting exit from seclusion.
It was acknowledged that there was still further work to be done in reducing prone, around using alternative seclusion exits or injection sites for rapid tranquilisation, however there was confidence that further reductions could be made.

(c) Is using prone restraint a cultural problem for the Trust and a case of "old habits die hard"?
It was recognised that prone restraint was the safest and securest way for staff to hold individuals, however there were other interventions being used and it was anticipated that the use of body cameras would make staff feel safer and have the confidence to take a different approach.

Agreed: that there would be a six monthly update report to QuAC with the next report due in May 2019 and that the QuAC Annual Schedule of reporting be updated accordingly.

Action: Ms D Oliver

18/151 PATIENT EXPERIENCE REPORT

The Committee received and noted the Patient Experience Report.

The main issues highlighted were:

(1) That the report provided assurance that robust systems were in place for monitoring patient and carer feedback and any issues relating to patient experience, with assurances on the monitoring of quality and performance indicator data and planned work streams.

It was acknowledged however that further improvements could be made to the Patient Experience Report, by unlocking the data that sat behind the narrative, to ensure that the key matters were brought to the forefront and analysed before being presented to the Committee.

It was noted that the Director of Nursing and Quality Governance planned to join the Patient Experience Group and work on standardising the report to frame the narrative and analysis of data around the CQC high quality questions. This work would take place over the next 6-12 months.

Action: Mrs J Illingworth

(2) Following review in September 2018 of the results of a deep dive into the Care Programme Approach an action plan would be produced and a follow up event held in November 2018.
Members requested further details around the outcome of the deep dive and this would be reported back to QuAC in February 2019.

Action: Dr S Wright

Following discussion it was noted that since the Carers Trust no longer had sufficient funding to support Triangle of Care it was thought that the Royal College of Nursing (RCN) might take over the project, however there was no set timescale for this as it was in the early stages of development.

The Director of Nursing provided assurance that in the interim period there would continue to be a regional Triangle of Care and a further 13 sessions had been planned with 212 staff booked on to the training.

Members queried the issue of localities not providing updates for the Patient Experience Report and it was noted that since an amendment to the terms of reference for the Patient Experience Group localities would not submit data every month to allow for more depth to the information.
For localities where data was not requested to be submitted the Committee requested that the report in future state “report not required”.

Action: Dr S Wright

18/152 QUALITY ACCOUNT Q2 PROGRESS REPORT

The Committee received and noted the Quality Account Q2 progress report.

The key matters highlighted from the report were:

(1) Delivery of the four key quality priorities for 2018/19 was largely on track.
(2) Three out of nine of the Quality Metrics were reported as green with six out of nine reported as red.
On this matter it was noted that those areas scoring red had been reflected in other reports and discussed in the Committee.

(3) The Stakeholder engagement outcomes had been fed into the Trust’s planning process and the Board’s Planning Workshop. Discussions led to the recommendation to the Board of Directors that the existing four quality account improvement priorities be extended to 2019/20, with reviewing the urgent care delivery model added as a 5th improvement priority.

Following discussion around the wording in Metric 3: Number of incidents of physical intervention/restraint per 1000 occupied bed days, it was agreed that a review of the narrative should be undertaken before sharing the Quality Account with stakeholders to ensure that this important matter was put into context.

Action: Mr C Lanigan

18/153 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception to note.

18/154 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

The Committee agreed to escalate to the Board of Directors the lack of an early warning system when community teams get into difficulties.

This was in relation to staffing related issues that had been coming through serious incidents (minute 18/146 refers), and the impact of the balance of caseloads for staff, sickness absence levels and the lack of an escalation system in community teams.

The Chairman of the Trust expressed concerns around the importance of the Board of Directors being sighted early on serious incidents, particularly very serious assaults on staff members (minute 18/145 refers).

18/155 ISSUES DISCUSSED THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS

The Committee considered the potential impact on the Trust's reputation which could be caused by National reporting on the statistics around restraint.

> **Agreed:** *that any gaps in assurance would be considered further, against potential reputational damage from National publications on restraint and that this would be mitigated against by the work streams underway by the Positive and Safe team and pending the outcome of the NHS England and NHS Improvement pilot to improve the reporting of physical interventions.*
>
> **Action: Mr C Martin/Mr P Bellas**

18/156 QUALITY ASSURANCE COMMITTEE ASSURANCE TRACKER

The Committee received the updated Quality Assurance Committee Assurance Tracker.

The suggested amendments made at the October 2018 QuAC meeting had been incorporated into the tracker; to include more narrative around assurance, items that would be referred to the Board of Directors and a link to the minute reference for tracking and audit purposes. Members agreed that the tracker reasonably represented an account of the assurances the Committee had received in relation to the business discussed.

18/157 COMMITTEE EVALUATION

Members expressed no concerns around the meeting, agenda and reports.

18/158 ANY OTHER BUSINESS

There was no other business to discuss.

18/159 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 06 December 2018, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.30pm

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Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM No. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th January 2019**
TITLE:	**Learning from deaths**
REPORT OF:	**Jennifer Illingworth, Director of Quality Governance**
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 Learning from Deaths report sets out the approach the Trust is taking towards the identification, categorisation and investigation of deaths. The new style mortality dashboard is included at Appendix 1 and which now includes 2017/18 data for comparison. We are currently reviewing approximately 19% of total deaths per quarter. This will be a discussion point at the upcoming regional mortality group at the end of January 2018 to determine how this compares with our regional peers.

We have continued to observe an increase of the numbers of deaths that are reported through our incident management system (over and above the unexpected deaths that have always been reported via this route). This is a positive development as it allows a greater number of incidents to be channelled through our mortality review process which, in turn, will lead to greater opportunities for learning. To date this year (Q1&Q2) the mortality review process has reviewed more than the total number of reviews in the whole of 2017/18 which demonstrates more effective processes are in place.

Work continues to implement recommendations from the National Quality Board (NQB) guidance for NHS trusts on working with bereaved families and carers which was published in July 2018. The work is being monitored by the Patient Safety Group and a more detailed progress update will be included in the Q3 Learning from Deaths board report.

Recommendations:

The Board of Directors is requested:

- to note the content of this report, the dashboard and the areas for ongoing improvement
- to note the main learning points from investigations undertaken in Q1 & Q2 2018/19

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**29th January 2019**
TITLE:	**Learning from deaths**

1. INTRODUCTION & PURPOSE:

1.1 To formally report to the Board of Directors key information on 'Learning from deaths' in line with national guidance and the Trust 'Learning from deaths: the right thing to do' policy (CORP 00-65). The Trust has prioritised working more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of the death of their loved one right through to actions taken following from an investigation (if deemed appropriate). Understanding the data around the deaths of our service users is a vital part of our commitment to learning from deaths. We will also learn from developments nationally as these occur.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Following the publication of the Southern Health report in 2015 there has been enhanced national scrutiny on how all NHS organisations respond to the deaths of service users in their care. This culminated in the release of a 'Learning from deaths framework' which was published by the National Quality Board (NQB) in 2017. The ongoing implementation of the requirements of this framework will be monitored on a quarterly basis via the Patient Safety Group.

All NHS Trusts are now required to publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis, which are in-scope of the learning from deaths policy, and also the proportion of those deaths which were subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all of the deaths categorised as 'in scope for the learning from deaths policy' are subject to an initial clinical review before determining if they require further investigation.

3. KEY ISSUES:

3.1 Identification of deaths to be reviewed

We have continued to observe an increase of the numbers of deaths that are now reported through our incident management system (over and above the unexpected deaths that have always been reported via this route). This is a positive development as it allows a greater number of incidents to be channelled through our mortality review process which, in turn, will lead to greater opportunities for learning.

3.2 Mortality Review

Our current approach to mortality review is to identify those service users on the Care Programme Approach who have died but do not fall into the category of a Serious Incident. To date there have been 119 reviews undertaken during 2018/19 which has exceeded the total of 108 reviews undertaken in 2017/18. This reflects both the increased reporting of deaths and improvements to the Trust mortality review processes.

3.3 Appendix 1: Dashboard

The revised learning from deaths dashboard is attached at Appendix 1 which also now includes 2017/18 data. For Q2 2018/19 the dashboard highlights the following:

- 549 deaths were recorded in total
- 31 serious incident reviews were completed
- 18 learning points* were identified from the 31 serious incidents
- 66 cases were reviewed as part of the mortality review process
- 6 learning disability deaths (community) were reviewed and also reported to LeDeR however there were 8 community deaths not reported through our system in Q2 for which we are requesting further information to ensure all necessary reviews can be undertaken.

We are currently reviewing approximately 19% of total deaths per quarter. This will be a discussion point at the upcoming regional mortality group at the end of January 2018 to determine how this compares with our regional peers.

*For the purpose of this report the learning identified from Serious Incidents has been categorised as those cases which concluded with either a root cause or contributory finding meaning the outcome *may* have been different if different decisions had been made or different circumstances in place.

3.4 National Quality Board Guidance for NHS trusts on working with bereaved Families and Carers

Work continues to implement the recommendations from the National Quality Board (NQB) guidance for NHS trusts on working with bereaved families and carers which was published in July 2018. The work is being monitored by the Patient Safety Group and a more detailed progress update will be included in the Q3 Learning from Deaths board report.

4.0 Learning from reviews

During Q1 & Q2 2018/19 there were 65 Serious Incident reviews completed and 119 mortality reviews. Of those mortality reviews undertaken 19 (16%) were 'stepped up' to a structured judgement review.

For the Serious Incidents reviewed in the period the most common finding overall was related to the risk assessment and management process. Within this some related to a lack of consideration given to risk factors, inadequate formulation and to poor care planning/ intervention. The second commonest theme was regarding communication/information sharing and this was split relatively evenly between failure to communicate between team members / between different teams / regarding escalating risks and with others (e.g. family, GP, multi-agency). Formal action plans are in place for all incidents with a root cause or contributory finding which are closely monitored by Patient Safety and also our commissioners. Key messages regarding the findings from incidents are shared via the patient safety bulletin. The director of quality governance is also attending LMGB meetings to share and discuss both locality and trust wide information, provide support and seek additional assurance that key issues are understood and being learned from.

The themes from the mortality reviews were more aligned to issues with physical health which is in keeping with the profile of the majority of patients reviewed through this process who typically have multiple co-morbidities. One of the key learning points

identified from these reviews is the number of very frail elderly patients residing in residential or nursing homes who remain on CPA but have minimal contact with our services. This issue has been passed to the MHSOP SDG to review and propose how this can be addressed. During Q2 2018/19 we sent 2 of our more detailed structured judgement reviews back to relevant commissioners where we identified learning points for other providers following our review of care and treatment**.** It was pleasing to note that in the majority of the structured judgement reviews undertaken it actually confirmed that appropriate care and treatment had been provided – letters have been sent to teams where this had been the case.

Detailed analysis of all themes from both serious incident and mortality reviews for 2018/19 and comparison with previous years will be provided in the annual patient safety report in May 2019.

5.0 IMPLICATIONS:

5.1 **Compliance with the CQC Fundamental Standards:**
CQC look at a range of data to help them monitor trusts that provide mental health services. This report provides evidence in respect of Regulation 17 – Good Governance.

5.2 **Financial/Value for Money:**
There are financial and reputational implications associated with poor standards of quality service.

5.3 **Legal and Constitutional (including the NHS Constitution):**
CQC's Fundamental Standards in respect of Regulation 17 - Good Governance.

5.4 **Equality and Diversity:**
Feedback received associated with discrimination is, where this is apparent, forwarded for review by the Equality and Diversity lead.

5.5 **Other implications:** No other implications identified.

6. RISKS: There is a risk that the data published is compared by others with the data of other organisations who may not provide similar services.

7. CONCLUSION:
This report contains the trust information relating to the national learning from deaths agenda. Work continues to ensure the numbers of deaths reported (both in and out of scope) are as accurate as possible to allow us to gain maximum learning from this process. There will be an enhanced focus on ensuring that all deaths in the community of people with a learning disability are reported through our incident management system.

The main learning points from the reviews have already been shared with the Executive Management Team and are in the process of being cascaded via each Locality Management Governance Board. This will ensure staff are aware of both their own incidents and associated learning and also that of the rest of the organisation.

8. RECOMMENDATIONS:

The Board of Directors is requested:

- to note the content of this report, the dashboard and the areas for ongoing improvement
- to note the learning points from investigations undertaken in Q1 & Q2 2018/19

Jennifer Illingworth
Director of Quality Governance
January 2019

Background Papers:

NQB Learning from Deaths – Guidance for NHS trusts on working with bereaved families and carers
https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/

Learning From Deaths Framework
https://www.england.nhs.uk/?s=Learning+from+Deaths

Trust Learning from deaths policy
http://www.tewv.nhs.uk/site/search-results?query=learning+from+deaths+policy

Southern Health Report
https://www.england.nhs.uk/2015/12/mazars/

Serious Incident Framework
https://www.england.nhs.uk/?s=serious+incident+framwework

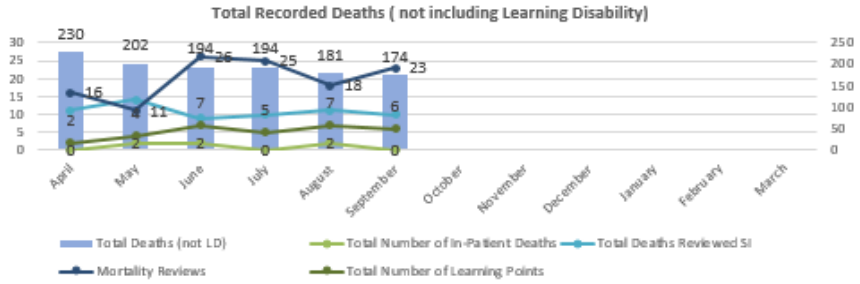
Appendix 1 Current Dashboard

Learning from Deaths Dashboard - Data Taken from Paris and Datix **Reporting Period - Quarter 2 - July - September 2018**

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

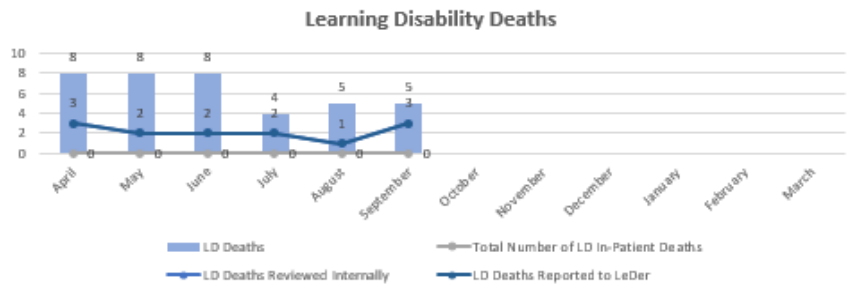
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18
Q1	626	↗ 539	4	↗ 2	34	↗ 17	53	↗ 26	13	↗ 9
Q2	549	↗ 521	2	↘ 3	31	↗ 16	66	↗ 26	18	↗ 7
Q3	-	568	-	6	-	30	-	28	-	12
Q4	-	678	-	5	-	36	-	28	-	16
YTD	1175	2306	6	16	65	99	119	108	31	44



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18
Q1	24	↗ 10	0	⇔ 0	7	↗ 0	7	↗ 5
Q2	14	↗ 12	0	⇔ 0	6	↗ 3	6	↗ 4
Q3	-	14	-	1	-	3	-	7
Q4	-	11	-	0	-	6	-	4
YTD	38	47	0	1	13	12	13	20



Item 12

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**29 January 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 31 December 2018**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 December 2018 is a surplus of £7,239k, representing 2.8% of the Trust's turnover and is £610k ahead of the revised NHSI plan.

Performance Against Plan – year to date (3.2)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £610k **ahead** of its year to date financial plan.	-610	-7	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are £179k **behind** financial plan.	Recurrent	4,490	↑
	Non recurrent	-4,311	→
	Target	0	
	Variance	179	↑

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the rolling 3 year period are £14,709k **behind** the £21,000k CRES target.	Recurrent	14,709	↑

A Waste Reduction Programme has been established to assist the Trust in delivering the current year CRES requirements in full, and a 3 year recurrent CRES plan. The 3 year CRES target will be updated once the business planning process has concluded in January.

Capital (3.4)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £787k **behind** its capital plan.	787	685	↑

Expenditure against the capital programme to 31 December 2018 is £10,038k and is £787k behind plan due to in-month slippage on two schemes, combined heat and power and York and Selby inpatient facility plus a delayed start on Middlesbrough crisis assessment suite. These are partially offset by expenditure incurred on I.T. licenses.

The Trust received a capital rebate relating to prior year schemes (£2,289k) and has incurred £2,936k expenditure relating to Roseberry Park rectification work. With these included, capital expenditure is £140k behind plan.

Workforce (3.5)

	Variance £000	Monthly Movement £000	Movement
The Trust is currently £2,420k (56%) **in excess** of its agency cap.	2,420	384	↓

Agency expenditure remains high in month 9 across all localities, nursing agency expenditure accounts for 71% of the variance and is used to support vacancies and enhanced observations with complex clients.

Use of Resources Risk Rating (UoRR) (3.7)

	Plan	Actual	Movement
The Trust is currently **behind** its planned UoRR which is rated 1 to 4 with 1 being good.	1	3	→

The UoRR for the Trust is assessed as 3 for the period ending 31 December 2018 and is behind plan (Table 4). The agency position exceeds the 50% NHSI cap and is rated as a 4. As a result the Trust's highest achievable rating is overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remains behind plan due to agency expenditure. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**29 January 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 31 December 2018**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2018 to 31 December 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to monitor the Trust's key financial duties and performance indicators which are both statutory requirements.

2.2 NHS Improvement's Use of Resources Rating (UORR) evaluates Trusts based on ability to service debt, liquidity, I&E margin, achievement of planned I&E margin and agency expenditure.

3. KEY ISSUES:

3.1 Key Performance Indicators

The Trust is achieving the control total set by NHSI.

The UoRR for the Trust is assessed as 3 for the period ending 31 December 2018 and is behind plan. The agency position exceeds the 50% NHSI cap and is rated as a 4. As a result the Trust's highest achievable rating is overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remains behind plan due to agency expenditure.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 December 2018 is a surplus of £7,239k, representing 2.8% of the Trust's turnover and is £610k ahead of the revised NHSI plan.

Table 1

	Annual Plan	Year to Date Plan	Year to Date Actual	YTD Variance	November Variance
	£000	£000	£000	£000	£000
Income From Activities	(336,370)	(247,049)	(246,677)	372	328
Other Operating Income	(16,115)	(12,738)	(12,888)	(149)	(240)
Total Income	**(352,485)**	**(259,787)**	**(259,565)**	**223**	**88**
Pay Expenditure	265,161	198,687	197,660	(1,027)	(776)
Non Pay Expenditure	68,361	47,116	47,555	439	285
Depreciation and Financing	9,100	7,356	7,110	(245)	(201)
Variance from plan	**(9,863)**	**(6,629)**	**(7,239)**	**(610)**	**(603)**

The above table does not include the PFI termination impact. This is still under discussion with NHSI.

3.3 Cash Releasing Efficiency Savings (CRES)

The Trust's performance against the 2018/19 CRES target is shown in Table 2 below. The Trust is behind plan (£179k) and continues to identify schemes to ensure full delivery of recurrent CRES requirements.

Table 2	**CRES Type**	**Annual Variance £000**	**Movement**
Identified CRES schemes for the financial year are £179k **behind** financial plan.	Recurrent	4,490	
	Non recurrent	-4,311	
	Target	0	
	Variance	179	

3.4 Capital

Expenditure against the capital programme to 31 December 2018 is £10,038k and is £787k behind plan due to in-month slippage on two schemes, combined heat and power and York and Selby inpatient facility plus a delayed start on Middlesbrough crisis assessment suite. These are partially offset by expenditure incurred on I.T. licenses.

The Trust received a capital rebate relating to prior year schemes (£2,289k) and has incurred £2,936k expenditure relating to Roseberry Park rectification work. With these included, capital expenditure is £140k lower than planned.

3.5 Workforce

Table 3 below shows the Trust's performance on some of the key financial drivers identified by the Board.

Table 3	**Pay Expenditure as a % of Pay Budgets**						
Tolerance	Tolerance Dec-18	Jul	Aug	Sep	Oct	Nov	Dec
Establishment (a) (90%-95%)	93.37%	92.77%	92.72%	92.31%	93.46%	93.96%	93.37%
Agency (b)	1.00%	2.98%	3.05%	3.19%	3.25%	3.40%	3.40%
Overtime (c)	1.00%	1.12%	1.13%	1.11%	1.09%	1.07%	1.10%
Bank & ASH (flexed against establishment) (100%-a-b-c)	4.63%	2.93%	2.98%	3.09%	3.13%	3.22%	3.20%
Total	**100.00%**	**99.80%**	**99.88%**	**99.70%**	**100.93%**	**101.65%**	**101.01%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For December 2018 the tolerance for Bank and ASH is 4.63% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 31 December 2018 is £6,762k which is £2,420k (56%) in excess of the agreed year to date capped target of £4,342k. Nursing agency expenditure accounts for 71% of the variance and is used to support vacancies and enhanced observations with complex clients. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

3.6 Cash

Total cash at 31 December 2018 is £70,112k, and is £6,255k higher than planned, largely due to working capital variations.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The UoRR for the Trust is assessed as 3 for the period ending 31 December 2018 and is behind plan. The agency position exceeds the 50% NHSI cap and is rated as a 4. As a result the Trust's highest achievable rating is overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remains behind plan due to agency expenditure. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

Table 4: Use of Resource Rating at 31 December 2018

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

TEWV Performance	Actual Achieved	Actual Rating	YTD Plan Planned	YTD Plan Rating	RAG Rating
Capital service cover	1.61x	3	1.46x	3	
Liquidity	45.7 days	1	48.4 days	1	
I&E margin	2.8%	1	2.6%	1	
I&E margin distance from plan	0.2%	1	0.0%	1	
Agency expenditure	£6,762k	4	£4,342k	1	
Overall Use of Resource Rating		**3**		**1**	

3.7.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.61x (can cover debt payments due 1.61 times), which is ahead of plan and rated as a 3.

3.7.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 45.7 days; this is behind plan and is rated as a 1.

3.7.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 2.8%, which is ahead of plan and rated as a 1.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding PSF income. The Trust I&E margin distance from plan is 0.2% which is ahead of plan and rated as a 1.

3.7.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 56% higher than the capped target and is rated as a 4.

The margins on UoRR are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £1,253k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £40,252k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £610k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £610k is required.
- Agency Cap rating – to improve to a 3 a reduction in agency expenditure of £250k is required.

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 At the end of December the Trust is £610k ahead of the revised control total submitted to NHSI.

6.2 The amount of CRES identified for the financial year and rolling 3 year period is below required levels; however, the Trust continues to identify schemes to ensure full delivery of recurrent CRES requirements.

6.3 The UoRR for the Trust is assessed as 3 for the period ending 31 December 2018 and is behind plan. The agency position exceeds the 50% NHSI cap and is rated as a 4. As a result the Trust's highest achievable rating is overridden as a 3. Excluding this override the Trust would be assessed as a rating of 2 which remains behind plan due to agency expenditure. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

7. RECOMMENDATIONS:

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

Patrick McGahon
Director of Finance and Information

ITEM 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th January 2019**
TITLE:	**Board Dashboard as at 31st December 2018**
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:

Recommendations:

MEETING OF:	**Board of Directors**
DATE:	**29th January 2019**
TITLE:	**Board Dashboard as at 31st December 2018**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st December 2018 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. Definitions of the KPIs within the dashboard are provided in Appendix B.

2. KEY ISSUES:

2.1 Performance Issues

The key issues in terms of the performance reported are as follows:

- As at the end of December 2018, 4 (22%) of the indicators reported are not achieving the expected levels and are red across three domains excluding workforce. This is a slight deterioration on the 3 that were reported as at the end of November but is still a much improved position from the position reported earlier in the year. In addition there are 9 KPIs (50%) that whilst not achieving the target are within the 'amber' tolerance levels, which is one less than that reported as at the end of November.

  Of the 13 indicators that are either red or amber 5 (56%) are showing an improving trend over the previous 3 months.

  The year to date position is that there are 6 KPIs (33%) which are reported as red which is the same number as the position reported as at the end November.

- In terms of the Single Oversight Framework targets the Trust achieved all the operational targets in December and for Quarter 3 at Trust level. Specific issues are as follows:
  - The 7 day follow up following discharge was not achieved in 4 CCGs in November, and 2 for Quarter 3 as a whole, but there are no specific concerns in terms of trends.
  - Access to Early Intervention in Psychosis – we failed to achieve the target in December in the North Yorkshire Services and DDES CCG service. However for the Quarter 3 position as a whole it was only not achieved in the North Yorkshire services. There has continued to be particular challenges regarding staffing across in the North Yorkshire Services however the staffing position has started to improve so referrals have now returned to the specific EIP team, rather than the generic community team, and it is expected that performance will improve as a consequence.
  - IAPT/Talking Therapies – proportion of people completing treatment who move to recovery" – There were three CCGs areas where the target was not achieved in December (DDES CCG, Scarborough and Ryedale CCG and Vale of York CCG). For Quarter 3 as a whole we did not achieve target in only two CCG areas (DDES and Vale of York). Work continues in York to implement the IAPT action plan however the current focus is on increasing access rates whilst maintaining waiting times. In the service for DDES CCG specific work has taken place with individual members of staff which saw the position in December improve from that in November.
  - IAPT/Talking Therapies – waiting time to begin treatment within 6 weeks – the target was not achieved by the service in Scarborough & Ryedale CCG in December and for Quarter 3 as a whole. The service is receiving a high number of referrals which is exceeding the capacity available. Discussion have been ongoing with the CCG and additional resource has been agreed which should help to address the position in the coming months.
  - Inappropriate Out of Area Occupied Bed Days – the target was not achieved in 3 CCGs areas in December and for Quarter 3. These all

related to 'Internal' Out of Area admissions i.e. admissions within other areas of the Trust. There were no patients admitted externally from the Trust due to pressure on beds.

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

- The outstanding KPIs around activity have now been included within the Dashboard and will be monitored for the remainder of this financial year. Discussions will take place on whether 'targets' should be set for these indicators in 2019/20.

2.3 Key Risks

- Waiting times (KPI 1 and 2) – Both indicators are currently worse than target (although within the amber tolerance range). There are some areas where achieving the targets is more of a challenge. A 'deep dive' report will be presented to the Board in February 2019 as requested at the October Board meeting.
- %age of patients reporting their experience as excellent or good (KPI 4) – Performance of this indicator has continued to decline in the month of December to one of the lowest points over the past two years. The outliers are Forensic Services, North York and York and Selby. Each have got specific actions they are taking forward in order to improve the feedback they are getting from patients surveyed.
- Number of Unexpected Deaths Classed as a Serious Incident (KPI 5) – This still remains worse than target with a significant increase in the rate and the absolute number in December. There were 17 unexpected deaths classed as a SUI in December compared to 10 in November. Whilst the vast majority (11) of the deaths occurred in Durham and Darlington there are no specific trends noted for December (i.e. no common wards or teams).
- Outcome Indicators (KPIs 6 and 7) – Performance against the two outcome indicators (clinically reported (HONOS) and patient reported (SWEMWEBS) continues to be worse than target with both showing a deterioration in December. A dedicated Performance Improvement Group was held in early December which focused specifically on Outcomes. A number of actions were agreed including the continuation of work with services to improve understanding and support increased ownership within services and the provision of a key set of information to be reported at the various huddles including both OMT and EMT started in January. A paper has been drafted about the Trust's current position on outcomes with some recommendations and options of how we might take this forward across the Trust's services. This paper will be discussed at the Clinical Leaders Board in January 2019 in order to agree a way forward.
- Bed Occupancy (KPI 12) – Whilst the position continues to be worse than the target there has been continued improvement in December such that the position is the best in the year to date (although higher than the same point in 2017/18). Whilst the monthly aggregate figure is positive there are particular challenges within Teesside. All localities are monitoring bed

occupancy daily and are ensuring that admissions over 30 day length of stay are reviewed to ensure they remain appropriate or if further action is required to support discharge however there are a number of complex patients on the wards who do required longer lengths of stay. In addition work across the localities is taking place as part of improving our approach to bed management in order to support the reprovision of inpatient services from the Friarage which commenced in January 2019.

- Sickness Absence Rate (KPI 19) – the Trust continues not to achieve target and the performance reported in December (sickness in November) is a deterioration on the position reported in November. This follows the trend in previous years. A review of the Trusts approach to managing sickness absence has recently been concluded and a revised procedure for managing absence is currently being considered.
- Financial Targets (KPIs 21) – In the month of December (and Year to Date) we have not achieved the target for CRES delivery although an improvement has been seen compared to the previous month. Work is ongoing via the Programme Board to identify further recurrent CRES schemes and it is expected that the target will be achieved by the year end.

2.4 Data Quality Assessment.

The data quality assessment of the Dashboard indicators is included in Appendix D. A process is to be established from January 2019 to routinely review this assessment and identify any changes on a more regular basis.

3. RECOMMENDATIONS:

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

Appendix A

Quality

	December 2018				April 2018 To December 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90.00%	88.10%			90.00%	87.12%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	56.96%			60.00%	55.74%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,326.00	1,524.00			2,326.00	1,524.00		2,326.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	89.84%			92.45%	91.28%		92.45%
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	3.11			9.00	17.49		12.00
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	67.25%	57.84%			67.25%	56.59%		67.25%
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	78.25%	71.43%			78.25%	67.50%		78.25%

Activity

	December 2018				April 2018 To December 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
8) Number of new unique patients referred		6,192.00				63,003.00		
9) The number of new unique patients referred with an assessment completed		3,931.00				39,291.00		
10) Number of new unique patients referred and taken on for treatment		1,280.00				13,717.00		
11) Number unique patients referred who received treatment and were discharged		1,982.00				20,866.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	89.28%			85.00%	94.03%		85.00%

Trust Dashboard Summary for TRUST

	December 2018				April 2018 To December 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	68.00	67.00			68.00	67.00		68.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.93%	28.72%			23.93%	23.72%		23.93%

Workforce

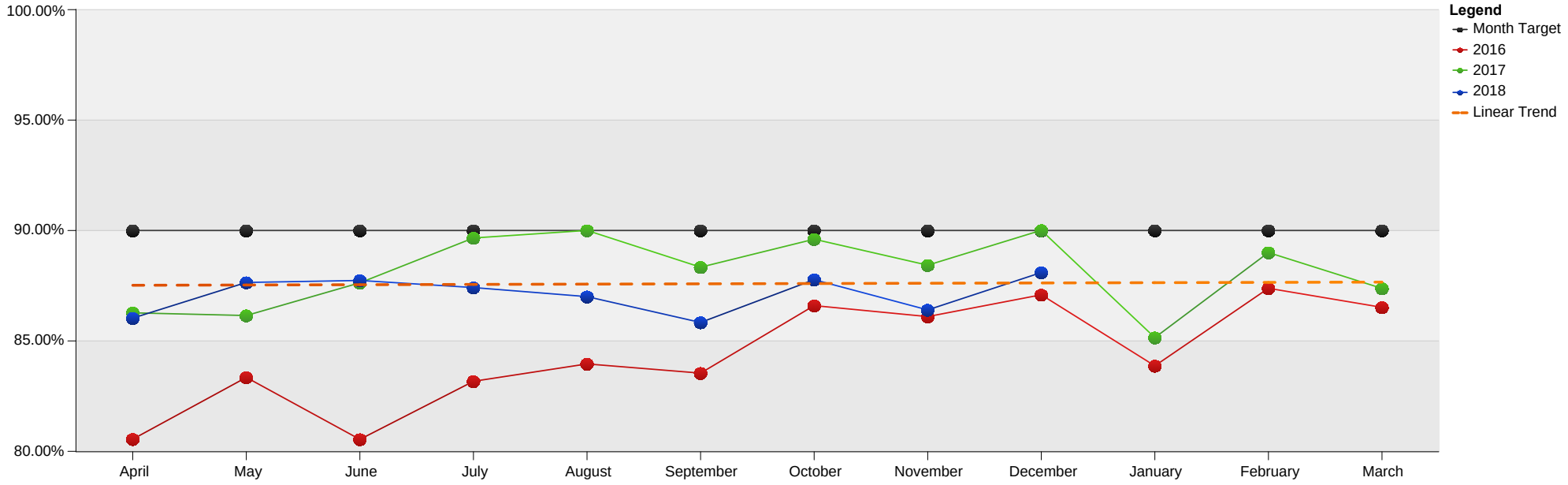
	December 2018				April 2018 To December 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	93.37%			95.00%	93.37%		95.00%
16) Vacancy fill rate	90.00%	84.71%			90.00%	79.60%		90.00%
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.25%			95.00%	92.25%		95.00%
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	92.11%			92.00%	92.11%		92.00%
19) Percentage Sickness Absence Rate (month behind)	4.50%	5.13%			4.50%	4.89%		4.50%

Money

	December 2018				April 2018 To December 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
20) Delivery of our financial plan (I and E)	-946,000.00	-951,358.00			-6,630,000.00	-7,238,991.00		-9,864,000.00
21) CRES delivery	686,782.00	540,953.00			6,181,038.00	4,777,432.00		8,241,384.00
22) Cash against plan	61,798,500.00	72,167,000.00			61,798,500.00	72,167,000.00		56,640,000.00

Trust Dashboard Graphs for TRUST

1) % of patients who were seen within 4 weeks for a 1st appointment following an external referral

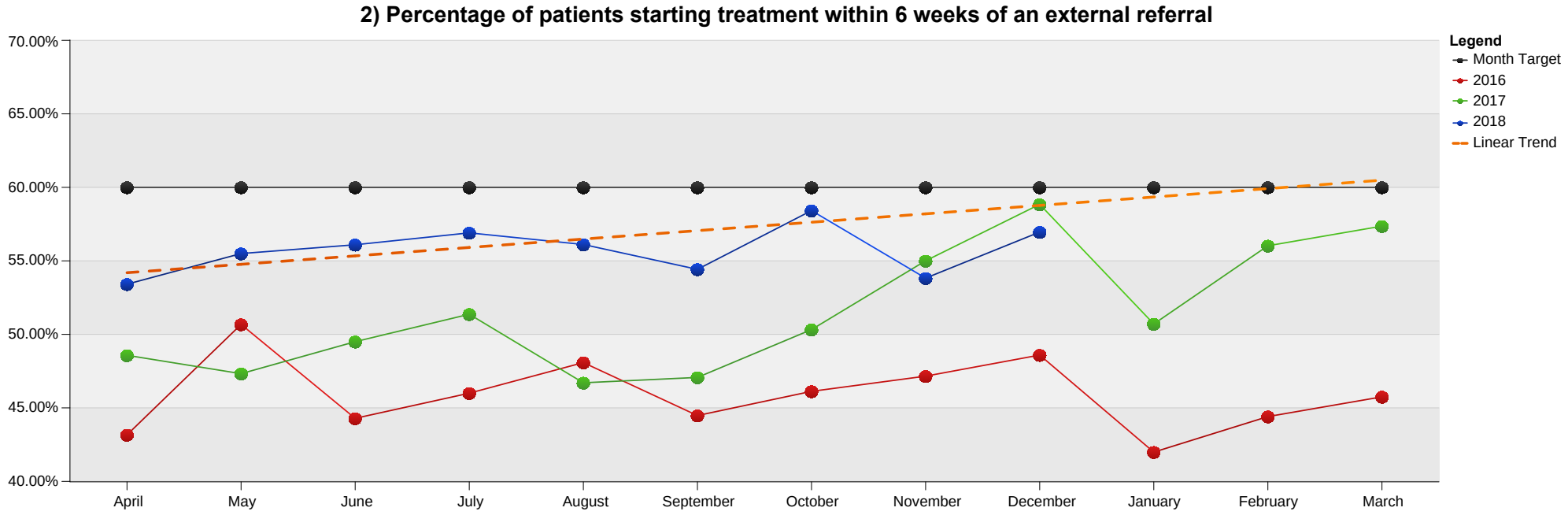


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	88.10%	87.12%	86.15%	86.45%	92.53%	91.86%	76.53%	75.74%	100.00%	99.50%	86.41%	81.40%		

Narrative

The position for December 18 is 88.10% relating to 4840 patients out of 5494 who were seen within 4 weeks. This is worse than the target of 90% however an improvement on the position reported in November 18 and the best position in the year to dateAreas of concern:• York AMH at 78.54% (161 of 205 patients) 44 patients were not seen within 4 weeks which is a continued deterioration on the 82.87% reported in November 18. Performance continues to be impacted by the high DNA rate, sickness and vacancies and an agency worker is in place. Data quality issues are being investigated. • Yorkshire AMH at 66.67% (234 of 351 patients) 117 patients were not seen within 4 weeks. This is a deterioration compared to the 71.50% reported in Oct / Nov. The Service had a peak in referrals in November which has impacted on December waiters and also 6 weeks waiters. Sickness and vacancies have also impacted, and recruitment is in progress. • North Yorkshire MHSOP at 78.64 (365 of 481 patients) 116 patients were not seen within 4 weeks. This is a continued improvement on the 75.88% reported in November 18. MHSOP have a number of staffing issues and plans are in place.• Durham and Darlington AMH at 63.36% (275 out of 434 patients) 159 patients were not seen due to a high number of referrals, staff sickness and vacancies. Capacity will increase through the recruitment of fixed term staff.

Trust Dashboard Graphs for TRUST

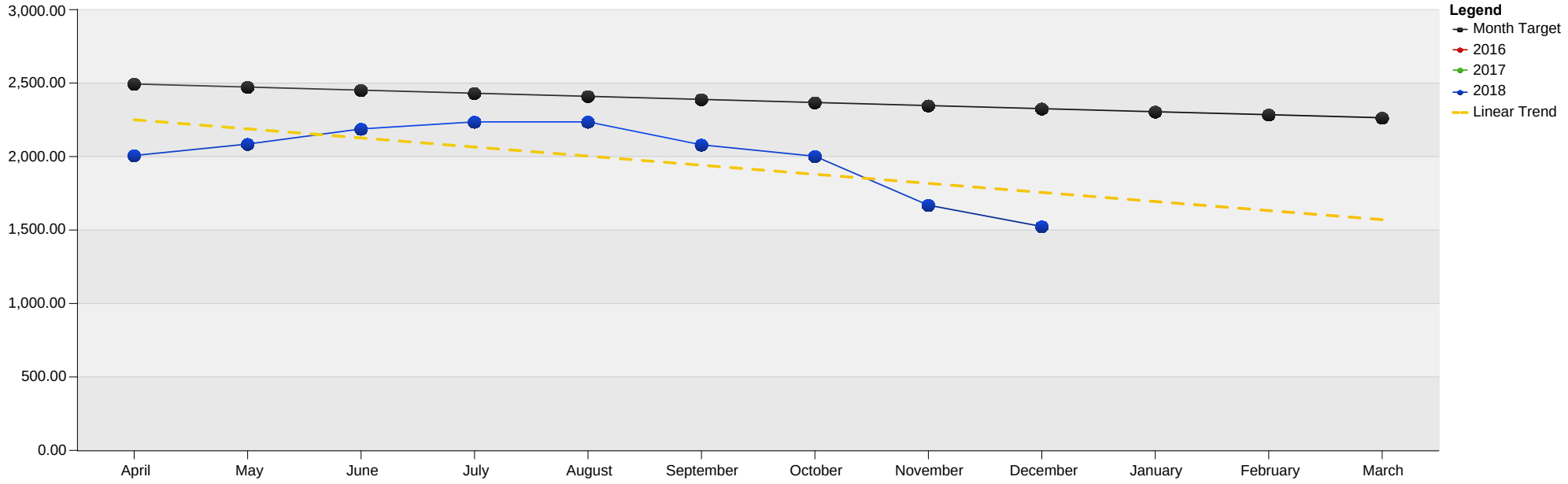


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients starting treatment within 6 weeks of an external referral	56.96%	55.74%	54.68%	53.97%	64.20%	63.68%	43.89%	46.16%	93.94%	91.21%	55.70%	46.64%		

Narrative
The Trust position for December 2018 is 56.96%, which is worse than the target however an improvement on the position reported in November 18. All localities, with the exception of Teeside and Forensic services, are below target. The logic to support the reporting of this indicator has been reviewed and this has resulted in a change in the reported position. This was due to an error in the construction of this metric and appropriate action has been taken to prevent a recurrence. Revised data is being discussed in huddles and monitoring mechanisms are being put in place.All data has been subject to refresh including previous years as data was being under reported

Trust Dashboard Graphs for TRUST

3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)

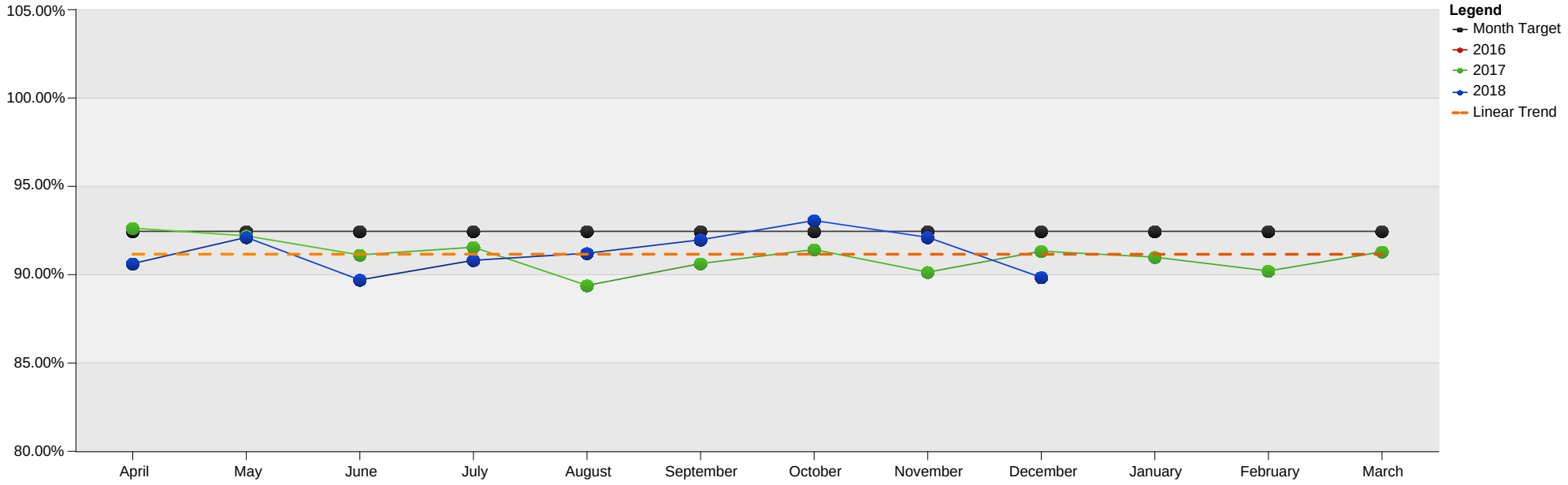


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	1,524.00	1,524.00	173.00	173.00	688.00	688.00	401.00	401.00			258.00	258.00		

Narrative
The Trust position for December 18 is 1,524 which is meeting the target of 2,326 and is an improvement on the November position.Durham and Darlington is the only locality not meeting target. – 173 occupied bed days (30 AMH and 143 MHSOP. This relates to 6 patients admitted out of area over the 3 month period, 5 MHSOP and 1 AMHBoth areas continue to have a number of patients from the other 3 localities admitted to their beds. As a result they have had to find alternative beds for patients from the home areas. Work continues to return patients to their home area. All localities are monitoring this on a continual basis with actions agreed in daily huddles. There are two action plans agreed with commissioners (one for Durham & Darlington & Tees and one for North Yorkshire & York). These are managed jointly with the CCGs via the Contract Management Boards.

Trust Dashboard Graphs for TRUST

4) Percentage of patients surveyed reporting their overall experience as excellent or good

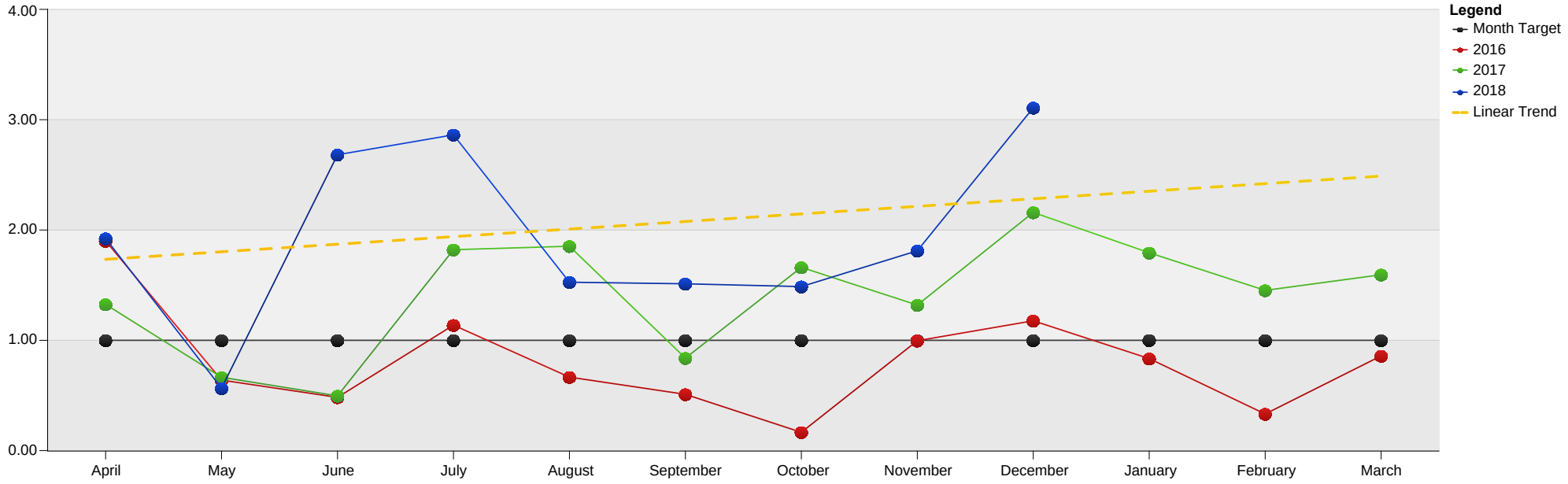


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	89.84%	91.28%	92.99%	92.64%	93.01%	92.30%	89.81%	92.02%	77.14%	80.99%	89.04%	89.47%		

Narrative
The Trust position for December 2018 is 89.84% which is not meeting the target of 92.45% and a deterioration on the position reported in November 18. This is one of the lowest positions reported in the year to date.Forensic Services, York and Selby and North Yorkshire are not meeting target. A member of staff from the Patient Experience Team is to meet with all York staff, as focused work progresses. Some QIS work is to be undertaken with LD and AMH are ensuring that patients receive surveys on discharge for both carer and service user, inviting people to reception to give feedback. A further update as to North Yorkshire will be provided in next months reportWithin Forensics work continues to ensure service users feel more actively engaged and connected in planning and reviewing their care and treatment which will improve experience ratings. Opportunities to capture learning from similar services continue to be explored.Please note due to changes with this indicator in 2016, this year is not displayed on the graph above.

Trust Dashboard Graphs for TRUST

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

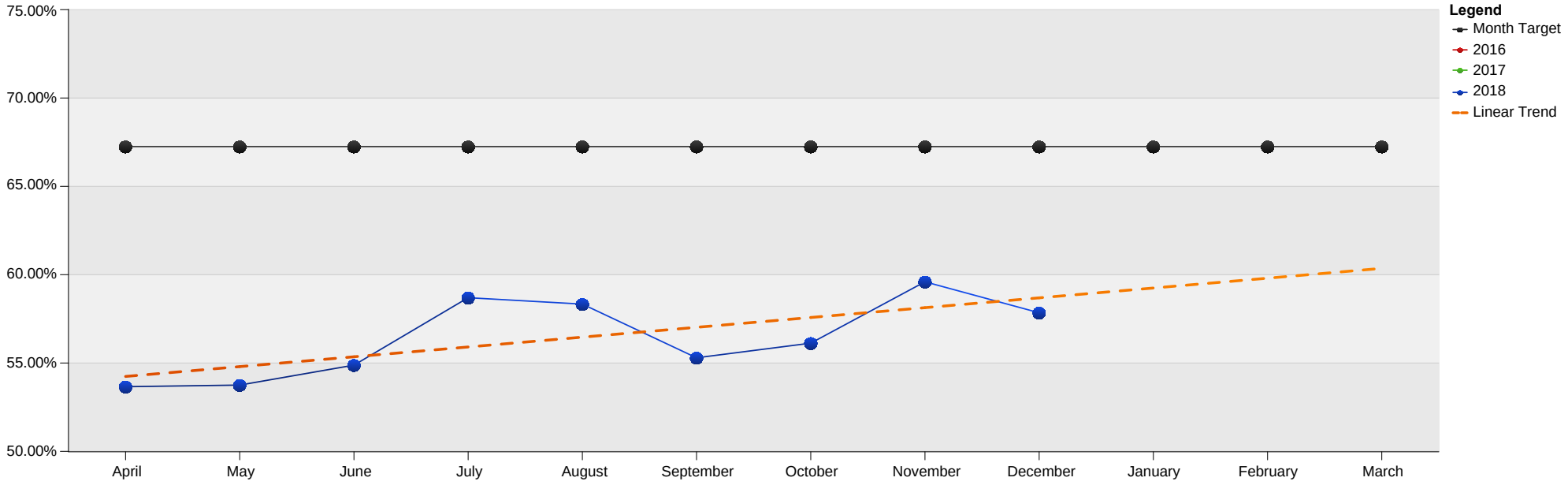


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	3.11	17.49	4.72	15.49	2.68	12.99	0.00	20.07	100.00	800.00	1.41	18.87		

Narrative
The Trust position for December 2018 is 1.81, which is worse than the expected number of 1.00 and the highest number of unexpected deaths reported since 15/16. This rate relates to 17 unexpected deaths in December which is an increase on the 10 recorded in November. The absolute number has increased by 7 in comparison to the figure in November. The Patient Safety Team is monitoring the overall trend for any particular patterns, which are monitored and discussed by the Patient Safety Group. Any findings will be reported in the in the 2018/19 Annual Patient Safety Report.Of the 17 unexpected deaths the details below shows a breakdown by locality:• 11 x Durham and Darlington• 4 x Teesside• 1 x York• 1 x ForensicOf the unexpected deaths that occurred in December, 13 occurred in AMH, 3 in MHSOP and 1 in Offender Health.

Trust Dashboard Graphs for TRUST

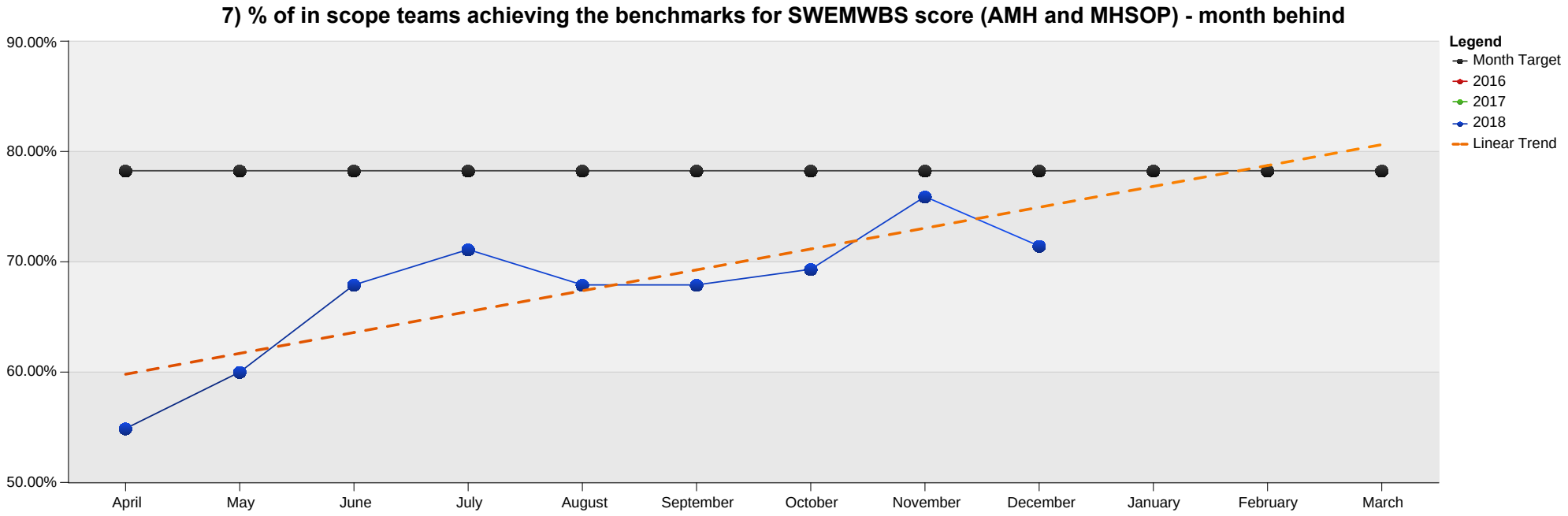
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	57.84%	56.59%	54.55%	50.20%	53.57%	60.79%	57.14%	60.34%			76.92%	54.26%		

Narrative
The Trust position for December 2018 is 57.84%, which is worse than the target of 67.25% and a deterioration on the position reported in November.Within this KPI an improvement in HONOS is shown by a decrease in the patient's actual HONOS score on PARIS. The change is identified by comparing the first HONOS score calculated on admission to TEWV, and the score on discharge.All localities are below target with the exception of Forensics, and Teesside report the lowest performance at 53.57%Actions were agreed at a dedicated Performance Improvement Group which was held in December 2018 which focused specifically on Outcomes. These included the continuation of work with the services to improve understanding and support increased ownership within services and the provision of a key set of information to be reported at the various huddles including both OMT and EMT which started in the New Year. A paper is being drafted about the Trust's current position on outcomes with some recommendations and options of how we might take this forward across the Trust's services. Further discussions will be held with the Clinical Leaders Board and EMT in early 2019 linked to this paper.

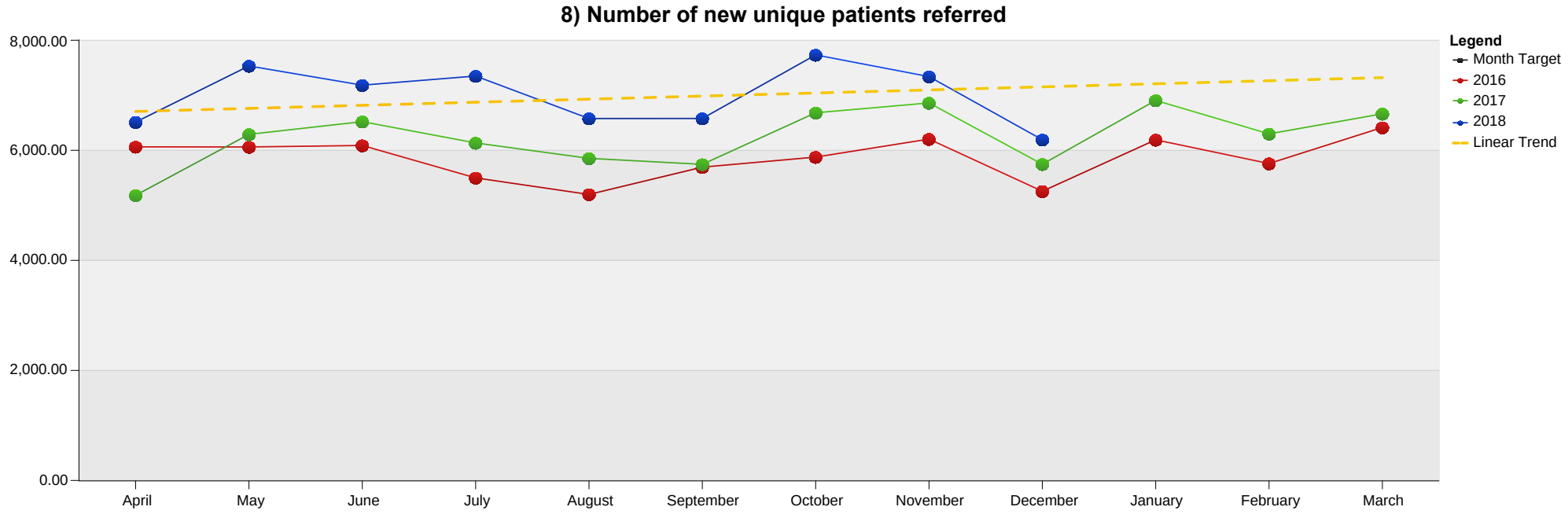
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	71.43%	67.50%	68.97%	64.29%	74.07%	67.74%	75.00%	72.94%			63.64%	61.90%		

Narrative
The Trust position for December 2018 is 71.43%, which is worse than the target of 78.25% and a deterioration on the position reported in November.Within this KPI, an improvement in SWEMWBS (which is a patient experience measure) is shown by an increase in the patient's actual SWEMWBS score. The change is identified by comparing the first SWEMWBS score calculated on admission, and the score on discharge.Actions were agreed at a dedicated Performance Improvement Group which was held in December 2018 which focused specifically on Outcomes. These included the continuation of work with the services to improve understanding and support increased ownership within services and the provision of a key set of information to be reported at the various huddles including both OMT and EMT which started in the New Year. A paper is being drafted about the Trust's current position on outcomes with some recommendations and options of how we might take this forward across the Trust's services. Further discussions will be held with the Clinical Leaders Board and EMT in early 2019 linked to this paper.

Trust Dashboard Graphs for TRUST

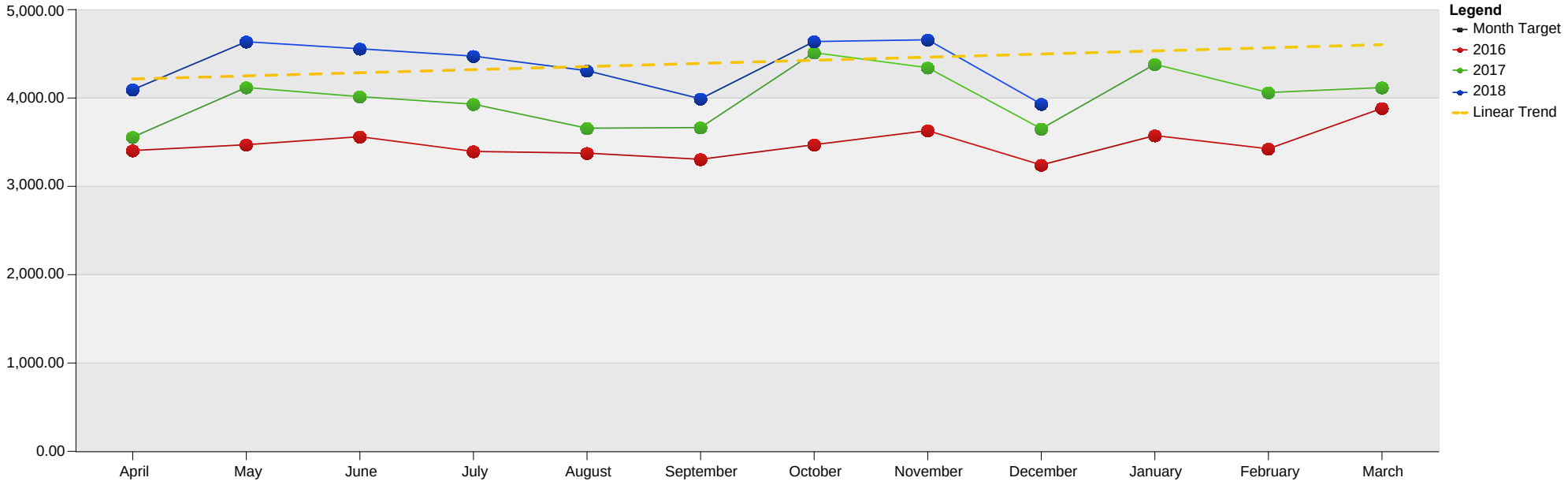


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Number of new unique patients referred	6,192.00	63,003.00	1,920.00	19,207.00	2,027.00	21,740.00	1,087.00	10,562.00	456.00	4,430.00	702.00	7,064.00		

Narrative
The Trust position for December 2018 is 6192 which is a reduction on the position reported for November; however the data shows that 2018/19 is higher than the previous two years. This indicator will be monitored for the remainder of this financial year and will be reviewed for the 19/20 Trust Dashboard. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

Trust Dashboard Graphs for TRUST

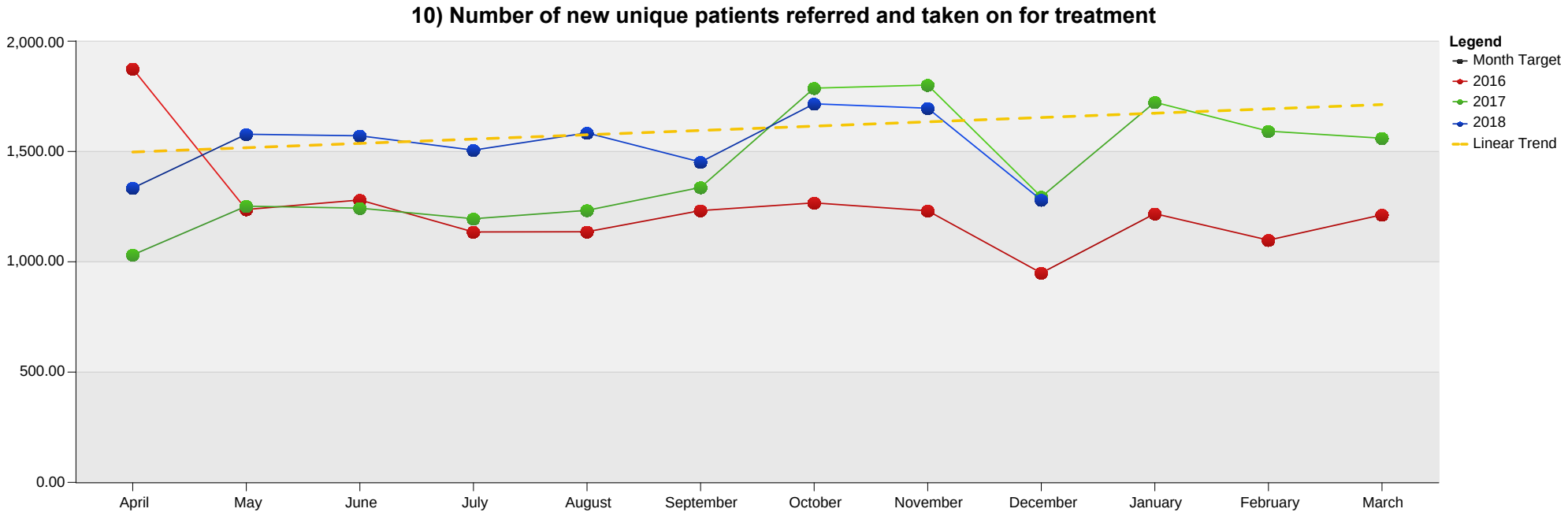
9) The number of new unique patients referred with an assessment completed



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The number of new unique patients referred with an assessment completed	3,931.00	39,291.00	1,212.00	11,740.00	1,309.00	13,766.00	687.00	6,319.00	338.00	3,244.00	385.00	4,222.00		

Narrative
The Trust position for December 2018 is 3931 which is a reduction on the position reported for November; however the data shows that 2018/19 is higher than the previous two years. This indicator will be monitored for the remainder of this financial year and will be reviewed for the 19/20 Trust Dashboard. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

Trust Dashboard Graphs for TRUST

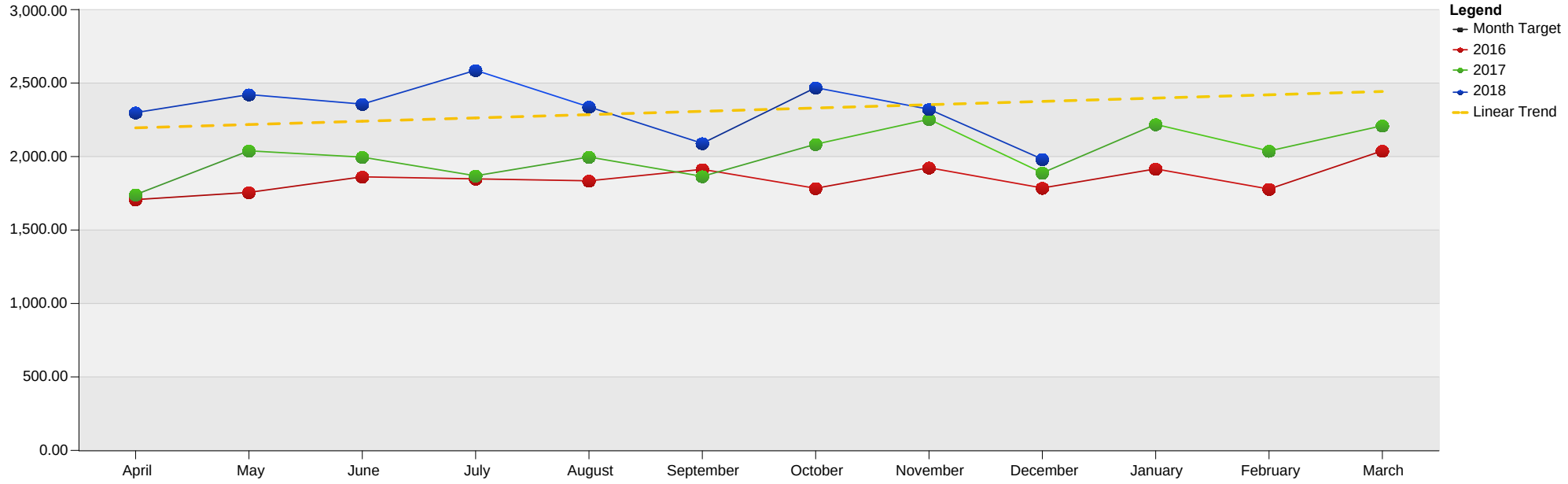


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Number of new unique patients referred and taken on for treatment	1,280.00	13,717.00	418.00	4,191.00	421.00	4,909.00	273.00	2,728.00	19.00	251.00	148.00	1,582.00		

Narrative
The Trust position for December 2018 is 1280 which is a reduction on the position reported for November. This indicator will be monitored for the remainder of this financial year and will be reviewed for the 19/20 Trust Dashboard. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

Trust Dashboard Graphs for TRUST

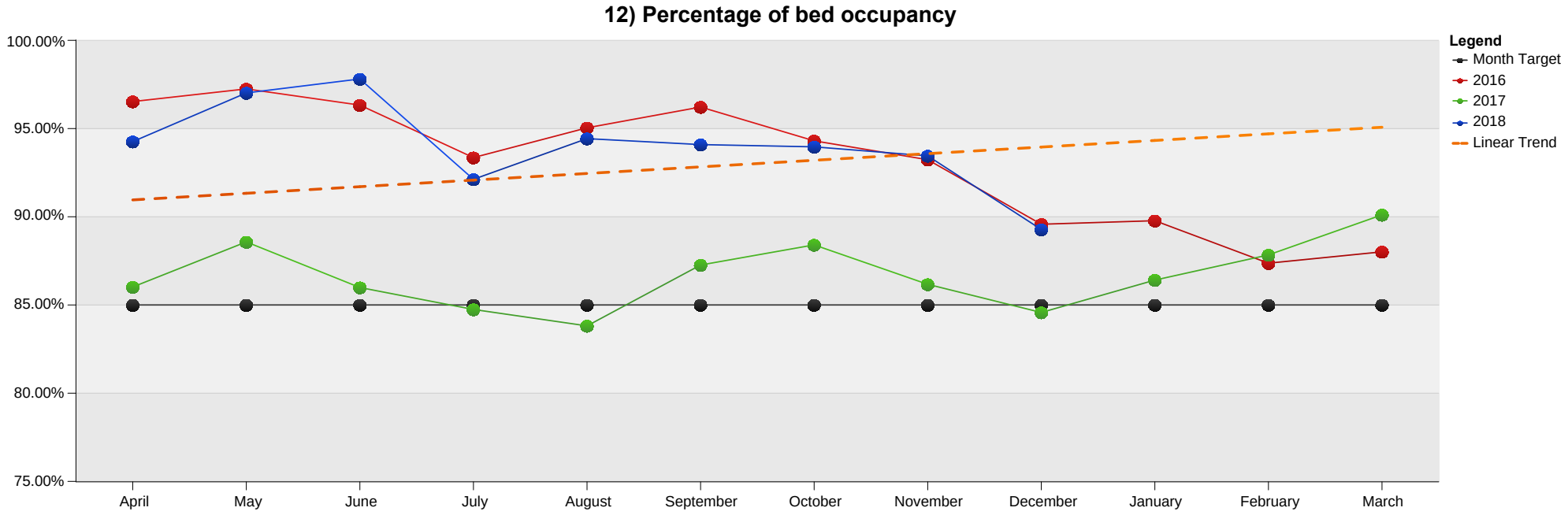
11) Number unique patients referred who received treatment and were discharged



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number unique patients referred who received treatment and were discharged	1,982.00	20,866.00	549.00	6,053.00	680.00	7,361.00	410.00	4,288.00	34.00	387.00	309.00	2,777.00		

Narrative
The Trust position for December 2018 is 1982 which is a reduction on the position reported for November. This indicator will be monitored for the remainder of this financial year and will be reviewed for the 19/20 Trust dashboard. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be monitored by EMT as well as the data being reviewed by localities.

Trust Dashboard Graphs for TRUST

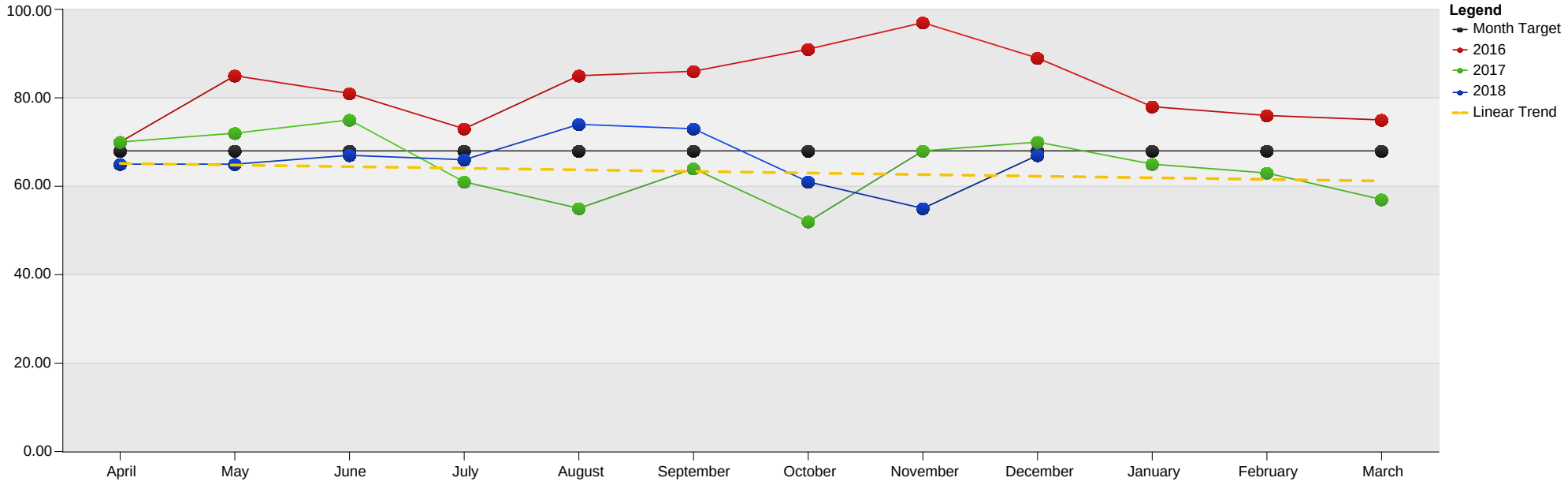


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	89.28%	94.03%	88.13%	92.29%	97.89%	101.74%	87.78%	92.27%	NA	NA	81.43%	88.96%		

Narrative
The Trust position for December 2018 is 89.28% which is worse than target however an improvement to the position reported in November 2018 and the lowest bed occupancy reported in the year to date.Tees are reporting the highest bed occupancy at 97.89%.This KPI is impacted by the number of patients occupying a bed with a length of stay greater than 90 days (KPI 13) and percentage of patients readmitted within 30 days (KPI 14). Within AMH there has been a significant number of detentions recently. In addition to this, the service has started to admit patients from Northallerton as ward 14 & 15 have now stopped taking admissions.All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

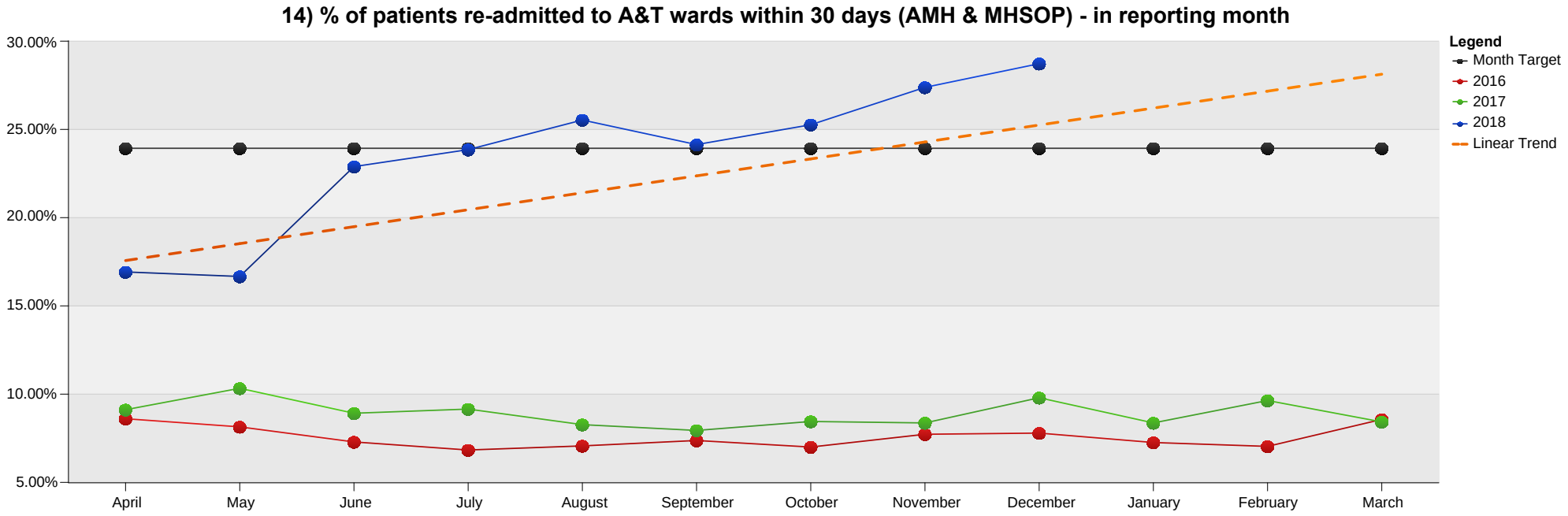
13) No. of patients occupying a bed with a LoS (from admission) > 90 days (AMH and MHSOP A&T Wards)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	67.00	67.00	17.00	17.00	15.00	15.00	19.00	19.00			15.00	15.00		

Narrative
The Trust position for December 2018 is 67 which is meeting the target of 68 however a deterioration on the 55 achieved in November 2018. Teesside are the only locality not meeting target: with 15 patients with a length of stay over 90 days (13 AMH and 8 MHSOP). This is under investigation and an update will be provided in next month's report.In North Yorkshire issues around finding suitable packages of care and also care home placements for patients upon discharge continue. In Hambleton & Richmondshire a new care manager has been appointed in the county council; therefore improvements are anticipated in the coming months. A number of complex patients requiring a longer length of stay that was appropriate to patient need continue to impact on the metric.

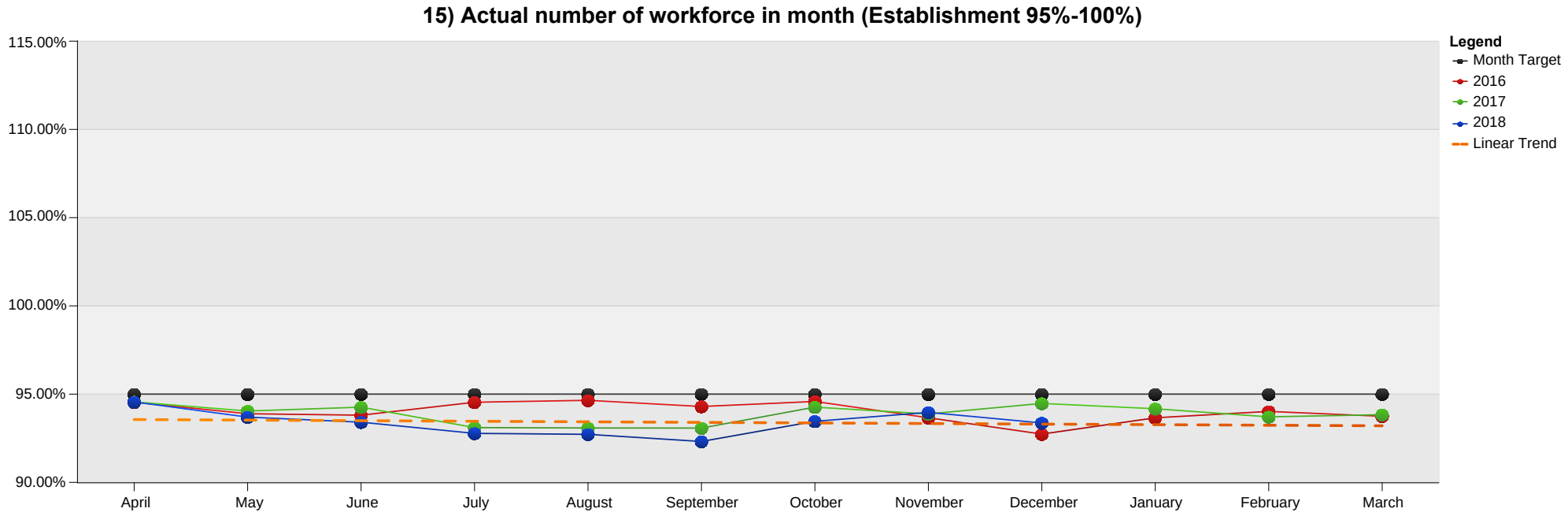
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	28.72%	23.72%	23.53%	22.14%	32.26%	24.29%	50.00%	24.26%			17.65%	23.70%		

Narrative
The Trust position ending December 2018 is 28.72%, which relates to 27 patients out of 94 that were readmitted within 30 days. This is within 10% of the target of 23.93% however a deterioration on the position achieved in November 2018. North Yorkshire are worse than target with a position of 50.00%. All readmissions for December had appropriate discharge plans in place but were complex patients and readmissions were clinically appropriate with the majority being formal readmissions. Teesside are also worse than target with a position of 32.26%; this is 7 patients out of 14 in AMH. There has been an increase in Mental Health Act detentions in AMH out of hours, the appropriateness of which the Service is to review as a piece of work alongside 3 or more admissions to try to put in a more robust process around the those patients who are admitted frequently.

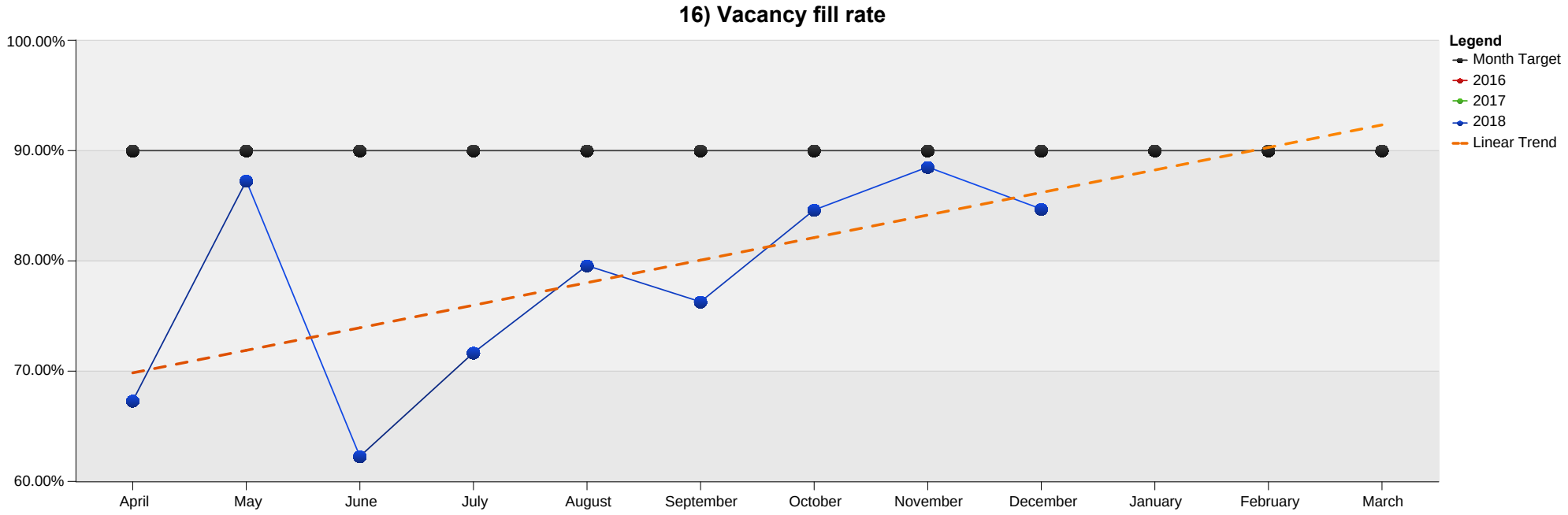
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Actual number of workforce in month (Establishment 95%-100%)	93.37%	93.37%	93.93%	93.93%	98.99%	98.99%	91.52%	91.52%	92.54%	92.54%	87.67%	87.67%		

Narrative
The Trust position for 31 December 2018 is 93.37% which is marginally worse than the targeted establishment level of 95-100%. It is expected that the establishment rate will continue to improve due to staff taking up post after completion of training and further recruitment events that will take place during 2019.

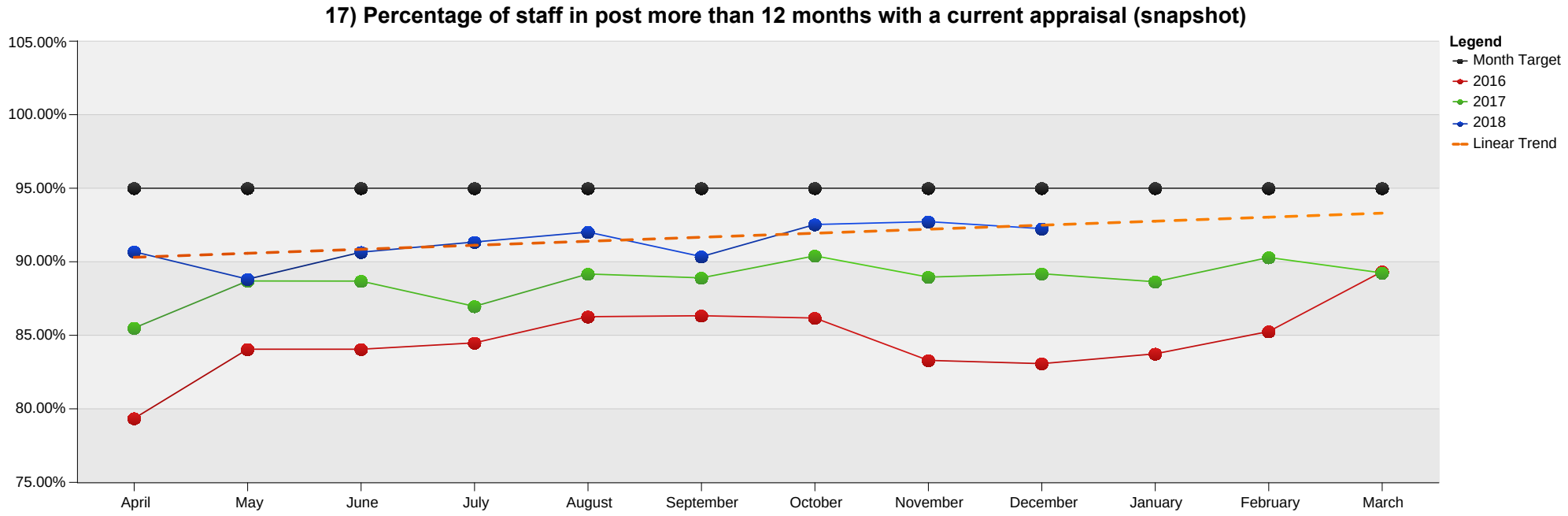
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Vacancy fill rate	84.71%	79.60%	82.35%	82.59%	92.86%	85.47%	82.76%	68.89%	100.00%	88.16%	70.00%	75.29%		

Narrative
The vacancy fill rate reports the percentage rate of health care professional vacancies band 5 and above with a conditional offer of employment made within 8 weeks of the post being advertised. The rate for December remained at similar level at 84.71% from 84.62% reported in November. This figure is worse than the target of 90%. This figure represents 72 vacancies with a conditional offer made out of 85.

Trust Dashboard Graphs for TRUST

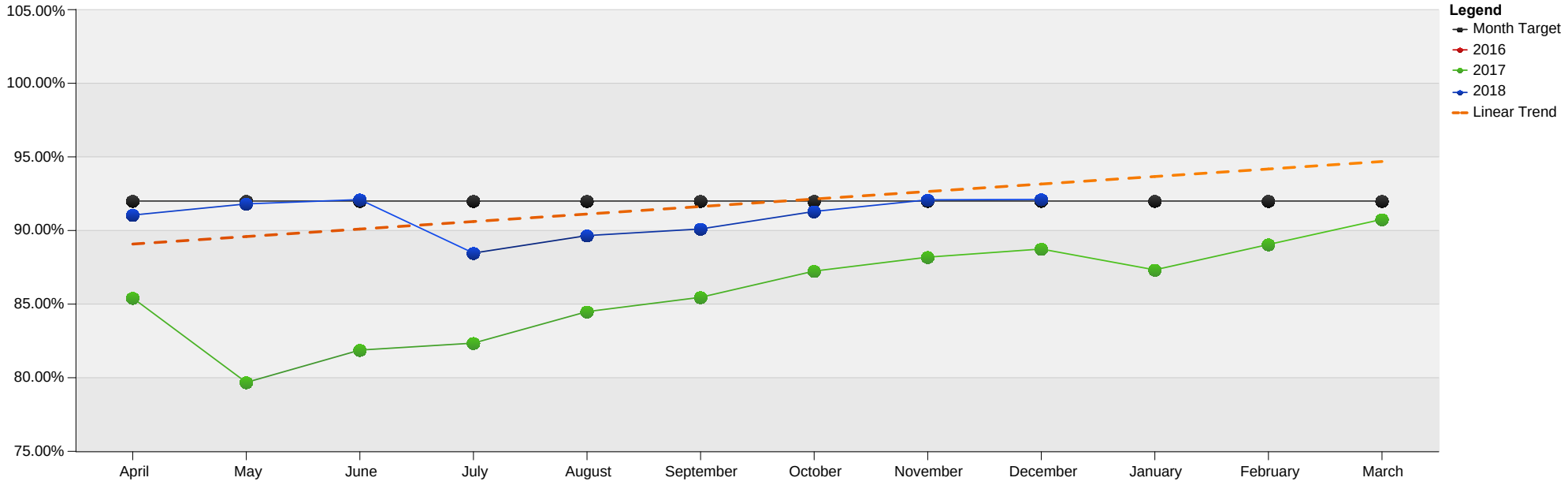


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	92.25%	92.25%	93.41%	93.41%	94.71%	94.71%	85.31%	85.31%	96.47%	96.47%	90.81%	90.81%		

Narrative
The Trust position for December 2018 has decreased slightly to 92.95% which relates to to 531 members of staff out of 5773 that do not have a current appraisal.Only Forensic Services are reporting above target. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels.

Trust Dashboard Graphs for TRUST

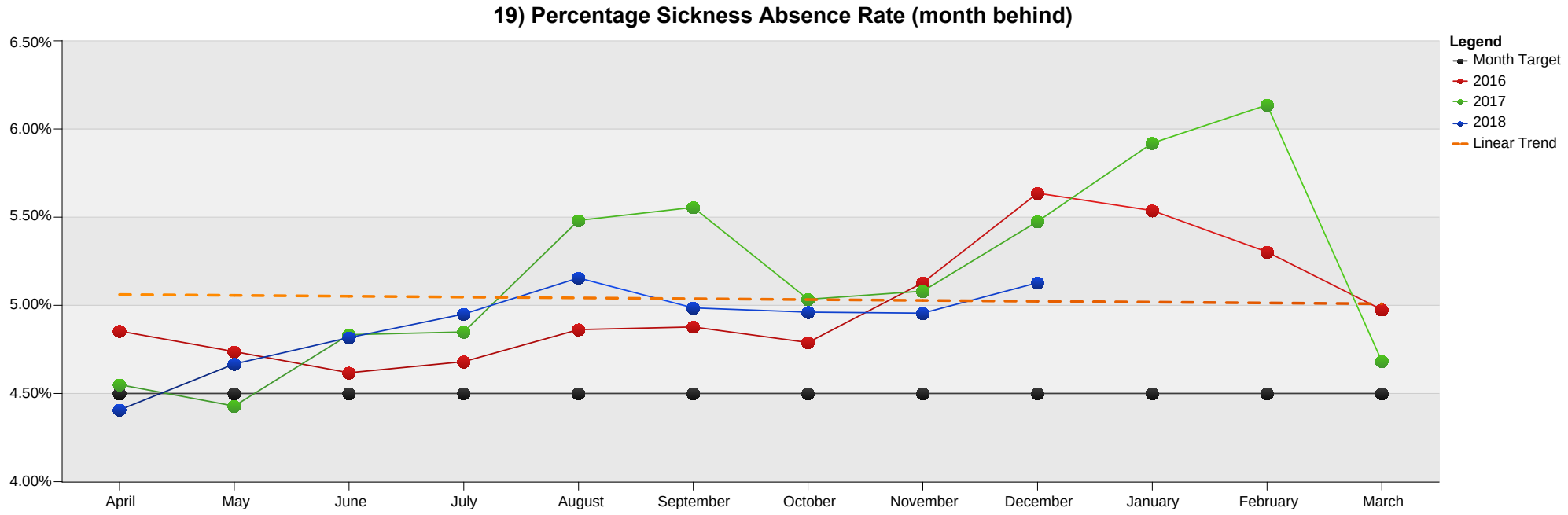
18) Percentage compliance with ALL mandatory and statutory training (snapshot)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.11%	92.11%	90.53%	90.53%	93.37%	93.37%	87.84%	87.84%	95.29%	95.29%	92.26%	92.26%		

Narrative
The position for December 2018 is consistent with November, increasing very slightly to 92.11% from 91.09% and is above target for the second time since June 2018The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh also allows a timelier update of accurate performance information to managers, enabling proactive action to take place.

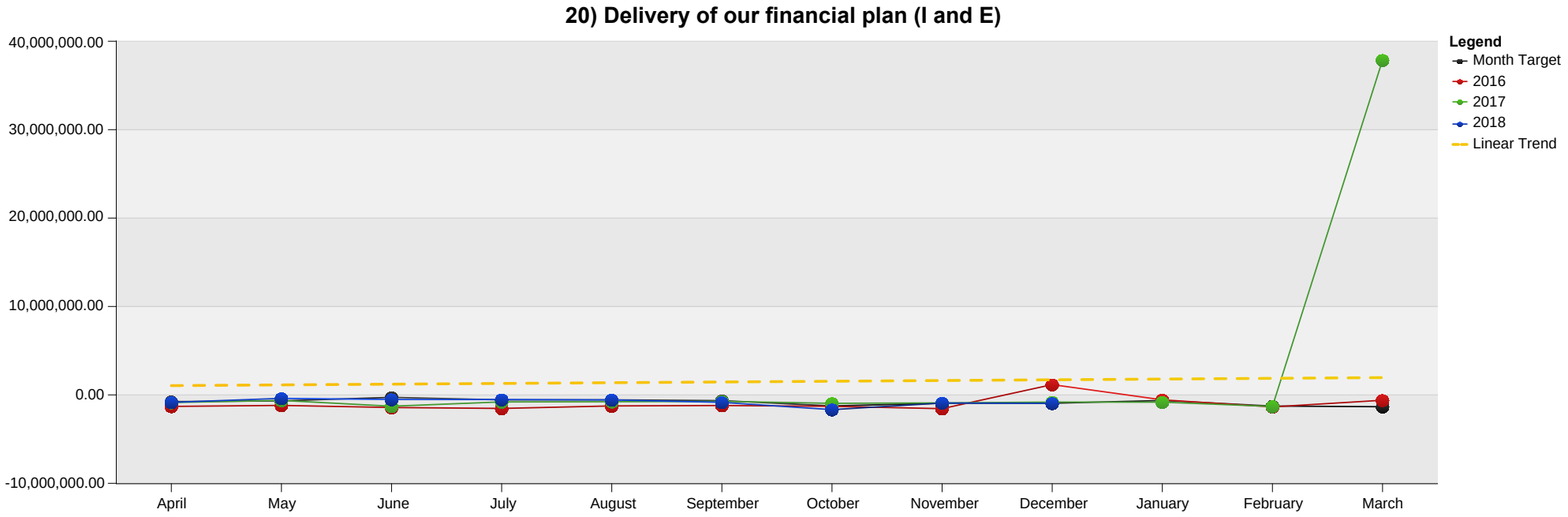
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage Sickness Absence Rate (month behind)	5.13%	4.89%	5.42%	5.45%	4.76%	4.45%	4.70%	4.35%	6.32%	6.27%	5.92%	4.67%		

Narrative
The Trust position reported in December relates to the November sickness level. The Trust position reported in December 2018 of 5.13% is a slight reduction to that reported in November and is not achieving the target 4.50%. A review of the approach to managing sickness absence has recently been concluded with a revised procedure due to be considered by JCC on 15th February. Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 months.

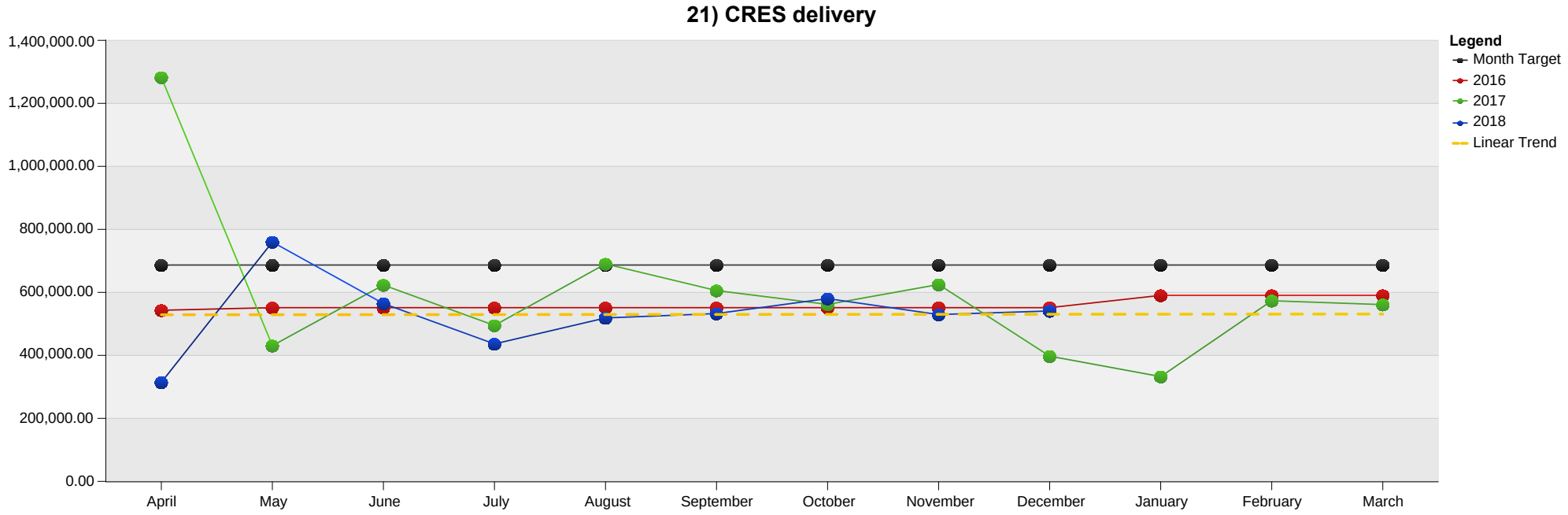
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Delivery of our financial plan (I and E)	-951,358.00	-7,238,991.00	120,753.00	-38,315.00	242,262.00	1,438,830.00	91,399.00	910,182.00	136,297.00	1,215,656.00	-27,834.00	179,009.00		

Narrative
The comprehensive income outturn for the period ending 31 December 2018 is a surplus of £7,239k, representing 2.8% of the Trust's turnover and is £610k ahead of plan.

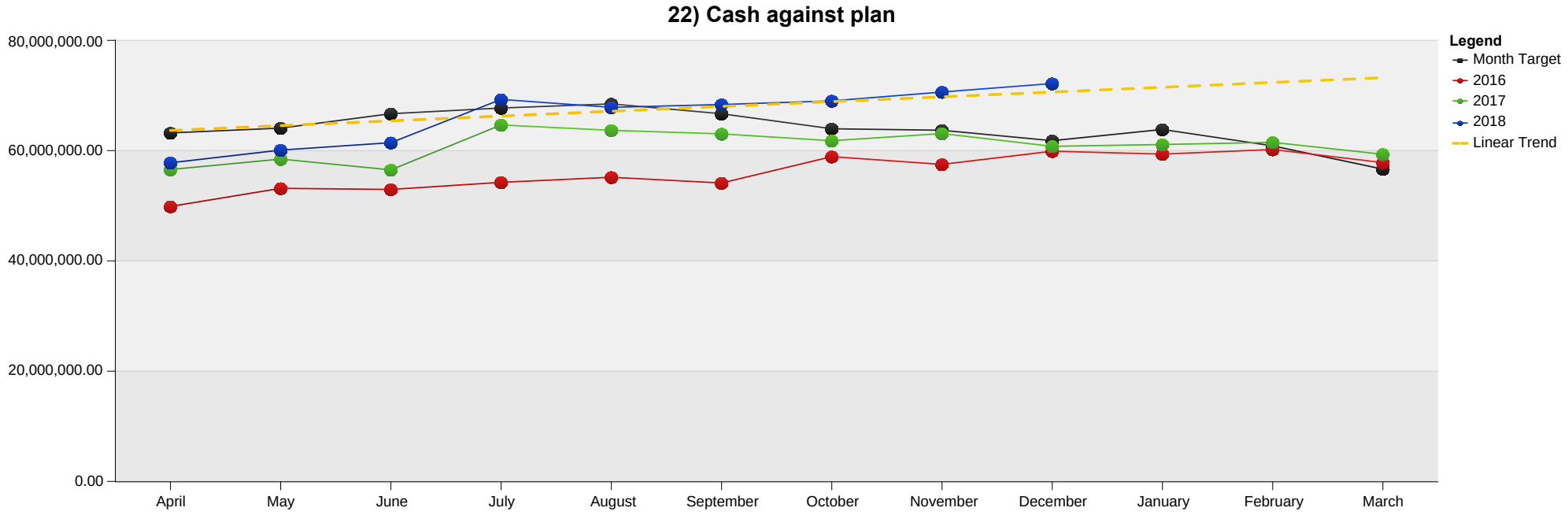
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) CRES delivery	540,953.00	4,777,432.00	85,240.00	767,155.00	53,215.00	387,770.00	14,589.00	131,303.00	18,275.00	164,498.00	78,293.00	704,637.00		

Narrative
Identified Cash Releasing Efficiency Savings at 31 December 2018 is £4,777k and is £1,404k behind plan for the year to date. NHS Improvement has confirmed a reduction in the Trust's annual control total (£1,692k) which is non-recurrently mitigating CRES delivery at month 9 (£1,255k). As a result year to date CRES is £149k behind plan. The Trust continues to identify and develop schemes to ensure the full delivery of the next 3 years CRES requirements.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Cash against plan	72,167,000.00	72,167,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 31 December 2018 is £70,112k, and is £6,255k higher than planned, largely due to working capital variations.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	December 2018														April 2018 To December 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral		88.10%		86.15%		92.53%		76.53%		100.00%		86.41%				87.12%		86.45%		91.86%		75.74%		99.50%		81.40%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		56.96%		54.68%		64.20%		43.89%		93.94%		55.70%				55.74%		53.97%		63.68%		46.16%		91.21%		46.64%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		1,524.00		173.00		688.00		401.00				258.00				1,524.00		173.00		688.00		401.00				258.00		
4) Percentage of patients surveyed reporting their overall experience as excellent or good		89.84%		92.99%		93.01%		89.81%		77.14%		89.04%				91.28%		92.64%		92.30%		92.02%		80.99%		89.47%		
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated		3.11		4.72		2.68		0.00		100.00		1.41				17.49		15.49		12.99		20.07		800.00		18.87		
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		57.84%		54.55%		53.57%		57.14%				76.92%				56.59%		50.20%		60.79%		60.34%				54.26%		
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		71.43%		68.97%		74.07%		75.00%				63.64%				67.50%		64.29%		67.74%		72.94%				61.90%		

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	December 2018														April 2018 To December 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
8) Number of new unique patients referred		6,192.00		1,920.00		2,027.00		1,087.00		456.00		702.00				63,003.00		19,207.00		21,740.00		10,562.00		4,430.00		7,064.00		
9) The number of new unique patients referred with an assessment completed		3,931.00		1,212.00		1,309.00		687.00		338.00		385.00				39,291.00		11,740.00		13,766.00		6,319.00		3,244.00		4,222.00		
10) Number of new unique patients referred and taken on for treatment		1,280.00		418.00		421.00		273.00		19.00		148.00				13,717.00		4,191.00		4,909.00		2,728.00		251.00		1,582.00		
11) Number unique patients referred who received treatment and were discharged		1,982.00		549.00		680.00		410.00		34.00		309.00				20,866.00		6,053.00		7,361.00		4,288.00		387.00		2,777.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		89.28%		88.13%		97.89%		87.78%	NA	NA		81.43%				94.03%		92.29%		101.74%		92.27%	NA	NA		88.96%		
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)		67.00		17.00		15.00		19.00				15.00				67.00		17.00		15.00		19.00				15.00		
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		28.72%		23.53%		32.26%		50.00%				17.65%				23.72%		22.14%		24.29%		24.26%				23.70%		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	December 2018														April 2018 To December 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
15) Actual number of workforce in month (Establishment 95%-100%)		93.37%		93.93%		98.99%		91.52%		92.54%		87.67%				93.37%		93.93%		98.99%		91.52%		92.54%		87.67%		
16) Vacancy fill rate		84.71%		82.35%		92.86%		82.76%		100.00%		70.00%				79.60%		82.59%		85.47%		68.89%		88.16%		75.29%		
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		92.25%		93.41%		94.71%		85.31%		96.47%		90.81%				92.25%		93.41%		94.71%		85.31%		96.47%		90.81%		
18) Percentage compliance with ALL mandatory and statutory training (snapshot)		92.11%		90.53%		93.37%		87.84%		95.29%		92.26%				92.11%		90.53%		93.37%		87.84%		95.29%		92.26%		
19) Percentage Sickness Absence Rate (month behind)		5.13%		5.42%		4.76%		4.70%		6.32%		5.92%				4.89%		5.45%		4.45%		4.35%		6.27%		4.67%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	December 2018														April 2018 To December 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
20) Delivery of our financial plan (I and E)		-951,358.00	NA	120,753.00	NA	242,262.00	NA	91,399.00	NA	136,297.00	NA	-27,834.00				-7,238,991.00	NA	-38,315.00	NA	1,438,830.00	NA	910,182.00	NA	1,215,656.00	NA	179,009.00		
21) CRES delivery		540,953.00		85,240.00		53,215.00		14,589.00		18,275.00		78,293.00				4,777,432.00		767,155.00		387,770.00		131,303.00		164,498.00		704,637.00		
22) Cash against plan		72,167,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA				72,167,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Appendix B

Trust Dashboard 2018/19 KPI Guide

No.	KPI	Target	Definition
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90%	This measures, the number of patients who attend their first appointment in 4 weeks of their referral date out of the total number of people who attend their first appointment following their referral. This KPI has been amended for 2018/19 and the clock will now NOT restart if the patient DNAs or the patient cancels an appointment. This looks at patients with an external referral only. This excludes IAPT patients.
2	Percentage of patients starting “treatment” within 6 weeks of external referral	60%	This measures, the number of people starting treatment within 6 weeks of an external referral against number of people starting treatment. This looks at patients with an external referral only.
3	The total number of inappropriate OAP days over the reporting period (Rolling 3 months)	2,347	This measures, the total number of days patients have spent in an out of area bed inappropriately. In line with national reporting this measures a rolling 3 months’ time frame
4	Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	Within all inpatient and community services, this measures: Of the number of people in the Patient Survey who answered the question: -"Overall how would you rate the care you have received?,” the number of patients who have scored "excellent" or "good".
5	Number of unexpected deaths classed as a serious incident per 10,000 open cases	12	This measure looks at the number of unexpected deaths classed as a serious incident per 10,000 open cases. This mirrors the data that is reported to the National Reporting and Learning System (NRLS)
6	The % teams achieving the agreed improvement benchmarks for HoNOS total score	67.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total HoNOS scores are compared from the first rating against the last. A reduction in total HoNOS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 40% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are

Appendix B

Trust Dashboard 2018/19 KPI Guide

No.	KPI	Target	Definition
			transferred to a different In Scope team.
7	The % teams achieving the agreed improvement benchmarks for SWEMWBS	78.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total SWEMWBS scores are compared from the first rating against the last. An increase in SWEMWBS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 50% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.
8	Number of new unique patients referred	N/A	This measure relates to the number of new individual patients referred (so a patient is only counted once and not open to any other team in the Trust). This excludes IAPT patients.
9	The number of new unique patients referred with an assessment completed	N/A	This measure relates to the number of new unique patients with an assessment completed (and is a subset of measure 8).
10	Number of new unique patients referred and taken on for treatment	N/A	This measure relates to the number of new unique patients referred, assessed and then taken on for treatment (and is a subset of measure 9).
11	Number unique patients referred who received treatment and were discharged	N/A	This measure relates to the number of new unique patients referred who were taken on for treatment and then discharged.
12	Bed Occupancy (AMH & MHSOP A & T Wards)	85%	This measures the number of days beds that are occupied out of the number of possible bed days available. (The calculation is on the number of beds available and the days in the month). This looks at AMH and MHSOP Assessment and Treatment wards only
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards (Snapshot)	68	This measures the number of patients occupying a bed with a length of stay longer than 90 days from the day they were admitted. This looks at AMH and MHSOP Assessment and Treatment wards only

Appendix B

Trust Dashboard 2018/19 KPI Guide

No.	KPI	Target	Definition
14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	23.93%	This measures the number of patients who are readmitted onto a ward within 30 days of their last discharge. This looks at AMH and MHSOP Assessment and Treatment wards only
15	Actual number of workforce in month	95%	This measures the total number of contracted staff against the number of budgeted staff.
16	Vacancy fill rate	90%	This measures the number of vacancies where an offer of employment has been made out of the number of vacancies that are being recruited to. There are vacancies that have been advertised and not filled due to no applicants or no one shortlisted, however from a recruitment vacancy perspective are closed off as an episode – These are not included in the figures as they do not go over the 8 week time frame. This looks at posts that have been vacant longer than 8 weeks. This KPI will exclude bank staff and only include professional health care posts of Band 5 and above
17	Percentage of staff in post more than 12 months with a current appraisal	95%	This measures the number of staff in post more than 12 months and of those how many have a current appraisal. For medical staff this is monitored against 13 months.
18	Percentage compliance with ALL mandatory and statutory training	92%	This measures the total number of courses completed by each member of staff for ALL mandatory and statutory training out of the number of courses due to be completed for each member of staff
19	Percentage Sickness Absence Rate	4.50%	This measures the number of days lost to sickness out of the number of days within the month
20	Delivery of our financial plan (I&E)	6,864,000	This shows the Trusts surplus or deficit position (£). The target is the planned surplus position.
21	CRES delivery	8,241,384	This shows the CRES Identified against the planned amount
22	Cash against plan	56,640	This shows the actual cash held by the Trust against the amount of cash forecasted to be held

App C Number of unexpected deaths and verdicts from the Coroner April 2018 - March 2019

	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	
Total	22	11	14	6	12	1	0	0	0	0	3	0	3	0	0	9	8	1	3	2	95

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
10	4	14	15	7	8	8	9	15	5		

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
35	19	18	9	14

Number of unexpected deaths and verdicts from the Coroner April 2017 - March 2018

	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	
Total	17	14	19	4	7	1	3	0	0	0	1	1	0	0	0	9	2	8	2	4	92

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	3	1	7	11	5	11	10	10	10	10	10

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
28	20	27	6	11

Appendix D

		Data Source					Data Reliability					KPI Construct/Definition					KPI amended/ Tested	KPI requires testing - programmed test date	Total Score	Percentage	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Y/N				
1	Pergentage of patients who were seen within 4 weeks for a first appointment following an external referral	5					5					5					Y		15	**100%**	
3	Total number of inappropriate OAP days over the reporting period (rolling 3 months)		4				5					5					Y		14	**93%**	Data is extracted electronically, validated manually and reuploaded into the system. Work is underway to amend PARIS to enable this to be recrrded completely on the system.
4	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					Y		12	**80%**	Patient and carer experience feedback is managed by the PaCE Team supported by the Meridian system, provided by an external provider; Optimum Contact. The system was implemented trust-wide on 1 April 2017. Data is collected via electronic devices for inpatient areas, on paper surveys for community teams as well as via kiosks in team bases where there are large footfalls. There is also a phone Application now where clinicians can send the survey to patients and carers phones via email or SMS. The Data Quality Team access the system to generate reports.
5	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					Not required - manual return		14	**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
6	The percentage of teams achieving the agreed improvement benchmarks for HoNOS total score		4					4				5					Y		13	**87%**	Data is extracted electronically and then processed manually. Work is underway with the services to ensure the data recorded on PARIS is accurate and this will improve data reliability.
7	The percentage of teams achieving the agreed improvement benchmarks for SWEMWBS total score		4					4				5					Y		13	**87%**	Data is extracted electronically and then processed manually. Work is underway with the services to ensure the data recorded on PARIS is accurate and this will improve data reliability.
12	Bed Occupancy (AMH & MHSOP A&T wards)	5					5					5					Y		15	**100%**	
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards)	5					5					5					Y		15	**100%**	
14	Percentage of patients readmitted to Assesement and treatment wards within 30 days	5					5					5					Y		15	**100%**	

Appendix D

		Data Source					Data Reliability					KPI Construct/Definition					KPI amended/ Tested	KPI requires testing - programmed test date	Total Score	**Percentage**	Notes
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15	Actual number of workforce in month		4				5					5					Y		14	**93%**	Data extracted elecronically but processed manually
16	Vacancy Fill rate				2		5					5					Not required - manual return		12	**80%**	Data recorded on the recruitment tracker database and manually uploaded into the system
17	Percentage of staff in post more than 12 months with a current appraisal	5						4				5					Y		14	**93%**	Issues with appraisal dates being entered to ESR have lessened considerably. Compliance levels are effectively being monitored via monthly Huddle meetings. There feels to be greater confidence in the data being reported through IIC.
18	Percentage compliance with ALL mandatory and statutory training	5						4				5					Y		14	**93%**	Issues with training compliance figures being reported have lessened - there appears to be greater confidence in the data being reported.
19	Percentage Sickness Absence Rate (month behind)	5						4				5					N	To be agreed in Managing Business Sub group	14	**93%**	Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR. There are some data quality issues concerned with failing to end sickness in a timely manner– this is picked up and monitored through sickness absence audits that the Operational HR team undertake.
20	Delivery of our financial plan (I and E)		4				5					5					Not required - manual return		14	**93%**	Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	CRES Delivery				2		5					5					Not required - manual return		12	**80%**	Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
22	Cash against plan		4				5					5					Not required - manual return		14	**93%**	An extract is taken from the system then processed manually to obtain actual performance.

Appendix D

		Data Source					Data Reliability					KPI Construct/Definition					KPI amended/ Tested	KPI requires testing - programmed test date	Total Score	Percentage	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
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ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th January 2019**
TITLE:	**Single Oversight Framework**
REPORT OF:	**Phil Bellas, Trust Secretary & Sharon Pickering, Director of Planning, Performance and Communications**
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:

The Single Oversight Framework (SOF) sets out NHS Improvement's approach to identifying the potential support needs of providers as they emerge.

The purpose of this report is to examine the Trust's position against the requirements of the SOF at the end of Quarter 3, 2018/19.

Overall, the report provides assurance, to the extent that information is available, that the Trust's segment 1 (maximum autonomy) rating should be maintained.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**29th January 2019**
TITLE:	**Single Oversight Framework**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to examine the Trust's position against NHS Improvement's (NHSI) Single Oversight Framework (SOF) at the end of Quarter 3, 2018/19.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The SOF (latest version published in November 2017) sets out NHSI's approach to overseeing NHS Trusts/Foundation Trusts and seeks to enable the regulator to identify where providers may benefit from, or require, improvement support.

2.2 NHSI uses a range of information across the following five themes: quality of care; finance and use of resources; operational performance; strategic change; and leadership and improvement capability.

2.3 Providers are placed in segments ranging from 1 (maximum autonomy) to 4 (special measures) based on NHSI's judgement of the seriousness and complexity of the issues they face.

2.4 The Trust has been placed in segment 1 since the introduction of the SOF.

2.5 In previous reports the Board has noted that:

(a) The Trust's position is a significant achievement in comparison to other local mental health providers.

(b) Although the Trust undertakes internal monitoring against the quality of care and operational performance metrics this is hampered by a number of issues principally related to the regulator's use of national data sources.

2.6 The Board is asked to note that the next Quarterly Review Meeting with NHSI is due to be held on 8th February 2019 and, therefore, feedback from the regulator will not be available for the Board meeting.

3. KEY ISSUES:

3.1 The following sections explore the Trust's position against the triggers used by NHSI for determining support to be provided under the SOF and seek to highlight any risks to the maintenance of the segment 1 position.

3.2 Changes to the segmentation of providers are not automatic if a trigger occurs. NHSI takes into account a provider's circumstances in determining the nature and extent of any support required.

Quality of Care

Triggers
▪ CQC 'inadequate' or 'requires improvement' assessment in overall rating, or against any of the safe, effective, caring or responsive key question ▪ CQC warning notices ▪ Other material concerns identified or relevant to CQC monitoring processes e.g. civil or criminal cases raised, whistleblowers etc. ▪ Concerns arising from trends in quality indicators ▪ Delivery against an agreed trajectory for the four priority standards for 7-day hospital services ▪ Any other material concerns about a provider's quality of care arising from intelligence gathered by or provided to NHSI

3.3 The Trust's position on the quality indicators is provided in Annex 1 to this report.

3.4 The Board is asked to note that:

(a) The Trust's segmentation reflects its "good" CQC rating. This rating was reaffirmed in October 2018.

(b) The Trust's overall ratings for the five themes assessed by the CQC (safe, effective, caring, responsive, well-led) have not changed following the inspection in 2018.

(c) There are no trends on the quality indicators which raise concerns at the present time.

(d) No CQC warning notices have been received since the last report.

(e) Plans to extend relevant services to meet 24/7 requirements are included in the Trust's Business Plan.

(f) There are no known exceptions to bring to the Board's attention.

Finance and Use of Resources

3.5 The Finance Report (agenda item 12) provides a summary of the Trust's position against the Use of Resources theme.

3.6 The report highlights that agency expenditure (at December 2018) was 56% higher than the capped target and rated as a 4 (the lowest rating category).

3.7 The Board is asked to note that the EMT has agreed to implement a formal Trust programme to address the breaching of the agency cap. The process is being led by Right Staffing with a programme manager leading a 10 week diagnostic based upon the NHS Improvement agency reduction model. Actions are being implemented during the diagnostic period to test if they will reduce agency spend e.g. weekly payroll for all bank staff from March 2019.

(See also paragraph 3.11 below)

Operational Performance

Triggers
▪ Failure to meet the trajectory for a metric for at least two consecutive months (quarterly for quarterly metrics) ▪ Other factors (eg a significant deterioration in a single month or multiple potential support

needs across standards and/or other themes) indicate NHSI needs to get involved before two months have elapsed ▪ Any other material concerns about a providers' operational performance arising from intelligence gathered by or provided to NHS Improvement

3.7 The Trust's position on the operational performance metrics is provided in Annex 2 to this report.

3.8 The Board is asked to note that, from the data available, there were no breaches of the targets at a Trustwide level during the reporting period.

Strategic Change

Triggers
Material concerns with a provider's delivery against the *local* transformation agenda, including new care models and devolution

3.9 Whilst there is a lack of clarity in the SOF on the assessment and application of the triggers under this theme, the Board will be aware that the Trust continues to engage positively with the local transformation agenda.

Leadership and Improvement Capability (Well-led)

Triggers
▪ CQC 'inadequate' or 'requires improvement' assessment against 'well-led'. ▪ Concerns arising from trends in the organisational health indicators ▪ Other material concerns about a provider's governance, leadership and improvement capability, arising from third-party reports, developmental well-led reviews or other relevant sources

3.10 The Trust's position on the organisational health metrics is provided in Annex 3 to this report.

3.11 In relation to this theme:

(a) The Trust's overall well-led rating, provided by the CQC, remained as "good" following the inspection in July 2018.

(b) No material issues were identified during the external governance review in 2017.

(c) Further to paragraph 3.4 above, the data provided in Annex 3 highlights the continuing high proportion of temporary staff used by the Trust.

(d) NHSI has been informed about the arrangements for the appointment of the new Chairman of the Trust.

(e) No issues have been raised by third parties (e.g. Healthwatch, HSE, complaints, whistleblowers, medical royal colleges) which suggest governance concerns in the Trust.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** There are no direct CQC implications arising from this report; however NHSI's aim is to help providers attain and maintain CQC ratings of "good" or "outstanding".

4.2 **Financial/Value for Money:** Assessments of the Trust's position against the SOF's theme of finance and use of resources are provided in the Finance Reports.

4.3 **Legal and Constitutional (including the NHS Constitution):** The legal basis for enforcement action in relation to NHS Foundation Trusts remains unchanged. This means that, for example, a Foundation Trust will only be in segments 3 or 4 where it has been found to have been in breach or suspected breach of its licence.

4.4 **Equality and Diversity:** Information on delivering Workforce Race Equality Standards (WRES) will be used as part of assessments under the Leadership and improvement capability theme; however, no further information on this matter is included in the SOF.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 The key risk identified relates to the position on temporary staffing.

5.2 In-quarter risks to the Trust's segmentation under the SOF continue to be reported in the monthly Performance Dashboard reports.

6. CONCLUSIONS:

6.1 Overall, the Trust should expect to maintain its segment 1 position for Quarter 3, 2018/19; however, close monitoring by NHSI is expected to continue.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary
Ashleigh Lyons, Corporate Performance Manager

Background Papers:
Single Oversight Framework published by NHS Improvement in November 2017

SINGLE OVERSIGHT SCORECARD - QUALITY INDICATORS - 2018/19

All Providers																	
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Written compliants - rate	NHS Digital	N/A	Q	N/A			9.49			12.10							Last published data September 2018
Staff and Friends and Family test % recommended - care	NHSE	Trust assessment	Q	N/A			86.59%			88.34%			87.19%				
		N/A	Q	N/A			70.17%			70.30%							Last published data September 2018
Occurrence of Never Event	NHS Improvement	Governance - verified	M	N/A	0	0	0	0	0	0	0	0					Data published up to 30 November 2018
NHS England/NHS Improvement Patient Safety Alerts outstanding	NHS Improvement	Governance - verified	M	N/A	0	0	0	0	0	0	0	0					Data published up to 04 December 2018
Mental Health Providers																	
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
CQC inpatient/mental health and community survey	CQC	N/A	A	N/A													Trusts are no longer provided with an overall score and are rated as Better, About the Same or Worse on a range of questions in eleven categories. Our Trust scored 'About the Same' in every category for 2018.
Mental Health scores from Friends and Family Test - % positive	NHSE	N/A	M	N/A	87.58%	87.75%	84.83%	88.48%	88.19%	88.40%	88.01%						Latest published data October 2018
Admissions to adult facilities of patients who are under 16 years old	NHS Digital	Trust assessment	M	N/A	0	0	0	0	0	0	0	0	0				
		N/A	M	N/A													No public data available
Quality Indicators	**SOF Source**	**Other known source**	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Proportion of discharges from hospital followed up within 7 days (all discharges treated as being on CPA)		Trust assessment - pre validated IIC	M	95%	**98.54%**	**97.07%**	**97.52%**	**96.18%**	**97.13%**	**96.31%**	**95.42%**	**96.37%**	**95.22%**				Pre-validated position is reported direct from the IIC
		Trust assessment - post validated IIC			**98.54%**	**97.07%**	**98.57%**	**96.53%**	**97.49%**	**96.31%**	**96.11%**	**97.18%**	**96.17%**				Post validated position stated is from our intenal files which are used to provide the UNIFY submission.
		UNIFY	Q		**98.16%**			**97.43%**									Latest published data as at 30th September 2018
% clients in settled accommodation	NHS Digital	Trust assessment	M	N/A			82.95%	83.42%	83.37%	82.93%	82.58%	82.58%					Latest data based on the primary MHSDS submission for November 2018
		NHS Digital	M	N/A	82.54%	82.63%	83.13%	83.79%	83.46%	82.95%							Latest published data September 2018
% clients in employment	NHS Digital	Trust assessment	M	N/A			14.34%	14.53%	14.81%	15.02%	15.04%	15.03%					Latest data based on the primary MHSDS submission for November 2018
		NHS Digital	M	N/A	13.86%	14.20%	14.30%	14.47%	14.71%	14.85%							Latest published data September 2018
Potential under-reporting of patient safety incidents	NHS England Dashboard	N/A	M	N/A													No data is published to reflect 'under-reporting'. Published data reports the Incidents reported between 01 October 2017 and 31 March 2018 reports 8134 incidents submitted to the NRLS.

SINGLE OVERSIGHT SCORECARD - OPERATIONAL PERFORMANCE METRICS - 2018/19

Mental Health Providers																				
Operational Performance Metrics	**SOF Identified source**	**Other Identified Source**	Freq.	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral	UNIFY2 and MHSDS	Trust assessment	Q	53%	**57.14%**	**48.84%**	**72.41%**	**63.41%**	**60.00%**	**70.83%**	**75.61%**	**67.24%**	**62.50%**				**61.03%**	**64.75%**	**68.35%**		
		NHS Digital	Q		**57.14%**	**48.84%**	**71.93%**	**63.41%**	**59.18%**								**60.74%**	**64.23%**			Last published data October 2018
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **inpatient wards**	Board declaration but can be triangulated with results of CQUIN audit	Trust assessment	Q	90%	Data for 2018/19 has been collated and sent to the NCAP Team. A sample will be generated and then returned to us for internal analysis and national submission in Quarter 3																2018/19 data yet to be submitted 2017/18 Data was submitted to National Clinical Audit of Pschosis (NCAP) **December 17**. Internal analysis indicated **92.50%**.
		National assessment			National data not available until Quarter 4																2017/18 Audit results as assessed by the Royal College of Psychiatry's 2017/18 Centre for Quality Improvement report **94.90%**.
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **early intervention in psychosis services**		Trust assessment	Q	90%	Data for 2018/19 has been collated and sent to the NCAP Team. A sample will be generated and then returned to us for internal analysis and national submission in Quarter 3								**91.55%**						**91.55%**		2018/19 data was submitted during Quarter 3
		National assessment			National data not available until Quarter 4																2017/18 Audit results as assessed by the Royal College of Psychiatry's 2018/19 Centre for Quality Improvement report are not yet published
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **community mental health services (people on CPA)**		Trust assessment	Q	65%	Data for 2018/19 has been collated and sent to the NCAP Team. A sample will be generated and then returned to us for internal analysis and national submission in Quarter 3																2018/19 data yet to be submitted 2017/18 Data was submitted to National Clinical Audit of Pschosis (NCAP) **December 17**. Internal analysis indicated **74.39%**.
		National assessment			National data not available until Quarter 4																2017/18 Audit results as assessed by the Royal College of Psychiatry's 2017/18 Centre for Quality Improvement report **74.40%**.
IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	IAPT minimum dataset	Trust assessment	M	50%	**51.48%**	**52.52%**	**51.77%**	**47.29%**	**51.86%**	**51.08%**	**51.06%**	**52.44%**	**50.50%**				**51.93%**	**50.08%**	**51.43%**		
		PAVE Reports	Q		**51.29%**	**52.76%**	**51.43%**	**49.12%**	**51.76%**	**50.67%**	**50.93%**						**51.31%**	**50.80%**			Latest PAVE data October 2018
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 6 weeks**	IAPT minimum dataset	Trust assessment	M	75%	**99.49%**	**98.99%**	**99.04%**	**99.35%**	**98.81%**	**97.95%**	**98.16%**	**96.48%**	**95.05%**				**99.17%**	**98.74%**	**96.68%**		
		PAVE Reports	Q		**99.43%**	**98.87%**	**99.05%**	**98.62%**	**96.71%**	**85.88%**	**90.62%**						**99.12%**	**92.76%**			Latest PAVE data October 2018
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 18 weeks**	IAPT minimum dataset	Trust assessment	M	95%	**99.77%**	**100.00%**	**99.83%**	**100.00%**	**100.00%**	**100.00%**	**99.85%**	**100.00%**	**100.00%**				**99.87%**	**100.00%**	**99.95%**		
		PAVE Reports	Q		**99.72%**	**100.00%**	**99.83%**	**100.00%**	**99.95%**	**100.00%**	**99.95%**						**99.85%**	**99.98%**			Latest PAVE data October 2018
Data Quality Maturity Index (DQMI) – Mental Health Services Data Set Data Score	MHSDS	N/A	M	95			**95.5**										**95.5**				Latest published data Quarter 1 2018/19
Inappropriate out of area placements for adult mental health services	MHSDS	Trust assessment	M	2326	**2007**	**2085**	**2188**	**2236**	**2236**	**2080**	**2002**	**1669**	**1524**				**2188**	**2080**	**1524**		
		NHS Digital	M	N/A	1945	2040	2195	2180	2215	2055							2195	2055			Latest published data September 2018

SINGLE OVERSIGHT SCORECARD - Organisational Health- 2018/19

All Providers																	
Quality Indicators	**SOF Source**	**Other known**	**Freq.**	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Comments**
Staff Sickness	NHS Digital	Trust assessment (month behind)	M	N/A	4.41%	4.67%	4.82%	4.95%	5.16%	4.99%	4.96%	4.96%	5.13%				IIC reporting a month behind
		Finance Return	M & Q	N/A	4.62%	3.94%	5.17%	5.18%	5.18%	4.72%	4.82%	4.43%	4.19%				Finance Return to NHS Improvement - not required to report in April. All other figures are a month behind
		N/A	M & Q	N/A	4.68%	4.77%	4.90%	5.12%	4.91%								Last published data August 2018
Staff turnover (Finance Return)	NHS Digital	Finance Return	M & Q	N/A	0.85%	0.58%	1.00%	0.97%	0.97%	0.75%	0.74%	0.71%	0.65%				All figures are a month behind
NHS Staff survey	CQC	N/A	A	N/A													
Proportion of temporary staff	Provider Return	N/A	Q	N/A	2.65%	2.79%	2.81%	3.02%	3.06%	3.20%	3.27%	3.36%	3.42%				Finance Return to NHS Improvement

ITEM NO.15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29 January 2019**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

- 3 policies and 1 procedure that have undergone full review and require ratification:
  - MHA-0004-v8.1Associate Hospital Managers Policy
  - HR-0013-v8 Human Rights and Equality & Diversity Policy
  - PHARM-0001-v8.3 NMP Policy to Practice
  - HS-0001-014-v2 Suicide Prevention Survey Procedure

- 2 policies that have had the review date extended:
  - IA-0002-v6.1 CPA – The Care Programme Approach and Standard Care
  - IT-0006-v5 Email Policy

- 1 policy that is to be removed:
  - IPC-0001-010-v2 New and Refurbished Buildings Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meetings held on 12 December 2018 and 09 January 2019.

DATE:	**29 January 2019**
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.

2.3 Each policy 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 policies have undergone full review and require ratification:

Ref and Title	MHA-0004-v8.1 Associate Hospital Managers Policy
Review date	12 December 2021
Description of change	Change to job title and logo updated. Training Needs Analysis and monitoring sections updated.

Ref and Title	HR-0013-v8 Human Rights and Equality & Diversity Policy
Review date	23 January 2020
Description of change	This policy undergoes annual review as a requirement of the Code of Practice: Mental Health Act 1983. The policy has been reviewed but does not require change, so is to

	be re-ratified for a further 12 months.

Ref and Title	PHARM-0001-v8.3 NMP Policy to Practice
Review date	02 November 2019
Description of change	This policy has been reviewed and the following amendments made: • An increase in CPD time for each NMP • NMP's attendance at medics training including weekly sessions. • Job plans where possible for NMPs • Annual declaration within ESR • Technology usage for mixed supervision model i.e. skype. • Local supervision groups where appropriate for adult and LD specialties. • Level 3 application process updated.

Ref and Title	HS-0001-014-v2 Suicide Prevention Survey Procedure
Review date	09 January 2022
Description of change	The procedure has been amended as a requirement of a health and safety bulletin. Amendment to process to remove sentence in guidance section 'ligature points below 1 meter to be a managed risk'.

3.2 The following has had the review date extended:

Ref and Title	IA-0002-v6.1 CPA – The Care Programme Approach and Standard Care
Review date	06 April 2020
Description of change	The Care Programme Approach, and what this means to people accessing and working in our services, is currently under review following a year of establishing a local baseline position via audit, focus groups and discussions with those involved in this approach. It is highly likely that there are going to be significant changes made to the systems that support the CPA (i.e. CITO developments and the potential to use other technical solutions) and there will be training and development packages that must be created and rolled out. There is also a pressing need to use CPA to operationalise the principles and values that underpin recovery and wellbeing. Therefore, whilst the current policy remains applicable to services as they are now, it should remain in use to allow time for a new policy

	to be developed alongside the aforementioned highly likely and significant changes.

Ref and Title	IT-0006-v5 Email Policy
Review date	01 April 2019
Description of change	A number of secure email addresses that are currently in use by local authorities will be withdrawn from 31 March 2019 (those ending in .gcsx.gov.uk, .gsx.gov.uk, .gsi.gov.uk and .gse.gov.uk). Some local authorities/partner organisations have not yet confirmed which solution they will use as an alternative. This policy is requested to be extended until this fact finding is completed and advice can be included as to how to communicate securely with third parties.

3.3 The following has been withdrawn:

Ref and Title	IPC-0001-010-v2 New and Refurbished Buildings Policy
Reason for withdrawal	The information has been duplicated in a policy managed by Estates and Facilities.

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 12 December 2018 and 09 January 2019 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